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December 20, 2021

BY HAND DELIVERY
The Honorable Timothy Kelley
19th Judicial District Court, East Baton Rouge Parish
300 North Boulevard, 10th Floor, Room 10D
Baton Rouge, Louisiana 70801

Re: James J. Donelon, *et al.* vs. Jessica K. Altman *et al.*
Suit No. 713794

Dear Judge Kelley:

Enclosed is the original prehearing memorandum of the Commissioner of Insurance and Louisiana Department of Insurance as required by the scheduling order in this matter.

Respectfully,

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NINETEENTH JUDICIAL DISTRICT COURT
PARISH OF EAST BATON ROUGE
STATE OF LOUISIANA

JAMES J. DONELON IN HIS OFFICIAL CAPACITY AS COMMISSIONER OF INSURANCE FOR THE STATE OF LOUISIANA AND THE LOUISIANA DEPARTMENT OF INSURANCE	**NUMBER: 713794**
	SECTION: 22

Plaintiff

VERSUS

JESSICA K. ALTMAN, IN HER CAPACITY AS STATUTORY REHABILITATOR OF SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA, *AND* SENIOR HEALT INSURANCE COMPANY OF PENNSYLVANIA, IN REHABILITATION

Defendant

MEMORANDUM OF JAMES J. DONELON IN HIS OFFICIAL CAPACITY AS COMMISSIONER OF INSURANCE FOR THE STATE OF LOUISIANA AND THE LOUISIANA DEPARTMENT OF INSURANCE IN SUPPORT OF PAYER FOR ISSUANCE OF A PRELIMINARY INJUNCTION PURSUANT TO COUNT 1 OF PETITION

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INTRODUCTION

James J. Donelon, in his official capacity as Commissioner of Insurance for the State of Louisiana (Commissioner) and the Louisiana Department of Insurance (LDI), file their prehearing memorandum in support of Count 1 of the petition in this matter requesting entry of a preliminary prohibitory injunction against Defendants Senior Health Insurance Company of Pennsylvania (SHIP) and Jessica K. Altman, Insurance Commissioner of the Commonwealth of Pennsylvania, in her capacity as statutory Rehabilitator (Rehabilitator) of SHIP.

Issuance of the injunction is necessary in order to prevent Defendants' violation of Louisiana law and the constitutional and statutory obligation of the Commissioner and LDI to regulate insurance premium rates for Louisiana citizens. The SHIP plan disregards the long-standing state-based system for approval of insurance rates and instead imposes rates on Louisiana policyholders set by the Rehabilitator and approved by the Pennsylvania Insurance Department and the Commonwealth Court, neither of which have any authority over premium rates for SHIP policies issued in Louisiana. The decision of this Court presents a question of first impression nationwide. The Commissioner and LDI are not aware of any plan of rehabilitation, either in Pennsylvania or in any other jurisdiction, that has purported to supersede State rate regulation and set rates payable by policyholders in other jurisdictions without review and approval by the insurance regulators of and in violation of the laws of those jurisdictions.

1. STANDARD FOR ISSUANCE OF PRELIMINARY INJUNCTION

In Louisiana, an "injunction shall be issued in cases where irreparable injury, loss, or damage may otherwise result to the applicant..." La. Code Civ. P. art. 3601(A). A preliminary injunction is an interlocutory procedural device that preserves the status quo between the parties before a trial.[1] It is an extraordinary remedy.[2] To obtain a preliminary injunction, the mover must show that it will likely prevail on the merits and irreparable injury, loss, or damage will result without the injunction.[3] The court should also consider whether the threatened harm to the plaintiff outweighs the potential for harm to the defendant and whether the preliminary injunction will disserve the public interest.[4]

However, absence of irreparable injury need not be shown when the act sought to be enjoined is unlawful as in this case.[5] The Rehabilitator and the Commonwealth Court of Pennsylvania has no authority to set premium rates for SHIP policyholders in Louisiana in disregard of Louisiana law. The Commissioner and LDI have the exclusive authority to regulate the insurance industry in Louisiana. Plaintiffs are entitled to a preliminary injunction because they are likely to prevail on the merits and Defendants cannot prove any demonstrable harm from the issuance of a narrowly tailored injunction limited to policies issued only in Louisiana.

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[1] *Stevens v. St. Tammany Par. Gov't*, 16-0197, p. 4 (La. App. 1 Cir. 1/18/17), 212 So. 3d 562, 565.

[2] *Concerned Citizens for Proper Planning, LLC v. Par. of Tangipahoa*, 04-0270, p. 5 (La. App. 1 Cir. 3/24/05), 906 So. 2d 660, 664.

[3] *See Ard v. GrrlSpot, LLC*, 19-0312, p. 14 (La. App. 4 Cir. 10/23/19), 2019 WL 5432098, at *6; *Stevens, supra*, 212 So. 3d at 565.

[4] *Piazza's Seafood World, LLC v. Odom*, 07-2191, p. 10 (La. App. 1 Cir. 12/23/08), 6 So. 3d 820, 826.

[5] *Dale v. La. Sec'y of State*, 07-2020, p. 4 (La. App. 1 Cir. 10/11/07), 971 So. 2d 1136, 1141; *Concerned Citizens*, *supra,* 906 So. 2d at 664; *Piazza's*, *supra,* 6 So. 3d at 826. Even if the absence of irreparable injury was a requirement the Defendants will not suffer any injury due to the limited scope of the injunction sought and the inconsequential monetary effect (if any) on the rehabilitation proceeding.

2. SHIP'S INSOLVENCY AND REHABILITATION PROCEEDING

SHIP was an operating company that issued long-term care (LTC) policies[6] in forty-six states and additional jurisdictions. As of September 30, 2021 SHIP reported that it had approximately 35,000 policies in force.[7]

According to SHIP's 2018 Annual Statement, SHIP is licensed in every state except Connecticut, New York, Rhode Island, and Vermont, and is also licensed in the District of Columbia and the U.S. Virgin Islands. Prior to the filing of the rehabilitation, SHIP's business consisted exclusively of closed blocks of LTC policies including more than 70 distinct policy forms with many state variations for each form. SHIP's policy forms include home health care, nursing home, and comprehensive plans. About 275 SHIP policies are in force in Louisiana.[8] Upon information and belief, the average age of SHIP's Louisiana policyholders is over 86 years. Total premiums paid by SHIP's Louisiana policyholders amounts to about one-half of one percent of SHIP's total premium revenue.

On January 29, 2020, upon the application[9] of the Rehabilitator, the Commonwealth Court of Pennsylvania, in suit number 1 SHP 2020 (the Rehabilitation Proceeding), entered an Order[10] of Rehabilitation placing SHIP into rehabilitation in accordance with the provisions of Pennsylvania law. The Order of Rehabilitation appointed

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[6] LTC insurance is designed to cover long-term services and support for individuals, including personal and custodial care in a variety of settings such as a person's home, community organization, or other facility. LTC policies reimburse policyholders a daily amount (up to a pre-selected limit) for services to assist them with activities of daily living such as bathing, dressing, or eating. The policyholder can select a menu or range of care options and benefits. The cost of an LTC policy is based on a number of factors, including the insured's age at time of issuance, the maximum amount that a policy will pay per day, the maximum number of days (or years) that a policy will pay, the maximum amount per day times the number of days that determines the lifetime maximum amount that the policy will pay, and any optional benefits that may be selected, such as benefits that increase with inflation and non-forfeiture options.

[7] Plan, p. 81. SHIP had about 45,000 policies in force as of the end of 2019. The reduction in policies is due to death of the policyholder, non-payment of premium, or other forfeiture cause.

[8] The policies that are within the jurisdiction of and subject to any relief granted by this Court are the "state of issue policies," meaning all policies that were issued while the policyholder resided in Louisiana, even if the policyholder has moved out of state.

[9] Petition Exhibit 3.

[10] Petition Exhibit 4.

the Rehabilitator and her successors in office as statutory rehabilitator of SHIP pursuant to the provisions of 40 P.S. § 221.14, *et seq.* and required the Rehabilitator to prepare a plan of rehabilitation. SHIP's current deficit (liabilities in excess of assets, or "funding gap") exceeds $1.2 billion dollars according to testimony in the Rehabilitation Proceeding, and the average SHIP policyholder age is 86 and the average claimant is 89 years old.

On April 22, 2020 the Rehabilitator filed her Application for Approval of the Plan of Rehabilitation for SHIP and contemporaneously filed a Rehabilitation Plan (Plan). The Plan[11] was approved by a Memorandum Opinion and Order of the Commonwealth Court on August 24, 2021 that was amended on November 4, 2021 (Plan Approval Order).[12] The Plan Approval Order is not a final order and has been appealed to the Pennsylvania Supreme Court by three state insurance regulators (Maine, Massachusetts, and Washington, the State Insurance Regulators or SIR) which appeared in the Rehabilitation Proceeding and objected to the Plan. The Commissioner and LDI are one of about 20 State insurance regulators that have filed pleadings as *amici curiae* before the Pennsylvania Supreme Court to express their opposition to the Plan and support for the appeal by the SIR.

3. THIS COURT HAS JURISDICTION OVER THIS MATTER

In the December 6, 2021 scheduling conference with this Court, counsel for Defendants made a statement that this Court has no jurisdiction over this matter or the Defendants. That statement is wrong.[13]

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[11] Petition Exhibit 5.

[12] Petition Exhibit 6. Neither the Commissioner or LDI, nor SHIP's policyholders, are parties to the Rehabilitation Proceeding and policyholders were not represented by class representatives or counsel in that proceeding.

[13] In an effort to avoid jurisdiction in this Court and evade Louisiana law, Defendants might remove this case to the United States District Court for the Middle District of Louisiana prior to the scheduled hearing in this matter. However, in a prior case between the parties in the Middle District (and in a similar suit in Federal Court in South Carolina brought by the South Carolina Department of Insurance) Defendants alleged in briefs that there was no jurisdiction in Federal Court. As such, if this case is removed it will be remanded to this Court.

(a) The Rehabilitator's Limited Powers Under Pennsylvania Law

Each jurisdiction has enacted statutes for the rehabilitation and liquidation of insurance companies.[14] Under Pennsylvania law, as in all states, the power of the rehabilitator is prescribed and limited by law. The authority of a rehabilitator is circumscribed and limited to control of the assets and business of the insurer and does not extend to regulatory over the insurer's business. "The rehabilitator may take such action as he deems necessary or expedient to correct the condition or conditions which constituted the grounds for the order of the court to rehabilitate the insurer. He shall have all the powers of the directors, officers and managers, whose authority shall be suspended, except as they are redelegated by the rehabilitator. He shall have full power to direct and manage, to hire and discharge employees subject to any contract rights they may have, and to deal with the property and business of the insurer."[15] Nothing in this language provides authority beyond what the insurer and its officers and managers could have done.

Under Pennsylvania law, an insurance commissioner acting as a rehabilitator "can only exercise those powers which have been conferred upon it by the Legislature in clear and unmistakable language." *Aetna Cas. and Sur. Co. v. Com., Ins. Dept.*, 638 A.2d 194 (Pa. 1994) (quoting *Commonwealth, Human Relations Commission v. Transit Casualty Insurance Company*, 478 Pa. 430, 438, 387 A.2d 58, 62 (1978)). *See also Koken v. Legion Ins. Co.*, 831 A.2d 1196 (Pa. Commw. 2003), *aff'd sub nom. Koken v. Villanova Ins. Co.*, 878 A.2d 51 (Pa. 2005). The statute provides that "during the course of a rehabilitation, the commissioner, not the board, has responsibility for the management of the insurer's business." *Koken*, 831 A.2d at 1227-1228.

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[14] "Most states have enacted statutes that govern the conservation, rehabilitation and liquidation of insurance companies and that are patterned after one of three models acts that have been adopted by the NAIC over the years: the Uniform Insurers Liquidation Act …; the Insurers Rehabilitation and Liquidation Model Act…; and the Insurer Receivership Model Act…." https://content.naic.org/sites/default/files/publication-rec-bu-receivers-handbook-insolvencies.pdf

[15] 40 P.S. § 221.16(b), emphasis added. Pennsylvania's law for insurance company rehabilitation is attached as Exhibit 12. See also the "Pennsylvania Rehabilitation Primer" distributed by the Rehabilitator attached as Exhibit 13. (Exhibits to this memorandum are sequentially numbered beginning with 12 to follow petition Exhibits 1-11.)

Pennsylvania law authorizes the Rehabilitator to manage SHIP. It does not provide, explicitly or implicitly, authority to supplant otherwise applicable regulatory authority over the business of the insurer in rehabilitation, particular the regulatory authority of other jurisdictions. That a rehabilitator may "prepare a plan for the reorganization, consolidation, conversion, reinsurance, merger or other transformation of the insurer," 40 P.S. § 221.16(d), does not authorize the Rehabilitator to proceed without required regulatory approvals. The purpose of rehabilitation is "to rehabilitate the business of an insurer," 40 P.S. § 221.15(b), not – as the Rehabilitator and Commonwealth Court would have it – to displace the regulation by sister jurisdictions of the insurer in a parochial, local manner.[16] An insurer in rehabilitation is subject to rate regulation like any other insurer.

Nowhere in the text of Pennsylvania's law (or in any model law or NAIC publications) is there "clear and unmistakable language" that allows a rehabilitator in Pennsylvania or elsewhere to displace, disregard, and supplant the regulatory rate approval authority of an insurance regulator in another jurisdiction.[17] (See also the discussion in Section 4, below.)

(b) Louisiana's Insurance Rehabilitation Law

Louisiana enacted La. Rev. Stat. 22:2038-2044, the Uniform Insurers Liquidation Law, in 2008. The statutes apply to both rehabilitation and liquidation proceedings. Under Louisiana law, "because the rehabilitator, in effect, steps into the shoes of the insurer, he is bound by the same constraints as is the insurer in the normal course of business" and

[16] *Cf. Hanson v. Denckla*, 357 U.S. 235, 246 (1958) ("Founded on physical power...the *in rem* jurisdiction of a state court is limited by the extent of its power and by the coordinate authority of sister States."); *In re Rehabilitation of National Heritage Life Ins. Co.*, 656 A.2d 252, 259-261 (Del. Ch. 1994) (*in rem* nature of domiciliary proceeding does not support turnover orders directed to persons in other States).

[17] Indeed, the NAIC states that a receiver in a conservation or rehabilitation proceeding should consider "rate increases needed on business and insurer's ability to secure those increases from regulatory authorities." National Association of Insurance Commissioners, *Receiver's Handbook for Insurance Company Insolvencies* at 12 (2021), emphasis added, https://content.naic.org/sites/default/files/publication-rec-bu-receivers-handbook-insolvencies.pdf

"[o]ne of the constraints placed upon him is that he must follow the provisions [of law]."[18] This language is similar in scope to Pennsylvania law.

Louisiana law considers Pennsylvania a "reciprocal state" under the provisions of La. Rev. Stat. 2038(7), defined as "any state other than this state in which in substance and effect the provisions of this law are in force..." La. Rev. Stat. 22:2039(B) limits the powers of the Pennsylvania Rehabilitator as the "domiciliary receiver" of SHIP:

> The domiciliary receiver for the purpose of liquidating an insurer domiciled in a reciprocal state, shall be vested by operation of law with the title to all of the property, contracts, and rights of action, and all of the books and records of the insurer located in this state, and he shall have the immediate right to recover balances due from local agents and to obtain possession of any books and records of the insurer found in this state. He shall also be entitled to recover the other assets of the insurer located in this state except that upon the appointment of an ancillary receiver in this state, the ancillary receiver shall during the ancillary receivership proceedings have the sole right to recover such other assets.

Nothing in Louisiana law displaces the authority of the Commissioner and LDI over for rate regulation.

In *All Star Advertising Agency, Inc. v. Reliance Insurance Company*, 2004-C-1544 (La. 4/12/05), 898 So. 2d 369, the Supreme Court held that Pennsylvania was a reciprocal state under Louisiana law. As such, the Court held that an order of liquidation in Pennsylvania divested Louisiana courts from jurisdiction as to the specific dispute in that case over an asset of the insurer. In *All Star*, Reliance was placed in liquidation in Pennsylvania and plaintiff All Star sought to enjoin Reliance (in liquidation) from drawing on a letter of credit in favor of Reliance to secure All Star's insurance contract allowing retroactive premium adjustments.

The Supreme Court discussed the purposes for the adoption by Louisiana (and other states) of the Uniform Insurance Liquidation Act (UILA) (the basis of Louisiana's insurance law on insurer liquidations at that time):

> The Prefatory Note to the UILA identifies six specific features of insurer delinquency proceedings that were then causing the "greatest embarrassment." Prefatory Note, Uniform Insurers Liquidation Act, 13 U.L.A. 322 (1986) (superseded). If each state enacted the uniform law, the National Conference of Commissioners on Uniform State Laws reasoned, these past embarrassments could be remedied by the following: (1) provision that the insurance commissioner or an equivalent official shall serve as receiver; (2) authority for domiciliary receivers to proceed in non-domiciliary states so as to prevent dissipation of

[18] *Dardar v. Insurance Guaranty Association*, 88-CA-1881 (La. App. 1 Cir. 1/24/90), 556 So.2d 272.

assets therein; (3) vesting of title to assets in the domiciliary receiver; (4) provision for non-domiciliary creditors to have the option to proceed with claims before local ancillary receivers; (5) uniform application of the laws of the domiciliary state to the allowance of preferences among claims; and (6) prevention of preferences for diligent non-domiciliary creditors with advance information.[19]

The issue in All Star was control of a specific asset belonging to Reliance that was governed by a specific contract, a matter clearly within the control of the liquidator.[20]

To the contrary, in this matter, Louisiana is not attempting control and recover a specific asset, or *res*, of SHIP in Louisiana. The legal issue matter is whether the Defendants must comply with Louisiana law requiring prior regulatory approval of premium rates and policy forms. No provision of Louisiana law allows the Commissioner, as a rehabilitator, the power to set premium rates in another state[21] and, equally true, no provision of Louisiana law delegates to a "reciprocal state" the authority and jurisdiction of the Commissioner and LDI of matters expressly reserved to Louisiana's insurance regulator by the Louisiana legislature. None of the reasons for the adoption of uniform laws and reciprocity in delinquency proceedings provide for extraterritorial rate-setting by domiciliary states.

(c) Louisiana Statutory Basis for This Court's Jurisdiction

a. Statutory Authority

Numerous provisions of Louisiana law provide ample basis for jurisdiction in this Court over Defendants Rehabilitator and SHIP.

La. Rev. Stat. 22:868 provides that:

No insurance contract delivered or issued for delivery in this state and covering subjects located, resident, or to be performed in this state, or any group health and accident policy insuring a resident of this state regardless of where made or delivered, shall contain any condition, stipulation, or agreement either:

(1) Requiring it to be construed according to the laws of any other state or country except as necessary to meet the requirements of the motor vehicle financial responsibility laws of such other state or country.

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[19] *All Star* at p. 375.

[20] In a matter over a reinsurance claim of a Pennsylvania insurer, the result was the same in *Steamship Mut. Underwriting Ass'n (Bermuda), Ltd. v. Sun Life Assur. Co. of Canada*, 2006-1082 (La. App. 1 Cir. 6/8/07), 965 So. 2d 883, 884, writ denied, 2007-1390 (La. 10/12/07), 965 So. 2d 400. Again, the facts are different with SHIP.

[21] La. Rev. Stat. 22:2009, "Duties of Commissioner of Insurance as Rehabilitator."

(2) Depriving the courts of this state of the jurisdiction or venue of action against the insurer.

In *Bonura v. United Bankers Life Ins. Co.*, 552 So. 2d 1248, 1252 (La. Ct. App. 1989), writ denied, 558 So. 2d 1125 (La. 1990), the First Circuit held:

The jurisprudence construing and applying this statute is both consistent and too voluminous to require citation. Together, the statute and cases announce the unequivocal policy of this state that no foreign insurer may enjoy the benefits of a source of business in this state without being prepared to answer any claims based on that business by a Louisiana resident in the Louisiana courts. This policy comports with due process requirements and the insurer suffers no undue hardship thereby. We find no sufficient reason to abrogate that policy here.[22]

Further, La. Rev. Stat. 22:971.1(B)(1) provides that notwithstanding any other provision of law to the contrary, any entity issuing or providing coverage in Louisiana for health care services (such as an LTC insurance policy for long term care) shall be presumed to be subject to the jurisdiction of the Commissioner and thus subject to the jurisdiction of this Court. Under the provisions of 40 P.S. § 221.14 *et seq.*, the Rehabilitator stands in the shoes of SHIP's officers and directors in the conduct of SHIP's affairs while the rehabilitation is pending, and therefore pursuant to Louisiana law the Rehabilitator is subject and amenable to this Court's jurisdiction just as SHIP would have been prior to its rehabilitation. SHIP does business in Louisiana and is required to comply with all Louisiana laws and regulations regarding insurance.[23] Further, in accordance with La. Rev. Stat. 22:332 and 335, SHIP appointed a registered agent in Louisiana as required by law "who may be served any notice, process, or pleading [for SHIP]."[24]

b. Long-Arm Analysis

The Louisiana long-arm statute, La. Rev. Stat. 13:3201 controls when a Louisiana court may assert personal jurisdiction over a nonresident defendant. Louisiana's long-arm statute extends personal jurisdiction to the fullest limits allowed by constitutional due process. Under the statute, "a court of this state may exercise personal jurisdiction over

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[22] Emphasis added. When *Bonura* was decided, the statute was numbered La. Rev. Stat, 22:629.

[23] See Exhibit 1 to Plaintiffs' petition (SHIP's Certificate of Authority to transact business in Louisiana, issued by LDI) and Exhibit 2 (Consent Agreement between LDI and SHIP dated May 11, 2021).

[24] See Exhibit 14.

a nonresident on any basis consistent with the constitution of this state and of the Constitution of the United States." La. Rev. Stat. 13:3201(B). The Defendants are subject to personal jurisdiction in Louisiana under the "specific jurisdiction" prong.

Personal jurisdiction may be asserted as long as due process is not offended…Due process requires the nonresident defendant to have certain "minimum contacts" with the forum state, such that maintaining a suit against the defendant does not offend traditional notions of fair play and substantial justice. *International Shoe Co. v. State of Washington, Office of Unemployment Compensation and Placement*, 326 U.S. 310, 316, 66 S.Ct. 154, 158, 90 L.Ed. 95 (1945). The exercise of finding minimum contacts has evolved into the first of a two-part test…The second part of the due process test involves consideration of the minimum contacts in light of other fairness factors to determine whether it would be reasonable to require the nonresident defendant to defend the lawsuit in the forum state…

The minimum contacts prong of the due process test is satisfied by a single act or actions where the defendant "purposefully avails itself of the privilege of conducting activities within the forum state, thus invoking the benefits and protections of its laws." *Broussard v. Diamond Aircraft Industries, Inc.*, 2010-1611 (La. App. 1st Cir. 5/3/11), 65 So.3d 187, 190 (quoting *A & L Energy, Inc. v. Pegasus Group,* 2000-3255 (La. 6/29/01), 791 So.2d 1266, 1271, cert. denied, 534 U.S. 1022, 122 S.Ct. 550, 151 L.Ed.2d 426 (2001)…The purposeful availment factor must be such that the nonresident defendant should "reasonably anticipate" being haled into court in the forum state. The rationale of the purposeful availment requirement is to ensure that the nonresident defendant will not be brought into a jurisdiction solely as a result of a "random, fortuitous, or attenuated contact, *or by the unilateral activity of another party or a third person.*" [Emphasis added in quote from cited case.]

There is a well-established distinction between two types of personal jurisdiction - "general" and "specific."…Specific jurisdiction is when the lawsuit arises out of or is related to the nonresident defendant's contacts with the forum state and the defendant purposefully avails itself of the privilege of conducting activities in the forum state.[25]

The "minimum contacts" requirement ensures that the defendant will not be haled into a jurisdiction solely as a result of a random, fortuitous, or attenuated contact, or by the unilateral activity of another party or a third person.[26]

The Defendants activities in Louisiana fulfill the requirements of due process for specific personal jurisdiction. Factors that may be considered with respect to SHIP's contacts include whether SHIP is admitted as an insurer in the State, is licensed to do business in the State, solicits insurance business in the State, issues policies of insurance to residents of the State, collects or receives premiums from anyone in the State, has assets or property in the State, pays taxes in the State, advertises or solicits business in the State,

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[25] *Robinson v. Jeopardy Prods., Inc.,* 2019-1095 (La. App. 1 Cir. 10/21/20), 315 So. 3d 273, 277–78, writ denied, 2020-01343 (La. 1/20/21), 308 So. 3d 1166.

[26] *Bannister v. SFB Companies, Inc.,* 2019-0079 (La. App. 1 Cir. 11/15/19), 290 So. 3d 1134, 1139, *reh'g denied* (Jan. 29, 2020), *writ denied sub nom. Bannister v. SFB Companies, Inc. of Delaware*, 2020-00263 (La. 5/1/20), 295 So. 3d 943.

or has an office, agents, or employees in the State.[27] All of the foregoing are true for the Defendants.[28]

The Rehabilitator stands in the shoes of SHIP's former managers, and controls SHIP and is not a party in this case in her capacity insurance commissioner. When acting as Rehabilitator, the Commissioner possesses a legal status that is separate and distinct from her role as Commissioner. *See Di Loreto v. Costigan*, 600 F. Supp. 2d at 684. The Rehabilitator is not a state officer but one who acts on behalf of a private entity. *See id.* An insurance commissioner is not acting on behalf of the state's interest when pursuing a lawsuit in the role as liquidator. *In re Reliance Grp. Holdings, Inc.,* 273 B.R. 374, 387 (Bankr. E.D. Pa. 2002); *see also Di Loreto, supra.*; *Kelly v. Commw. Mut. Ins. Co.,* 299 A.2d 604, 606 (Pa. 1973); *Koken v. Cologne Reinsurance (Barbados), Ltd.,* 34 F. Supp. 2d 240, 247 (M.D. Pa. 1999).

The Louisiana First Circuit Court of Appeal found that a bank, acting as trustee of an insurance trust in Louisiana, was subject to personal jurisdiction. In *Green v. Group Programs, Inc.,* 622 So. 2d 275, 276 (La. App. 1 Cir. 1993) the court found that a bank, as a trustee, had sufficient minimum contacts to satisfy due process. Although the bank had no offices or employees and conducted no other business in Louisiana, the bank as trustee knew that relevant business was occurring in the state and that it would receive a trustee's

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[27] *Aetna Cas. & Sur. Co. v. Cont'l W. Ins. Co.,* 97-206, p. 6 (La. App. 3 Cir. 12/10/97), 704 So. 2d 900, 903, *writ denied*, 98-0077 (La. 3/13/98), 712 So. 2d 884.

[28] In *Brown v. Slenker,* 220 F.3d 411, 418 (5th Cir. 2000), the Fifth (Federal) Circuit held: "In light of this evidence, we agree with the district court's decision that the Commissioner had made a *prima facie* showing that the Defendants had "minimum contacts" with Louisiana. First, the Commissioner adequately showed that his causes of action related to the Defendants' contacts with Louisiana, such that the Commissioner had only to make a *prima facie* showing of specific, as opposed to general, jurisdiction...[t]he evidence made a *prima facie* showing that the Defendants availed themselves of the benefits of the liquidation proceeding on a reasonably continuous basis. *See Ruston Gas,* 9 F.3d at 419 ("The 'minimum contacts' prong, for specific jurisdiction purposes is satisfied by actions, or even just a single act, by which the non-resident defendant 'purposely avails itself of the privilege of conducting activities within the forum state, thus invoking the benefits and protections of its laws.' ") (citing *Burger King Corp. v. Rudzewicz,* 471 U.S. 462, 475, 105 S.Ct. 2174, 85 L.Ed.2d 528 (1985)). Considering another formulation of the minimum contacts test, resolving all factual inferences in the Commissioner's favor, we agree that the Defendants' contacts with Louisiana were sufficient, and sufficiently legal in nature, that they "should [have] reasonably anticipated being haled into court" there. *See id.* (citing *World–Wide Volkswagen Corp. v. Woodson,* 444 U.S. 286, 297, 100 S.Ct. 559, 62 L.Ed.2d 490 (1980))."

fee as a result of business activities in the state. See also *Washington v. Baker Petrolite Corp.*, No. 09-07926, 2010 WL 3430494, at *1 (E.D. La. Aug. 24, 2010), which a company acting as a trustee was subject to personal jurisdiction. Even though the company did not have offices or directly conduct business in the state, it was reasonable for the company as trustee to anticipate a lawsuit may be filed here. The company as trustee had "fair warning" of potential litigation and was aware of a relationship with Louisiana. *Id.* at 2. SHIP and the Rehabilitator had the same knowledge and "fair warning."

Considering the foregoing, the due process standards of minimum contacts are more than satisfied to establish jurisdiction over the Defendants. There is no question that SHIP is amenable to jurisdiction in Louisiana, as is the Rehabilaitor who has succeeded to the role of SHIP's directors and officers and is purposely availing herself of activities in Louisiana.[29]

4. THE STATE-BASED REGULATORY STRUCTURE OF THE BUSINESS OF INSURANCE - REGULATION OF PREMIUM RATES IS A MATTER COMMITTED TO THE STATES BY FEDERAL LAW

Rate regulation is a matter for the individual States. "A state may constitutionally regulate or require approval of rates and charges of insurance companies doing business within its borders." S. Plitt, D. Maldonado, J. Rogers, 1 *Couch on Insurance 3d* § 2:31 at 2-129 (2019). *See German Alliance Ins. Co. v. Lewis,* 233 U.S. 389 (1914); *Insurance Dept.* v. *City of Philadelphia,* 196 Pa. Super. 221, 173 A.2d 811, 813 (1961) ("It has long been settled that the insurance business is charged with a public interest, and that its regulation is constitutional."). "The intended purpose of the regulation of rates is to promote the general welfare by preventing rates which are excessive, inadequate, or unfairly discriminatory." 1 *Couch on Insurance 3d* § 2:31 at 2-134.

The decision of a state insurance regulator regarding rates are subject to review by the courts of their State in accordance with applicable statutory and constitutional standards. *See, e.g., Anthem Health Plan of Maine, Inc. v. Superintendent of Ins.*, 40 A.3d

[29] A Louisiana court may exercise personal jurisdiction over an insurer if (1) the insurer is a Louisiana corporation which has appointed an agent for service of process, or (2) the insurer is authorized to do business in Louisiana, or (3) the insurer has engaged in a business activity that makes it subject to the state's long-arm jurisdiction. § 2:3. Jurisdiction over the person, 1 La. Civ. L. Treatise, Civil Procedure § 2:3 (2d ed.).

380 (Me. 2012); *Genworth Life Ins. Co. v. Comm'r of Ins.*, 126 N.E.3d 1019, 1023 (Mass. App. Ct. 2019). The Plan's increase of rates without approval from the Commissioner and LDI removes and denies them their statutory roles and violates Louisiana law and is beyond the authority of the Rehabilitator under Pennsylvania or any other law.

In 1945, Congress enacted the McCarran-Ferguson Act, 15 U.S.C. § 1011 and stated the following as a declaration of policy: "Congress hereby declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States." Section 1012(a) of the McCarran-Ferguson Act provides that "[t]he business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business." The empowerment of each state with respect to the business of insurance was reinforced by Congress in 1999 with the enactment of the Gramm-Leach-Bliley Act, 15 U.S.C. § 6701 *et seq*. In that Act, Congress stated that the McCarran-Ferguson Act "remains the law of the United States" and that "the insurance activities of any person...shall be functionally regulated by the States."

"The primary state insurance regulatory functions remain as they have been since the enactment of [the] McCarran-Ferguson [Act]. This allows...states to perform solvency oversight of the U.S. insurance industry and to regulate insurer behavior in the marketplace...State legislatures are the public policymakers that establish . . . broad policy for the regulation of insurance by enacting legislation providing the 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...State insurance regulatory systems are accessible and accountable to the public and sensitive to local social and economic conditions. State regulation has proven that it effectively protects consumers and ensures that promises made by insurers are kept. Insurance regulation is structured around several key functions, including insurer licensing, producer licensing, product regulation (review and approval of rates (including benefits) and forms), market conduct, financial regulation and consumer services....State regulators

protect consumers by ensuring that insurance policy provisions comply with state law, are reasonable and fair, and do not contain major gaps in coverage that might be misunderstood by consumers and leave them unprotected. The nature of the regulatory reviews of rates, rating rules and policy forms varies somewhat among the states depending on their laws and regulations."[30]

There is no Federal law or regulation that governs the rehabilitation of insurance companies or allows the imposition of the SHIP Plan (at least to the extent that it imposes policy premiums and benefit changes) on Louisiana policyholders absent approval by the Commissioner and LDI in accordance the laws and regulations of the State of Louisiana. To the contrary, the policy of the United States and every state has consistently resisted nationalization of insurance rate making as Defendants are attempting to do in this case for the first time.

5. FULL FAITH AND CREDIT

(a) The Defendants are Required to Give Full Faith and Credit to Louisiana Law

The Rehabilitator's purposeful disregard of Louisiana law governing the authority of the Commissioner and LDI for approving premium rates violates the mandate of the Full Faith and Credit Clause of the United States Constitution. "Full Faith and Credit shall be given in each State to the public Acts, Records, and judicial Proceedings of every other State." U.S. Const., Art. IV, § 1. The purpose of the full faith and credit command "was to alter the status of the several states as independent foreign sovereignties, each free to ignore obligations created under the laws or by the judicial proceedings of the others." *Baker v. General Motors Corp.*, 522 U.S. 222, 232 (1998) (quoting *Milwaukee County v. M.E. White Co.*, 296 U.S. 268, 277 (1935)). "A statute is a 'public Act' within the meaning

[30] Petition Exhibit 7, *State Insurance Regulation*, National Association of Insurance Commissioners (NAIC), Center for Insurance Policy and Research (CIPR) (2011). Regulation of the insolvencies of insurance companies is also indirectly delegated to the states (and thus not nationalized) by virtue of the inability of insurance companies to seek bankruptcy relief under the United States Bankruptcy Code. See 11 U.S.C. 109(b) and (d) (providing that a "domestic insurance company" may not be a debtor under Chapter 7 or 11 of the Bankruptcy Code).

of the Full Faith and Credit Clause." *Franchise Tax Bd. Of Cal. v. Hyatt*, 136 S.Ct. 1277, 1281 (2016).

The Rehabilitator's view that Pennsylvania law authorizes control over policy rates in Louisiana and other States is erroneous, but even if correct it would violate the Constitution. Insurance rates are a matter of particularly local concern, law, and regulation, as shown above. One State cannot dictate to another State what rates are to be applied to policies issued in the second State. It has long been established that an insurer domiciled in one State writing insurance in another is subject to the second State's laws concerning that business. *American Fire Ins. Co. v. King Lumber & Mfg. Co.*, 250 U.S. 2, 10 (1919) (Pennsylvania insurer writing insurance in Florida had to do so "in accordance with the laws of Florida"). *See Pink v. A.A.A. Highway Exp., Inc.*, 314 U.S. 201, 209 (1941); *Clark v. Williard*, 294 U.S. 211, 213 (1935).[31] This principle applies to state review and approval of rates. Pennsylvania cannot unilaterally substitute its own laws for the laws governing relations between a corporation doing business in another State and the residents of that State. *See Phillips Petroleum Co. v. Shutts*, 472 U.S. 797, 822 (1985) (law of Kansas, the forum State in a nationwide class action, does not govern rights of residents in other States: Kansas "may not abrogate the rights of parties beyond its borders having no relation to anything done or to be done within them.") (quoting *Home Ins. Co. v. Dick*, 281 U.S. 397, 342 (1930)).

Further, the Rehabilitator cannot use the Full Faith and Credit Clause as a weapon to "require a State to substitute for its own statute, applicable to persons and events within it, the statute of another State reflecting a conflicting and opposed policy." *Hyatt*, 136 S.Ct. at 1281 (quoting *Carroll v. Lanza*, 349 U.S. 408, 412 (1955)). *See Pacific Empls. Ins. Co.*

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[31] The relations between the States concerning assets and claims in insurer liquidations have since been addressed through the adoption by the States of model acts promulgated by the National Association of Insurance Commissioners. *See* III National Association of Insurance Commissioners, *Model Laws, Regulations, and Guidelines, https://content.naic.org/model-laws* at ST-555-3 (2020) (Chart of States adopting model acts). Such statutes allocate responsibilities for assets and claims through common statutory provisions for domiciliary and ancillary receiverships. *See, e.g.*, 40 P.S. §§ 221.53-221.62. Notably, none of the statutes say nothing about rates, which continue to be governed by other law.

v. Industrial Acc. Comm., 306 U.S. 493, 503-505 (1939); *Ferrelli v. Com.*, 783 A.2d 891, 894 (Pa. Commw. Ct. 2001) (Full Faith and Credit Clause "does not require a state to subordinate public policy within its borders to the laws of another state"). "[T]he Full Faith and Credit Clause does not require a State to apply another State's law in violation of its own legitimate public policy." *Nevada v. Hall*, 440 U.S. 410, 421, 99 S.Ct. 1182, 1188, 1189 59 L.Ed.2d 416 (1979). States are precluded from "adopt[ing] any policy of hostility to the public Acts" of other states. *Hyatt,* 139 S. Ct. 1485, 1497. This is particularly the case where the Plan reflects hostility to the regulatory actions of Louisiana, which the Rehabilitator contends had resulted in an "inequitable" and "discriminatory" rate structure[32] despite Louisiana's approval of 96% of SHIP's requested premium increases. *Cf. Hyatt*, 136 S.Ct. at 1281. The Plan's attempt to supersede Louisiana's regulation of rates is unconstitutional.

(b) The Plan Approval Order is Not Entitled to Full Faith and Credit by This Court

With respect to judgments and orders, full faith and credit only applies to final judgments with adjudicatory authority over the subject matter and persons governed by the judgment. *V.L. v. E.L. et al.*, 577 U.S. 404, 407 (2016), quoting *Baker v. General Motors Corp.*, 522 U.S. 222, 233 (1998). The Plan Approval Order is not a final order, nor do the Defendants have "adjudicatory authority" under Pennsylvania law, Louisiana law, or Federal law over premium rates charged to Louisiana policyholders. A preliminary injunction prohibiting enforcement in Louisiana is properly issued.

6. REGULATORY AUTHORITY OF THE COMMISSIONER AND LDI

The Commissioner is empowered to exercise such function, possess such powers, and perform duties authorized by law. La. Const. Art. IV Sec. 11. Insurance is deemed an industry affected with the public interest and the purpose of the Louisiana laws on insurance is to regulate that industry in all its phases. La. Rev.Stat. 22:2A(1). The Commissioner is charged with the duty to administer the provisions of the Louisiana Insurance Code and make reasonable rules and regulations not inconsistent with law. La.

[32] See Plan at pp. 34, 88, 96

Rev. Stat. 22:2E. Regulations have been adopted to supplement provisions of the Louisiana Insurance Code and have the force of law. Louisiana Administrative Code (LAC) Title 37. Under Louisiana law, "no person shall be authorized to transact or shall transact a business of insurance in this state without complying with the provisions" of the Louisiana Insurance Code. La. Rev. Stat. 22:12.

Notwithstanding being in rehabilitation, the Rehabilitator and SHIP are subject to the Louisiana Insurance Code and the insurance regulations enacted thereunder. Louisiana has comprehensive statutes and regulations governing LTC policies. La. Rev. Stat. 22:1181–1191, and LAC 37:46.19.1901 *et seq.* Prior to implementing any rate increases, an LTC insurer such as SHIP must comply with all provisions of Louisiana law, including but not limited to Louisiana regulations on premium rate schedule increases set forth in LAC 37:46.19.1937 and 1939, among other provisions (i.e., "prior approval authority"). Most states have similar laws for their jurisdictions.

Further, "[e]very health insurance issuer shall file with the department [of insurance] every proposed rate to be used in connection with all of its particular products … All proposed rate filings may be reviewed for compliance with R.S. 22:1095 and with other provisions of law governing rates in the individual market and the small group market. A review of rates made pursuant to this Subpart shall not constitute a determination under the Administrative Procedure Act, R.S. 49:950 et seq., nor shall such a review of rates be subject to other administrative or judicial relief." La. Rev.Stat.22:1092(A) and (D). Forms for all insurance policies issued in Louisiana including LTC policies are required to be approved by the Commissioner. LAC 37:46.19.1913.

Prior to filing the Rehabilitation Proceeding, SHIP submitted to the Commissioner and LDI all applications for rate increases, policy forms, and policy modifications for Louisiana policyholders. SHIP complied with the decisions of the Commissioner and LDI on all such applications. The right of state insurance regulators to enforce prior approval authority is well-understood and is being purposely and improperly rejected by Defendants:

> Officials in states with prior approval authority may review a carrier's rate filing using the state's standards governing health insurance premium rates. In some cases, the state officials may also consider input from the public on the proposed rate, which can be obtained, among other ways, through public hearings or public comment periods. If a

proposed rate does not meet a state's standards, officials in states with prior approval authority can, among other things, deny the proposed rate or request that the carrier submit a new rate filing that addresses the issues that the state identified during its review. If a proposed rate meets a state's standards, the officials may approve the rate filing. (U.S. Government Accountability Office, https://www.gao.gov/assets/gao-11-701.pdf, emphasis added.)

7. THE PLAN UNLAWFULLY DISREGARDS AND OVERRIDES PLAINTIFFS' REGULATORY AUTHORITY OVER RATES CHARGED IN LOUISIANA AND REJECTS THE BENEFITS OF LOUISIANA'S GUARANTY ASSOCIATION PROTECTION

As discussed above, the SHIP Plan violates Louisiana law and Federal law through its intent to bypass state rate regulator authority. The Rehabilitator candidly admits that such course of action may be questionable:

Some concern has been expressed by certain state regulators about the notion that premium rate modifications under the Plan will not require approval of the states in which the policies were issued. The concern is understandable given that there have not been many troubled companies for which the issue of rate increases in rehabilitation has arisen. Moreover, insurance rate regulation tends to be an area of intense public and political focus. In some states, Commissioners are constrained by statute in the magnitude of rate increases they can authorize for long-term care insurance policies. [Plan, p. 96]

...

The Rehabilitator believes that the provisions of the Plan can be implemented with approval of the Commonwealth Court and without the need that insurance regulators in every state approve the Plan, including premium rate increases implemented under the Plan. However, regulators in other states may conclude that their approval is required. The Rehabilitator cannot provide any assurance that approval from other regulators will not ultimately be deemed necessary. Neither can the Rehabilitator provide assurances that if such other state approvals are necessary they can be obtained consistent with the timing and substance of the Plan. (Plan, p. 103ff., emphasis added.)

At the hearing for approval of the Plan, the Special Deputy Liquidator also testified candidly about the "unprecedented" nature of the Plan's intention to override State prior rate approval authority.[33]

(a) Under the Plan the Pennsylvania Commissioner of Insurance Will Decide Premium Rates for Louisiana Policyholders In Violation of Law

The Plan provides that the Rehabilitator, on behalf of SHIP, will submit policy premium rates on a company-wide and nationwide basis to the Commonwealth Court for each policy.

Rate increase and Policy Modifications will be submitted to the Commonwealth Court of Pennsylvania for approval as part of the Plan. The Rehabilitator will not seek separate

[33] Exhibit 15, Transcript of Hearing, pp. 81 l. 23-25, 82 l.1-5.)

approval of rate increases or benefit reductions from insurance regulators in states where the policies were issues.

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

Premium increases and Policy Modifications will not be submitted to individual insurance departments for approval. The Rehabilitation team believes that this is consistent with the established insurance rehabilitation practice in the U.S. under which the domiciliary regulator as domiciliary rehabilitator may, with only rehabilitation court approval and no approval from individual states, implement a rehabilitation plan, including one that might modify or terminate insurance policies issued by the delinquent insurer throughout the country. If its premium rates were subject to approval in each state, the Plan could not meet its goal of eliminating "subsidies" by having policyholders with substantially similar policies generally pay substantially similar premium regardless of the state in which the policyholder resides or in which the policy was issued. Moreover, the delay and expense of "traditional" state-by-state rate or benefit approval would make the Plan unfeasible. Finally, the state-by-state approval process might perpetuate or increase the nation-wide premium rate variations the Plan strives to eliminate. (Plan, p. 34, emphasis added.)

The text cited above states that the rate increases will be submitted to the Commonwealth Court. However, the Plan Approval Order of the Commonwealth Court states something much different:

The Rehabilitator, in her capacity as Insurance Commissioner, shall designate an appropriate deputy insurance commissioner to review the actuarial memorandum submitted to the Insurance Department. Thereafter, the Rehabilitator shall submit the approved actuarial memorandum to the Court.[34]

Thus, the Plan permits the Rehabilitator to step out of the role as Rehabilitator and into the role of a foreign state insurance regulator and, in that role, determine rates for Louisiana policyholders. This is remarkable, to use an understatement. Nothing in the Plan provides that "[T]he Rehabilitator, in her capacity as Insurance Commissioner" would (or could) be the rate-setter for SHIP's Louisiana policyholders or its other 35,000 policyholders nationwide.

The Plan permits the Pennsylvania Insurance Commissioner to arrogate to herself the position of rate maker, rate enforcer, and benefit downgrader under a plan that she, as "Rehabilitator," prepared. The Rehabilitator is completely conflicted. Plaintiffs are unaware of any provision of any law – here or in Pennsylvania – that empowers the

[34] Plan Approval Order, located on the last unnumbered page of Petition Exhibit 6 (emphasis added.)

Pennsylvania Commissioner *qua* "Commissioner," with extraterritorial rate-setting authority.[35] Indeed, in a prior rehabilitation proceeding, the Pennsylvania Department of Insurance acknowledged, and the NAIC concurred, that prior state-by-state approvals were required and a receiver and rehabilitator does not have power to set premium rates in another jurisdiction.[36]

Of course, even had the Commonwealth Court not included this curious provision in the Plan Approval Order and instead allowed the Rehabilitator ("as rehabilitator") to set extraterritorial rates, the order would be unenforceable for the other reasons set forth in this memorandum.

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[35] In support of the Rehabilitator's argument that she can set premium rates and downgrade policies in other states, the Commonwealth Court's Plan Approval Order (p. 50) cites to *Grode v. Mutual Fire, Marine and Inland Insurance Company*, 132 Pa. Cmwlth. 196. 572 A. 2d 798 (1991) ("*Mutual Fire I*"). However, Mutual Fire was a true rehabilitation case, unlike SHIP, which is a runoff of all policies via rehabilitation and eventual closure or liquidation. No other case was cited by the Commonwealth Court in support of its conclusion that the Rehabilitator can mandate rates in all affected states.

[36] *See In re Penn Treaty Network American Insurance Company in Rehabilitation,* 63 A. 3d 368, *Appellate Brief of Amicus Curiae National Association of Insurance Commissioners*, 2013 WL 9744013 (08/07/2013) pp. 24-27: "The Commonwealth Court is attempting to assume the traditional discretionary power and authority of state insurance commissioners with respect to ratemaking. Ratemaking is generally not a judicial function, but is left to the discretion of state insurance commissioners, who are in the best position to determine the reasonableness of rates. 1 Lee R. Russ & Thomas F. Segalla, *Couch on Insurance* 3d § 2:34 (2012). The Commonwealth Court cannot substitute its judgment for that of the Commissioner, and it must recognize the complexity of the ratemaking function and give due weight to the experience and expertise of the Commissioner....the Rehabilitator presumes that rate increases made a part of a rehabilitation plan will require state insurance department approval....It is generally understood that in a receivership proceeding, rate increases made a part of a rehabilitation plan will require state insurance department approval. See [NAIC] Receiver's Handbook at 9. Courts are prohibited from imposing rates different than those approved by the commissioner under the filed rate doctrine. *Couch on Insurance* 3d § 2:34. The Commonwealth Court cannot substitute its judgment for that of the Commissioner, or for the state insurance commissioners of other states in which policies of the Insolvent Companies have been issued. Furthermore, it must recognize the complexity of the ratemaking function and give due weight to the experience and expertise of the state insurance commissioners" *In re Penn Treaty Network American Insurance Company in Rehabilitation,* 63 A. 3d 368, *Appellate Brief of Amicus Curiae National Association of Insurance Commissioners*, 2013 WL 9744013 (08/07/2013) pp. 24-27. The trial brief of the Pennsylvania Commissioner of Insurance also assumed that individual state regulators would have to approve rate increase and benefit downgrades for insurers in rehabilitation. *Brief for Appellant Insurance Commissioner Consedine*, 2013 WL 9744011 (Pa.) 24-27.

(b) The Coercive "Opt-Out" Scheme

The Plan seeks to reduce SHIP's $1.2 billion funding gap by reducing policy benefits and increasing premiums (Plan, 10, 102-103) rather than spreading the burden of SHIP's insolvency through the guaranty association system. The Plan's scheme is designed to evade and attempt to end-run the law of Louisiana (and all other states) requiring prior regulatory approval of rates, the Plan contains a coercive "opt-out" procedure. The Plan Approval Order describes the opt-out process succinctly:

> Alternatively, under an Issue-State Rate Approval Option, a state may opt out of the rate approval section in the Plan. If a state opts out, the Rehabilitator will file an application to increase rates for policies issued in that state to the If Knew Premium level. The regulator for the opt-out state will render a decision on the Rehabilitator's rate increase application; if it is only partially approved, the Rehabilitator will downgrade the benefits under the affected policies accordingly. (Plan Approval Order, p. 58, emphasis added.)

Thus, if an "opt-out" state does not approve and accept the premium rates approved by the Commonwealth Court and demanded by the Rehabilitator, that state's policyholders will be punished in the form of a further downgrade to and loss of their contracted-for benefits. (Plan, pp. 108-118.) Although the SHIP Plan purports to give state regulators this "opt-out" as an "alternative" for premium rate approval for policyholders, such "approval" does not provide Louisiana or any other state complete prior regulatory authority as required by Louisiana law to approve both policy rates and benefits.[37]

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[37] The Plan implements this process in a complex "phase" process. In Phase One, policyholders whose premiums are below the "If Knew" premium level will be required to elect among options to modify premiums and/or benefits. (The If Knew Premium rate is defined in the Plan as "the rate that, if charged from inception, would have produced the greater of the initial target loss ratio or the minimum loss ratio applicable to the policy form." Plan, p. 27.) If KnewPremium rates are intended to price policies adequately on a lifetime basis, but not to recouplosses due to inadequate pricing in the past. (Plan, pp. 10, 23.) Policyholders must choose among five options, all based on If Knew premium. Option 1 ("downgrade") reduces benefits to the level supported by current premium on an If Knew basis. Option 2 is a "basic policy endorsement" with reduced benefits. Option 2(a) is an "enhanced basic policy" with an increased level of reduced benefits. Option 3 is "non-forfeiture option" or "NFO" with reduced benefits and no future premium. Option 4 is the current policy with premiums increased to If Knew levels. (Plan pp. 23-24.) Phase Two is intended to address the funding gap remaining after Phase One through further premium increases or benefit cuts largely based on "Self-sustaining Premium" and will not affect policyholders who selected Options 2 or 3 in Phase One (Plan pp. 11, 23, 58.) Policyholders who choose Options 1 or 4 in Phase One face the possibility of additional substantial rate increases or benefit reductions. (Plan, p. 15.) The substance of Phase Two is otherwise unknown, as the Plan does not specify all remedial measures that may be applied to policyholders in Phase Two and provides for an "alternative premium structure." (Plan pp. 23, 28, 59.) Phase Three will run-off the LTC business in force. (Plan p. 11.) Policyholder elections under the Plan will be permanent. (Plan p. 14.) If SHIP is placed in

The coercive nature of the "opt-out" is used as a weapon to attempt to force the Commissioner and LDI (and other State regulators) to grant rate increases demanded by the Rehabilitator that the Rehabilitator knows or suspects would otherwise be disapproved under the threat that, otherwise, benefits will be materially reduced or eliminated for policyholders. The rate increases to be imposed on Louisiana policyholders under the Plan are extreme and likely to impose considerable hardship on SHIP's Louisiana policyholders, all of whom are elderly and likely on fixed income. Under the Plan, it appears that premium increases for many Louisiana policyholders will exceed 300%. Policyholders may be able to avoid some of the increases, but only if they agree to the Plan's mandate to reduce their contractually-guaranteed benefits for which they have paid premiums for years or decades.

In addition to avoiding state rate regulation, another reason the Plan takes this approach is because the Rehabilitator has concluded that many of SHIP's policies were "substantially underpriced in that the premiums paid for a given group of...policies could be projected to fall short of what the company would need for the benefits due." (Plan, p. 88.)

This is part and parcel of the policy decision of the Rehabilitator to eliminate what the Plan refers to as "rate subsidies."

Premium increases and Policy Modifications will not be submitted to individual insurance departments for approval. The Rehabilitation team believes that this is consistent with the established insurance rehabilitation practice in the U.S. under which the domiciliary regulator as domiciliary rehabilitator may, with only rehabilitation court approval and no approval from individual states, implement a rehabilitation plan, including one that might modify or terminate insurance policies issued by the delinquent insurer throughout the country. If its premium rates were subject to approval in each state, the Plan could not meet its goal of eliminating "subsidies" by having policyholders with substantially similar policies generally pay substantially similar premium regardless of the state in which the policyholder resides or in which the policy was issued. Moreover, the delay and expense of "traditional" state-by-state rate or benefit approval would make the Plan unfeasible. Finally, the state-by-state approval process might perpetuate or increase the nation-wide premium rate variations the Plan strives to eliminate. (Plan, p.34.)

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liquidation after the Plan is implemented, the policies to which guaranty association coverage will apply will be those as modified under the Plan. (Plan pp. 14, 92). The modified (downgraded) policies will also be the basis for distributions from the liquidation estate. The Plan treats policyholders in different states differently based on the premium rates charged in the various states. SHIP's rates have varied across states. (Plan, p. 88.) The Plan seeks to "eliminate" these "nation-wide premium rate variations." (Plan p. 34, 105). Under the Plan, policyholders in different States will receive different levels of premium increases and benefit cuts.

The Plan Approval Order (p. 22, 69) endorsed this Pennsylvania policy decision. However, it is not within the power or province of any court to make policy decisions. "The legislature, not the courts, creates public policy..." *In re Katrina Canal Breaches Litig.*, 10-1823, p. 4 (La. 5/10/11), 63 So. 3d 955, 958-59. "It is not the prerogative of the judiciary to disregard public policy decisions underlying legislation or to reweigh balances of interests and policy considerations already struck by the legislature." *Progressive Sec. Ins. Co. v. Foster*, 97-2985, p. 21 (La. 4/23/98), 711 So. 2d 675, 688.[38]

Moreover, the Commissioner and LDI were most generous in granting SHIP the premium rate increases it historically requested. Since 2009, the Commissioner and LDI have approved about 96% of total premium increases applied for by SHIP for Louisiana policyholders, a higher percentage than all but eight States.[39] Assertions by the Rehabilitator that, generally, jurisdictions refused to grant SHIP adequate rate increases when requested are untrue with respect to policies issued in Louisiana.

Finally, not only does the Plan propose to reset without approval premium rates for Louisiana policyholders as of the effective date, it also provides the possibility of future unknown rate changes without Plaintiffs' approval. The Plan does not specify all remedial measures that may be applied to certain policyholders in Phase Two. "Depending on the results of Phase One, Phase Two may also include additional remedial measures." (Plan, p. 23.). In particular, it is possible that Phase Two will utilize an "alternative premium structure." (Plan, p. 28-29.)

(c) The Plan Improperly Rejects Guaranty Association Protection for Louisiana Policyholders

In its order approving the Plan, the Commonwealth Court adopted the Rehabilitator's view that SHIP's policyholders should have paid more for their coverage such that it is unjustified to "trigger" guaranty association coverage "rather than shifting the burden of the inadequate premiums to taxpayers." (Approval Order, p. 14.) This

[38] Pennsylvania law is the same. "[I]t is for the legislature to formulate the public policies of the Commonwealth." *Weaver v. Harpster*, 975 A.2d 555, 563 (Pa. 2009).

[39] Petition Exhibit 8, SHIP History of Approval of State Rate Increases prepared by Rehabilitator.

rationale is legally erroneous and contrary to the very purpose of the Louisiana Legislature enacting the guaranty association system (as have most other jurisdictions).[40]

Under the Plan, Under the Plan, benefits will be permanently cut and premiums permanently increased in Phase One. This means that if SHIP is liquidated after the Plan is implemented, the Guaranty Associations and liquidation estate will only cover contractual obligations as reduced under the Plan. (Plan, p. 14.) "It is important to note that Policyholder Elections are not intended to, and will not, eliminate the Unfunded Benefit Liability. To the extent that it cannot be paid, that liability is expected to be discharges in due course by the Commonwealth Court upon the Rehabilitator's application." (Plan, p. 92.)

The Rehabilitator pursued the Plan even though she concedes that the Plan is not likely to succeed in restoring SHIP to solvency. [41] Liquidation thus appears inevitable. This approach harms the policyholders because the premium increases and benefit cuts implemented under the Plan will be permanent, and only the reduced policies will be the basis for guaranty association coverage and liquidation dividends in a liquidation. The policyholders will receive less in the deferred liquidation than if SHIP were liquidated now.

The purpose of the Louisiana Life and Health Insurance Guaranty Association Act (LLHIGA Act), La. R.S. 22:2081 *et. seq.,* "is to protect, subject to certain limitations...persons...against the failure in the performance of contractual obligations, under life and health, and annuity policies, plans, or contracts...because of the impairment or insolvency of the member insurer that issued the policies, plans, or contracts."[42] SHIP's Louisiana policyholders are covered and protected by the LLHIGA Act up to the lesser of "the contractual obligation for which the member insurer is liable or would have been liable if it were not an impaired or insolvent insurer..[or] Five hundred thousand dollars in health

[40] See "The Safety Net at Work," National Organization of Life Insurance Guaranty Associations, nolhga.com/policyholderinfo/main.cfm/location/systemworks.

[41] Exhibit 14, pp. 80, 90, 189-190, 306.

[42] La. R.S. 22:2082(A). *See also* lalifega.org.

insurance benefits."[43] It is not within the Rehabilitator's discretion to reject these statutory protections because the Rehabilitator deems Louisiana policyholders – who purchased lawful contracts and paid the lawfully established premiums requested by SHIP and approved by the Commissioner and LDI – unworthy.

Guaranty associations have been established around the country to "protect, subject to certain limitations, [policyholders] against failure in the performance of contractual obligations...because of the impairment or insolvency of the member insurer that issued the policies, plans or contracts." *E.g.*, 40 P.S. § 991.1701. The statutes do not limit guaranty association coverage based upon forensic and retrospective analysis of premium adequacy which is what is happening in the Plan. The statutes serve to honor the insurer's contractual obligations. The LLHIGA Act reflects the legislative determination that policies are "worthy" of protection up to the statutory guaranty association limits except as specifically excluded. LLHIGA, as with most guaranty associations, are funded by assessment against covered insurers which can offset most of the assessments against any premium tax liability of the insurers.[44]

'The provisions of the [LLHIGA Act] must be interpreted to protect claimants and policyholders and to advance their interest rather than the interests of the associations." *Shane v. Sandifer*, 418 So.2d 543, 546 (La. 1982) Thus, as a matter of policy enacted by the Louisiana Legislature, the burden of an insurer's insolvency is spread broadly, instead as being imposed only on the policyholder as provided by the SHIP Plan.

Under the Plan, the amount by which liabilities are reduced in Phase One will not be covered by LLHIGA for Louisiana policyholders in the event of SHIP's likely liquidation. The Plan overrides this legislative judgment. The Plan deprives innocent policyholders of the benefits of the LLHIGA Act based on the Rehabilitator's disagreement with the legislative judgments about which policyholders warrant protection and how the cost of that protection should be supported. The Rehabilitator does not have discretion to

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[43] La. Rev. Stat. 22:2083(A) and (C).

[44] La. Rev. Stat. 28:2092.

disregard the protections of 40 P.S. § 991.1701 and Louisiana's LLHIGA Act and choose to impose a significant financial loss on SHIP Louisiana policyholders.

8. CONCLUSION

The Commissioner and LDI are entitled to issuance of a preliminary prohibitory injunction enjoining the Rehabilitator and SHIP from (a) attempting to enforce against any Louisiana policyholders of SHIP any plan implemented or attempted to be implanted by the that affects the rates paid by or benefits accorded to Louisiana policyholders of SHIP without compliance with all applicable provisions of Louisiana law and regulations, (b) soliciting any Louisiana policyholders of SHIP to select "options" under the Plan without compliance with all applicable provisions of Louisiana law and regulations, and (c) such other and further relief consistent therewith and in the public interest.

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CERTIFICATE OF SERVICE

I hereby certify that a copy of the above and foregoing been mailed, postage prepaid or emailed to counsel for the Defendants:

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Baton Rouge, Louisiana December 20, 2021.
/s/ David S. Rubin
David S. Rubin

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NINETEENTH JUDICIAL DISTRICT COURT
PARISH OF EAST BATON ROUGE
STATE OF LOUISIANA

JAMES J. DONELON
IN HIS OFFICIAL CAPACITY
AS COMMISSIONER OF INSURANCE
FOR THE STATE OF LOUISIANA AND
THE LOUISIANA DEPARTMENT OF
INSURANCE
Plaintiff

NUMBER: 713794

SECTION: 22

VERSUS

JESSICA K. ALTMAN, IN HER CAPACITY AS STATUTORY REHABILITATOR OF SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA, *AND*
SENIOR HEALT INSURANCE COMPANY OF PENNSYLVANIA, IN REHABILITATION
Defendant

PETITION EXHIBITS TO BE INTRODUCED BY PLAINTIFFS

Exhibits Attached to Petition

1. Louisiana Certificate of Authority for SHIP
2. Consent Agreement between LDI and SHIP
3. Application for Rehabilitation
4. Order of Rehabilitation
5. Approved SHIP Plan of Rehabilitation
6. Memorandum Opinion and Order approving the SHIP Plan
7. National Association of Insurance Commissioners – State Insurance Regulation
8. SHIP History of State Approval of Rate Increases
9. Rehabilitator's Notice and Election Form Under Plan
10. Commissioner and LDI Response to Rehabilitator's Notice and Election Form Under Plan
11. Rehabilitator's Response to Exhibit 10.

Additional Exhibits to Be Introduced Attached to Pre-Hearing Memorandum

12. 40 P.S.§221.16(b) *et seq.*
13. Pennsylvania Rehabilitation Primer
14. SHIP Appointment of LDI as Agent for Service of Process
15. Transcript from SHIP Hearing on Approval of Plan
16. Memo dated 11/22/21 from NAIC Receivership and Insolvency Task Force

Exhibit 12

Purdon's Pennsylvania Statutes and Consolidated Statutes
Title 40 P.S. Insurance (Refs & Annos)
Chapter 1. Insurance Department (Refs & Annos)
Article V. Suspension of Business--Involuntary Dissolutions (Refs & Annos)
(c) Formal Proceedings
A. Rehabilitation

40 P.S. § 221.15

§ 221.15. Rehabilitation orders

(a) The commissioner may apply by petition to the Commonwealth Court, for an order authorizing him to rehabilitate a domestic insurer or an alien insurer domiciled in this Commonwealth, alleging that the insurer has committed one or more acts which may constitute grounds for rehabilitation as set forth in section 514 of this article.[1]

(b) An order of the Commonwealth Court to rehabilitate the business of an insurer shall be issued only after a hearing before the court or pursuant to a written consent of the insurer.

(c) An order to rehabilitate the business of a domestic insurer, or an alien insurer domiciled in this Commonwealth, shall appoint the commissioner and his successors in office the rehabilitator, and shall direct the rehabilitator forthwith to take possession of the assets of the insurer including any deposits held by the commissioner, and to administer them under the orders of the court. The filing or recording of the order with the clerk of the Commonwealth Court or recorder of deeds of the county in which the principal business of the company is conducted, or the county in which its principal office or place of business is located, shall impart the same notice as a deed, bill of sale or other evidence of title duly filed or recorded with that recorder of deeds would have imparted.

(d) Entry of an order of rehabilitation shall not constitute an anticipatory breach of any contracts of the insurer.

Credits

1921, May 17, P.L. 789, art. V, § 515, added 1977, Dec. 14, P.L. 280, No. 92, § 2, imd. effective.

40 P.S. § 221.15, PA ST 40 P.S. § 221.15
Current through 2018 Regular Session Act 16

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Title 40 P.S. Insurance (Refs & Annos)
Chapter 1. Insurance Department (Refs & Annos)
Article V. Suspension of Business--Involuntary Dissolutions (Refs & Annos)
(c) Formal Proceedings
A. Rehabilitation

40 P.S. § 221.16

§ 221.16. Powers and duties of the rehabilitator

(a) The commissioner as rehabilitator may appoint a special deputy who shall have all the powers of the rehabilitator granted under this section. The commissioner shall make such arrangements for compensation as are necessary to obtain a special deputy of proven ability. The special deputy shall serve at the pleasure of the commissioner.

(b) The rehabilitator may take such action as he deems necessary or expedient to correct the condition or conditions which constituted the grounds for the order of the court to rehabilitate the insurer. He shall have all the powers of the directors, officers and managers, whose authority shall be suspended, except as they are redelegated by the rehabilitator. He shall have full power to direct and manage, to hire and discharge employes subject to any contract rights they may have, and to deal with the property and business of the insurer.

(c) If it appears to the rehabilitator that there has been criminal or tortious conduct, or breach of any contractual or fiduciary obligation detrimental to the insurer by any officer, manager, agent, broker, employe, or other person, he may pursue all appropriate legal remedies on behalf of the insurer.

(d) The rehabilitator may prepare a plan for the reorganization, consolidation, conversion, reinsurance, merger or other transformation of the insurer. Upon application of the rehabilitator for approval of the plan, and after such notice and hearing as the court may prescribe, the court may either approve or disapprove the plan proposed, or may modify it and approve it as modified. If it is approved, the rehabilitator shall carry out the plan. In the case of a life insurer, the plan proposed may include the imposition of liens upon the equities of policyholders of the company, provided that all rights of shareholders are first relinquished. A plan for a life insurer may also propose imposition of a moratorium upon loan and cash surrender rights under policies, for such period and to such an extent as may be necessary.

(e) The rehabilitator shall have the power to avoid fraudulent transfers under sections 528 and 529.[1]

Credits

1921, May 17, P.L. 789, art. V, § 516, added 1977, Dec. 14, P.L. 280, No. 92, § 2, imd. effective.

40 P.S. § 221.16, PA ST 40 P.S. § 221.16
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Purdon's Pennsylvania Statutes and Consolidated Statutes
Title 40 P.S. Insurance (Refs & Annos)
Chapter 1. Insurance Department (Refs & Annos)
Article V. Suspension of Business--Involuntary Dissolutions (Refs & Annos)
(c) Formal Proceedings
A. Rehabilitation

40 P.S. § 221.17

§ 221.17. Actions by and against rehabilitator

(a) On request of the rehabilitator, any court in this State before which any action or proceeding by or against an insurer is pending when a rehabilitation order against the insurer is entered shall stay the action or proceeding for such time as is necessary for the rehabilitator to obtain proper representation and prepare for further proceedings. The Commonwealth Court shall order the rehabilitator to take such action respecting the pending litigation as the court deems necessary in the interests of justice and for the protection of creditors, policyholders, and the public. The rehabilitator shall immediately consider all litigation pending outside this Commonwealth and shall petition the courts having jurisdiction over that litigation for stays whenever necessary to protect the estate of the insurer.

(b) The time between the filing of a petition for rehabilitation against an insurer and denial of the petition or an order of rehabilitation shall not be considered to be a part of the time within which any action may be commenced by or against the insurer. Any action by or against the insurer that might have been commenced when the petition was filed may be commenced for at least sixty days after the order of rehabilitation is entered.

Credits

1921, May 17, P.L. 789, art. V, § 517, added 1977, Dec. 14, P.L. 280, No. 92, § 2, imd. effective.

40 P.S. § 221.17, PA ST 40 P.S. § 221.17
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Article V. Suspension of Business--Involuntary Dissolutions (Refs & Annos)
(c) Formal Proceedings
A. Rehabilitation

40 P.S. § 221.18

§ 221.18. Termination of rehabilitation

(a) Whenever he has reasonable cause to believe that further attempts to rehabilitate an insurer would substantially increase the risk of loss to creditors, policy and certificate holders, or the public, or would be futile, the rehabilitator may petition the Commonwealth Court for an order of liquidation. A petition under this subsection shall have the same effect as a petition under section 520.[1] The Commonwealth Court shall permit the directors to take such actions as are reasonably necessary to defend against the petition and may order payment from the estate of the insurer of such costs and other expenses of defense as justice may require.

(b) The rehabilitator may at any time petition the Commonwealth Court for an order terminating rehabilitation of an insurer. If the Commonwealth Court finds that rehabilitation has been accomplished and that grounds for rehabilitation under section 514[2] no longer exists, it shall order that the insurer be restored to possession of its property and the control of its business. The Commonwealth Court may also make that finding and issue that order at any time upon its own motion.

Credits

1921, May 17, P.L. 789, art. V, § 518, added 1977, Dec. 14, P.L. 280, No. 92, § 2, imd. effective.

40 P.S. § 221.18, PA ST 40 P.S. § 221.18
Current through 2018 Regular Session Act 16

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Exhibit 13

pennsylvania
INSURANCE DEPARTMENT

Pennsylvania Rehabilitation Primer

The Rehabilitation Process

When an insurance company is placed into rehabilitation in Pennsylvania, the Insurance Commissioner, as Rehabilitator, has certain powers, provided under the Rehabilitation statute, that would not be available if the Company were a going concern[1]. Like other states, Pennsylvania's receivership laws are based on NAIC receivership models, and were enacted to ensure policyholders in all states are uniformly protected in the event of hazardous financial condition or insolvency. The Pennsylvania Commonwealth Court supervises this action. The goal of the Rehabilitator is to reduce or eliminate the causes of the delinquency proceeding and to preserve the company's assets for policyholder protection.

The Commonwealth Court issues an Order of Rehabilitation which puts numerous policyholder protections in place and gives the Rehabilitator the opportunity to perform an independent, in-depth financial analysis. In addition, the Order of Rehabilitation places the company under the statutory control of the Pennsylvania Insurance Department.
Pursuant to Pennsylvania Law:

- An order to rehabilitate SHIP shall appoint the Commissioner, and her successors in office, the Rehabilitator, and shall direct the Rehabilitator forthwith to take possession of the assets of the insurer and to administer them under the orders of the Court.

- The Commissioner as Rehabilitator may appoint a special deputy who shall have all the powers of the Rehabilitator granted under this section. The special deputy shall serve at the pleasure of the commissioner.

- The Rehabilitator may take such action as she deems necessary or expedient to correct the condition or conditions which constituted the grounds for the order of the court to rehabilitate the insurer. She shall have all the powers of the directors, officers and managers, whose authority shall be suspended, except as they are redelegated by the Rehabilitator. She shall have full power to direct and manage, to hire and discharge employees subject to any contract rights they may have, and to deal with the property and business of the insurer.

- If it appears to the Rehabilitator that there has been criminal or tortious conduct, or breach of any contractual or fiduciary obligation detrimental to the insurer by any officer, manager, agent, broker, employee, or other person, she may pursue all appropriate legal remedies on behalf of the insurer.

- The Rehabilitator may prepare a plan for the reorganization, consolidation, conversion, reinsurance, merger or other transformation of the insurer. Upon application of the Rehabilitator for approval of the plan, and after such notice and hearing as the court may prescribe, the court may either approve or disapprove the plan proposed or may modify it and approve it as modified. This provides an opportunity to comment or even object

[1] Article V of the Insurance Department Act of 1921, Act of May 19, 1921, P.L. 789, *as amended* ("Article V"), 40 P.S. §§ 221.1-221.63, and Rule 3774(c) of the Pennsylvania Rules of Appellate Procedure, Pa. R.A.P. 3774(c).

to the proposed plan for any interested party. If it is approved, the Rehabilitator shall carry out the plan as approved.

- Additionally, the Rehabilitator may file for liquidation of the company if it deems that further attempts to rehabilitate the company are futile or if a continued rehabilitation would increase the risk of loss to policyholders.

It is established law that the powers of the rehabilitator are broad. For example, The Insurers Rehabilitation and Liquidation Model Act (NAIC Model 555-4) provides at Article 18

C. The rehabilitator may take such action as the rehabilitator deems necessary or appropriate to reform and revitalize the insurer. The rehabilitator shall have all the powers of the directors, officers and managers, whose authority shall be suspended, except as redelegated by the rehabilitator. The rehabilitator shall have full power to direct and manage, to hire and discharge employees subject to any contract rights they may have, and to deal with the property and business of the insurer.

E. If the rehabilitator determines that reorganization, consolidation, conversion, reinsurance, merger or other transformation of the insurer is appropriate, the rehabilitator shall prepare a plan to effect such changes and shall file it with the Court within six (6) months after the entry of the rehabilitation order or such further time as the Court may allow for good cause. Upon application of the rehabilitator for approval of the plan, and after such notice and hearings as the court may prescribe, the court may either approve or disapprove the plan proposed, or may modify it and approve it as modified. Any plan approved under this section shall be, in the judgment of the court, fair and equitable to all parties concerned. If the plan is approved, the rehabilitator shall carry out the plan. In the case of a life insurer, the plan proposed may include the imposition of liens upon the policies of the company, if all rights of shareholders are first relinquished. A plan for a life insurer may also propose imposition of a moratorium upon loan and cash surrender rights under policies, for a period not to exceed six (6) months from the entry of the rehabilitation order, unless the Court, for good cause shown, shall extend the moratorium.

G. The enumeration, in this section, of the powers and authority of the rehabilitator shall not be construed as a limitation upon the rehabilitator, nor shall it exclude in any manner the right to do other acts not specifically enumerated or otherwise provided for, as may be necessary or appropriate for the accomplishment of or in aid of the purpose of rehabilitation.

Similarly, the successor Insurer Receivership Model Act (NAIC Model 555-1) provides at Section 402:

A. The rehabilitator may take such action as the rehabilitator deems necessary or appropriate to reform and revitalize the insurer, including but not limited to, canceling policies, insurance and reinsurance contracts (other than life or health insurance or annuities), surety bonds or surety undertakings, or transferring policies, insurance and reinsurance contracts, surety bonds or surety undertakings to a solvent assuming insurer, with court approval. The rehabilitator shall have all the powers of the directors, officers and managers of the insurer, whose authority shall be suspended, except as redelegated by the rehabilitator. The rehabilitator shall have full power to direct and manage, to hire and discharge employees, and to deal with the property and business of the insurer. The rehabilitator shall not be liable under [insert citation to state version of statute imposing liability for issuing policies while insolvent] as the result of good faith issuance or renewal of policies while in rehabilitation.

D. The enumeration, in this section, of the powers and authority of the rehabilitator shall not be construed as a limitation upon the rehabilitator, nor shall it exclude in any manner the right to do other acts not specifically enumerated or otherwise provided for, as may be necessary or appropriate for the accomplishment of or in aid of the purpose of rehabilitation.

Commissioner Altman has filed a Petition for Rehabilitation of SHIP, on Thursday, 1/23/2020, in Pennsylvania Commonwealth Court. At this time, we await the Court's entry of an Order of Rehabilitation. There may be a hearing before the Order is entered. This initial stage will only result in placing SHIP in rehabilitation and will not yet address any elements of the proposed rehabilitation plan.

After the entry of a Rehabilitation Order, we will have a period of time, probably 90 days or so, to conclude our work on the plan of Rehabilitation, which we will be discussing on our call on January 24. 2020. There will be time, during this period, to continue to exchange information and provide input on the plan, prior to the filing of a plan and a subsequent hearing being held on the approval of the plan.

If you have any questions, or wish to discuss this matter further, please feel free to reach out to Laura Lyon Slaymaker at the Pennsylvania Insurance Department or Patrick Cantilo.

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Office of Liquidations, Rehabilitations and Special Funds
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Exhibit 14

RECEIVED

DEC 19 2014

COMMISSIONER OF INSURANCE
COMPANY LICENSING

SHIP
SENIOR HEALTH INSURANCE COMPANY
OF PENNSYLVANIA
1099 West City Center Drive, Suite 200, Carmel, IN 46032

December 8, 2014

Louisiana Insurance Department
1702 N. 3rd Street
Baton Rouge, Louisiana 70802

RE: UCAA Form 12, Uniform Consent to Service of Process
Senior Health Insurance Company of Pennsylvania
NAIC No.: 76325

To Whom It May Concern:

Enclosed you will find the Amended Uniform Consent to Service of Process appointing the Officers of the States and their successors identified in Exhibit A, or where applicable appoints the required agent designated in Exhibit A as its attorney in such States upon whom may be served any notice, process or pleading as required by law for Senior Health Insurance Company of Pennsylvania (hereinafter "Company").

The following documents and information are being submitted in connection with the Amended Uniform Consent to Service of Process:

- Amended Uniform Consent to Service of Process (Form 12)
- Resolution authorizing Appointment of Attorney

Please approve the enclosed Amended Uniform Consent to Service of Process in your state and notify us of your approval at your earliest convenience. Please also date-stamp the enclosed copy of this letter to indicate your receipt of this request and return in the enclosed self-addressed envelope provided.

Thank you for your attention to this matter. Should you have questions or need further information to process this request, please contact me.

Very truly yours,

Kimberly J. Helsley

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Enclosures

CERTIFIED MAIL

SHIP
SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA
550 Congressional Boulevard, Suite 200, Carmel, IN 46032

7010 0290 0001 2643 0405

U.S. POSTAGE PITNEY BOWES
ZIP 46032 $ 006.69⁰
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0001392699 DEC. 09 2014

Shiip
Louisiana Insurance Department
1702 N. 3rd Street
P.O. Box 94214
Baton Rouge, Louisiana 70802

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COMMISSIONER OF INSURANCE
MAIL ROOM

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LOUISIANA DEPARTMENT OF INSURANCE
JAMES J. DONELON
COMMISSIONER

July 26, 2016

Ms. Jewel Moore
Commercial Division Supervisor
Louisiana Secretary of State
P. O. Box 94125
Baton Rouge, LA 70804-9125

RE: Senior Health Insurance Company of Pennsylvana NAIC # 76325

Dear Ms. Moore:

Enclosed are the amended Uniform Consent to Service of Process forms recently filed by the above captioned companies. Please adjust your records accordingly.

If you have any questions or if you would like to discuss this matter, please contact me.

Sincerely,

Candace Allen

Candace Allen
Insurance Specialist, Company Licensing
Office of Licensing and Compliance
(225) 219-9493, fax (225) 219-9322
(800) 259-5300
callen@ldi.la.gov

Enclosures

Applicant Name: Senior Health Insurance Company of Pennsylvania NAIC No. #76325
FEIN: #23-0704970

Uniform Consent to Service of Process

_____ Original Designation X Amended Designation
(must be submitted directly to states)

Insurer Name: Senior Health Insurance Company of Pennsylvania

Previous Name (if applicable): _____

Home Office Address: 550 Congressional Blvd., Suite 200

City, State, Zip: Carmel, IN 46032 NAIC Code: #76325

The entity named above, organized under the laws of Pennsylvania, for purposes of complying with the laws of the State(s) designate hereunder relating to the holding of a certificate of authority or the conduct of an insurance business within said State(s), pursuant to a resolution adopted by its board of directors or other governing body, hereby irrevocably appoints the officers of the State(s) and their successors identified in Exhibit A, or where applicable appoints the required agent so designated in Exhibit A hereunder as its attorney in such State(s) upon whom may be served any notice, process or pleading as required by law as reflected on Exhibit A in any action or proceeding against it in the State(s) so designated; and does hereby consent that any lawful action or proceeding against it may be commenced in any court of competent jurisdiction and proper venue within the State(s) so designated; and agrees that any lawful process against it which is served under this appointment shall be of the same legal force and validity as if served on the entity directly. This appointment shall be binding upon any successor to the above named entity that acquires the entity's assets or assumes its liabilities by merger, consolidation or otherwise; and shall be binding as long as there is a contract in force or liability of the entity outstanding in the State. The entity hereby waives all claims of error by reason of such service. The entity named above agrees to submit an amended designation form upon a change in any of the information provided on this power of attorney.

Applicant Officers' Certification and Attestation

One of the two Officers (listed below) of the Applicant must read the following very carefully and sign:

1. I acknowledge that I am authorized to execute and am executing this document on behalf of the Applicant.

2. I hereby certify under penalty of perjury under the laws of the applicable jurisdictions that all of the forgoing is true and correct, executed at Carmel, Indiana.

11/26/14
Date

Signature of President

Brian Charles Wegner
Full Legal Name of President

Nov 21, 2014
Date

Signature of Secretary

Ginger Susan Darrough
Full Legal Name of Secretary

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Uniform Consent to Service of Process

Exhibit A

Place an "X" before the names of all the States for which the person executing this form is appointing the designated agent in that State for receipt of service of process:

X	AL	Commissioner of Insurance # and Resident Agent*	X	MO	Director of Insurance #
X	AK	Director of Insurance #	X	MT	Commissioner of Securities and Insurance #
X	AZ	Director of Insurance # ^	X	NE	Officer of Company* or Resident Agent* (circle one)
X	AR	Resident Agent *	X	NH	Commissioner of Insurance #
_	AS	Commissioner of Insurance #	X	NV	Commissioner of Insurance Commission # ^
X	CO	Commissioner of Insurance # or Resident Agent*	X	NJ	Commissioner of Banking and Insurance #^
X	CT	Commissioner of Insurance #	X	NM	Superintendent of Insurance #
X	DE	Commissioner of Insurance #	X	NY	Superintendent of Financial Services #
X	DC	Commissioner of Insurance and Securities Regulation # or Local Agent* (circle one)	X	NC	Commissioner of Insurance
X	FL	Chief Financial Officer # ^	X	ND	Commissioner of Insurance # ^
X	GA	Commissioner of Insurance and Safety Fire # and Resident Agent*	X	OH	Resident Agent*
_	GU	Commissioner of Insurance #	X	OR	Resident Agent*
X	HI	Insurance Commissioner # and Resident Agent*	X	OK	Commissioner of Insurance #
X	ID	Director of Insurance # ^	X	PR	Commissioner of Insurance #
X	IL	Director or Insurance #	X	RI	Superintendent of Insurance ^
X	IN	Resident Agent* ^	X	SC	Director of Insurance #
X	IA	Commissioner of Insurance #	X	SD	Director of Insurance # ^
X	KS	Commissioner of Insurance ^	X	TN	Commissioner of Insurance #
X	KY	Secretary of State #	X	TX	Resident Agent*
X	LA	Secretary of State #	X	UT	Resident Agent* ^
X	MD	Insurance Commissioner #	X	VT	Secretary of State # or Resident Agent*
X	ME	Resident Agent* ^	X	VI	Lieutenant Governor/Commissioner#
X	MI	Resident Agent *	X	WA	Insurance Commissioner #
X	MN	Commissioner of Commerce #	X	WV	Secretary of State # @
X	MS	Commissioner of Insurance and Resident Agent* BOTH are required.	X	WY	Commissioner of Insurance #

\# For the forwarding of Service of Process received by a State Officer complete Exhibit B listing by state the entities (one per state) with full name and address where service of process is to be forwarded. Use additional pages as necessary. Colorado will forward Service of Process to the Secretary of the company and requires a resident agent for foreign entities. Exhibit not required for New Jersey, and North Carolina. Florida accepts only an individual as the entity and requires an email address. New Jersey allows but does not require a foreign insurer to designate a specific forwarding address on Exhibit B. SC will not forward to an individual by name; however, it will forward to a position, e.g., Attention: President (or Compliance Officer, etc.). Washington requires an email address on Exhibit B.

* Attach a completed Exhibit B listing the Resident Agent for the insurer (one per state). Include state name, Resident Agent's full name and street address. Use additional pages as necessary. (DC* requires an agent within a ten mile radius of the District).

^ Initial pleadings only.

@ Form accepted only as part of a Uniform Certificate of Authority application.

MA will send the required form to the applicant when the approval process reaches that point.

Exhibit A

Exhibit B

Complete for each state indicated in Exhibit A:

State: AL Name of Entity: CSC-Lawyers Incorporating Service, Incorporated

Phone Number: 1-800-927-9800 Fax Number: 302-636-5454

Email Address: sop@cscinfo.com

Mailing Address: 150 South Perry Street, Montgomery, AL 36104

Street Address: Same

State: AL Name of Entity: Senior Health Insurance Company of Pennsylvania – Patrick L. Carmody

Phone Number: 317-566-7567 Fax Number: 317-566-7585

Email Address: pcarmody@shipltc.com

Mailing Address: 550 Congressional Blvd., Suite 200, Carmel, IN 46032

Street Address: Same

State: AK Name of Entity: Senior Health Insurance Company of Pennsylvania – Patrick L. Carmody

Phone Number: 317-566-7567 Fax Number: 317-566-7585

Email Address: pcarmody@shipltc.com

Mailing Address: 550 Congressional Blvd., Suite 200, Carmel, IN 46032

Street Address: Same

State: AZ Name of Entity: Senior Health Insurance Company of Pennsylvania – Patrick L. Carmody

Phone Number: 317-566-7567 Fax Number: 317-566-7585

Email Address: pcarmody@shipltc.com

Mailing Address: 550 Congressional Blvd., Suite 200, Carmel, IN 46032

Street Address: Same

State: AR Name of Entity: Corporation Service Company

Phone Number: 1-800-927-9800 Fax Number: 302-636-5454

Email Address: sop@cscinfo.com

Mailing Address: 300 Spring Building, Suite 900, 300 South Spring Street, Little Rock, AR 72201

Street Address: Same

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Exhibit B

Complete for each state indicated in Exhibit A:

State: CO Name of Entity: Corporation Service Company

Phone Number: 1-800-927-9800 Fax Number: 302-636-5454

Email Address: sop@cscinfo.com

Mailing Address: 1560 Broadway, Suite 2090, Denver, CO 80202

Street Address: Same

State: CT Name of Entity: Senior Health Insurance Company of Pennsylvania – Patrick L. Carmody

Phone Number: 317-566-7567 Fax Number: 317-566-7585

Email Address: pcarmody@shipltc.com

Mailing Address: 550 Congressional Blvd., Suite 200, Carmel, IN 46032

Street Address: Same

State: DE Name of Entity: Senior Health Insurance Company of Pennsylvania – Patrick L. Carmody

Phone Number: 317-566-7567 Fax Number: 317-566-7585

Email Address: pcarmody@shipltc.com

Mailing Address: 550 Congressional Blvd., Suite 200, Carmel, IN 46032

Street Address: Same

State: DC Name of Entity: Corporation Service Company

Phone Number: 1-800-927-9800 Fax Number: 302-636-5454

Email Address: sop@cscinfo.com

Mailing Address: 1090 Vermont Avenue N.W., Washington, DC 20005

Street Address: Same

State: FL Name of Entity: Senior Health Insurance Company of Pennsylvania – Patrick L. Carmody

Phone Number: 317-566-7567 Fax Number: 317-566-7585

Email Address: pcarmody@shipltc.com

Mailing Address: 550 Congressional Blvd., Suite 200, Carmel, IN 46032

Street Address: Same

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Exhibit B

Complete for each state indicated in Exhibit A:

State: GA Name of Entity: Corporation Service Company

Phone Number: 1-800-927-9800 Fax Number: 302-636-5454

Email Address: sop@cscinfo.com

Mailing Address: 40 Technology Pkwy South, #300, Norcross, GA 30092

Street Address: Same

State: GA Name of Entity: Senior Health Insurance Company of Pennsylvania – Patrick L. Carmody

Phone Number: 317-566-7567 Fax Number: 317-566-7585

Email Address: pcarmody@shipltc.com

Mailing Address: 550 Congressional Blvd., Suite 200, Carmel, IN 46032

Street Address: Same

State: HI Name of Entity: Senior Health Insurance Company of Pennsylvania – Patrick L. Carmody

Phone Number: 317-566-7567 Fax Number: 317-566-7585

Email Address: pcarmody@shipltc.com

Mailing Address: 550 Congressional Blvd., Suite 200, Carmel, IN 46032

Street Address: Same

State: HI Name of Entity: CSC Services of Hawaii, Inc.

Phone Number: 1-800-927-9800 Fax Number: 302-636-5454

Email Address: sop@cscinfo.com

Mailing Address: 1003 Bishop Street, Suite 1600 Pauahi Tower, Honolulu, HI 96813

Street Address: Same

State: ID Name of Entity: Senior Health Insurance Company of Pennsylvania – Patrick L. Carmody

Phone Number: 317-566-7567 Fax Number: 317-566-7585

Email Address: pcarmody@shipltc.com

Mailing Address: 550 Congressional Blvd., Suite 200, Carmel, IN 46032

Street Address: Same

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Exhibit B

Complete for each state indicated in Exhibit A:

State: IL Name of Entity: Senior Health Insurance Company of Pennsylvania – Patrick L. Carmody

Phone Number: 317-566-7567 Fax Number: 317-566-7585

Email Address: pcarmody@shipltc.com

Mailing Address: 550 Congressional Blvd., Suite 200, Carmel, IN 46032

Street Address: Same

State: IN Name of Entity: Corporation Service Company

Phone Number: 1-800-927-9800 Fax Number: 302-636-5454

Email Address: sop@cscinfo.com

Mailing Address: 251 East Ohio Street, Suite 500, Indianapolis, IN 46204

Street Address: Same

State: IA Name of Entity: Senior Health Insurance Company of Pennsylvania – Patrick L. Carmody

Phone Number: 317-566-7567 Fax Number: 317-566-7585

Email Address: pcarmody@shipltc.com

Mailing Address: 550 Congressional Blvd., Suite 200, Carmel, IN 46032

Street Address: Same

State: KS Name of Entity: Senior Health Insurance Company of Pennsylvania – Patrick L. Carmody

Phone Number: 317-566-7567 Fax Number: 317-566-7585

Email Address: pcarmody@shipltc.com

Mailing Address: 550 Congressional Blvd., Suite 200, Carmel, IN 46032

Street Address: Same

State: KY Name of Entity: Senior Health Insurance Company of Pennsylvania – Patrick L. Carmody

Phone Number: 317-566-7567 Fax Number: 317-566-7585

Email Address: pcarmody@shipltc.com

Mailing Address: 550 Congressional Blvd., Suite 200, Carmel, IN 46032

Street Address: Same

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Exhibit B

Complete for each state indicated in Exhibit A:

State: LA Name of Entity: Senior Health Insurance Company of Pennsylvania – Patrick L. Carmody

Phone Number: 317-566-7567 Fax Number: 317-566-7585

Email Address: pcarmody@shipltc.com

Mailing Address: 550 Congressional Blvd., Suite 200, Carmel, IN 46032

Street Address: Same

State: MD Name of Entity: Senior Health Insurance Company of Pennsylvania – Patrick L. Carmody

Phone Number: 317-566-7567 Fax Number: 317-566-7585

Email Address: pcarmody@shipltc.com

Mailing Address: 550 Congressional Blvd., Suite 200, Carmel, IN 46032

Street Address: Same

State: ME Name of Entity: Corporation Service Company

Phone Number: 1-800-927-9800 Fax Number: 302-636-5454

Email Address: sop@cscinfo.com

Mailing Address: 45 Memorial Circle, Augusta, ME 04330

Street Address: Same

State: MI Name of Entity: CSC-Lawyers Incorporating Service (Company)

Phone Number: 1-800-927-9800 Fax Number: 302-636-5454

Email Address: sop@cscinfo.com

Mailing Address: 601 Abbot Road, East Lansing, MI 48823

Street Address: Same

State: MN Name of Entity: Senior Health Insurance Company of Pennsylvania – Patrick L. Carmody

Phone Number: 317-566-7567 Fax Number: 317-566-7585

Email Address: pcarmody@shipltc.com

Mailing Address: 550 Congressional Blvd., Suite 200, Carmel, IN 46032

Street Address: Same

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Exhibit B

Complete for each state indicated in Exhibit A:

State: MS Name of Entity: Corporation Service Company

Phone Number: 1-800-927-9800 Fax Number: 302-636-5454

Email Address: sop@cscinfo.com

Mailing Address: 506 South President Street, Jackson, MS 39201

Street Address: Same

State: MS Name of Entity: Senior Health Insurance Company of Pennsylvania – Patrick L. Carmody

Phone Number: 317-566-7567 Fax Number: 317-566-7585

Email Address: pcarmody@shipltc.com

Mailing Address: 550 Congressional Blvd., Suite 200, Carmel, IN 46032

Street Address: Same

State: MO Name of Entity: Senior Health Insurance Company of Pennsylvania – Patrick L. Carmody

Phone Number: 317-566-7567 Fax Number: 317-566-7585

Email Address: pcarmody@shipltc.com

Mailing Address: 550 Congressional Blvd., Suite 200, Carmel, IN 46032

Street Address: Same

State: MT Name of Entity: Senior Health Insurance Company of Pennsylvania – Patrick L. Carmody

Phone Number: 317-566-7567 Fax Number: 317-566-7585

Email Address: pcarmody@shipltc.com

Mailing Address: 550 Congressional Blvd., Suite 200, Carmel, IN 46032

Street Address: Same

State: NE Name of Entity: CSC-Lawyers Incorporating Service Company

Phone Number: 1-800-927-9800 Fax Number: 302-636-5454

Email Address: sop@cscinfo.com

Mailing Address: 233 South 13th Street, Suite 1900, Lincoln, NE 68508

Street Address: Same

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Exhibit B

Complete for each state indicated in Exhibit A:

State: NH Name of Entity: Senior Health Insurance Company of Pennsylvania – Patrick L. Carmody

Phone Number: 317-566-7567 Fax Number: 317-566-7585

Email Address: pcarmody@shipltc.com

Mailing Address: 550 Congressional Blvd., Suite 200, Carmel, IN 46032

Street Address: Same

State: NV Name of Entity: Senior Health Insurance Company of Pennsylvania – Patrick L. Carmody

Phone Number: 317-566-7567 Fax Number: 317-566-7585

Email Address: pcarmody@shipltc.com

Mailing Address: 550 Congressional Blvd., Suite 200, Carmel, IN 46032

Street Address: Same

State: NJ Name of Entity: Senior Health Insurance Company of Pennsylvania – Patrick L. Carmody

Phone Number: 317-566-7567 Fax Number: 317-566-7585

Email Address: pcarmody@shipltc.com

Mailing Address: 550 Congressional Blvd., Suite 200, Carmel, IN 46032

Street Address: Same

State: NM Name of Entity: Senior Health Insurance Company of Pennsylvania – Patrick L. Carmody

Phone Number: 317-566-7567 Fax Number: 317-566-7585

Email Address: pcarmody@shipltc.com

Mailing Address: 550 Congressional Blvd., Suite 200, Carmel, IN 46032

Street Address: Same

State: NY Name of Entity: Senior Health Insurance Company of Pennsylvania – Patrick L. Carmody

Phone Number: 317-566-7567 Fax Number: 317-566-7585

Email Address: pcarmody@shipltc.com

Mailing Address: 550 Congressional Blvd., Suite 200, Carmel, IN 46032

Street Address: Same

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Exhibit B

Complete for each state indicated in Exhibit A:

State: NC Name of Entity: Senior Health Insurance Company of Pennsylvania -- Patrick L. Carmody

Phone Number: 317-566-7567 Fax Number: 317-566-7585

Email Address: pcarmody@shiplic.com

Mailing Address: 550 Congressional Blvd., Suite 200, Carmel, IN 46032

Street Address: Same

State: ND Name of Entity: Senior Health Insurance Company of Pennsylvania -- Patrick L. Carmody

Phone Number: 317-566-7567 Fax Number: 317-566-7585

Email Address: pcarmody@shiplic.com

Mailing Address: 550 Congressional Blvd., Suite 200, Carmel, IN 46032

Street Address: Same

State: OH Name of Entity: CSC-Lawyers Incorporating Service (Corporation Service Company)

Phone Number: 1-800-927-9800 Fax Number: 302-636-5454

Email Address: sop@cscinfo.com

Mailing Address: 50 West Broad Street, Suite 1800, Columbus, OH 43215

Street Address: Same

State: OR Name of Entity: Corporation Service Company

Phone Number: 1-800-927-9800 Fax Number: 302-636-5454

Email Address: sop@cscinfo.com

Mailing Address: 285 Liberty Street, NE, Salem, OR 97301

Street Address: Same

State: OK Name of Entity: Senior Health Insurance Company of Pennsylvania -- Patrick L. Carmody

Phone Number: 317-566-7567 Fax Number: 317-566-7585

Email Address: pcarmody@shiplic.com

Mailing Address: 550 Congressional Blvd., Suite 200, Carmel, IN 46032

Street Address: Same

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Exhibit B

Complete for each state indicated in Exhibit A:

State: PR Name of Entity: Senior Health Insurance Company of Pennsylvania – Patrick L. Carmody

Phone Number: 317-566-7567 Fax Number: 317-566-7585

Email Address: pcarmody@shipltc.com

Mailing Address: 550 Congressional Blvd., Suite 200, Carmel, IN 46032

Street Address: Same

State: RI Name of Entity: Senior Health Insurance Company of Pennsylvania – Patrick L. Carmody

Phone Number: 317-566-7567 Fax Number: 317-566-7585

Email Address: pcarmody@shipltc.com

Mailing Address: 550 Congressional Blvd., Suite 200, Carmel, IN 46032

Street Address: Same

State: SC Name of Entity: Senior Health Insurance Company of Pennsylvania – Patrick L. Carmody

Phone Number: 317-566-7567 Fax Number: 317-566-7585

Email Address: pcarmody@shipltc.com

Mailing Address: 550 Congressional Blvd., Suite 200, Carmel, IN 46032

Street Address: Same

State: SD Name of Entity: Senior Health Insurance Company of Pennsylvania – Patrick L. Carmody

Phone Number: 317-566-7567 Fax Number: 317-566-7585

Email Address: pcarmody@shipltc.com

Mailing Address: 550 Congressional Blvd., Suite 200, Carmel, IN 46032

Street Address: Same

State: TN Name of Entity: Senior Health Insurance Company of Pennsylvania – Patrick L. Carmody

Phone Number: 317-566-7567 Fax Number: 317-566-7585

Email Address: pcarmody@shipltc.com

Mailing Address: 550 Congressional Blvd., Suite 200, Carmel, IN 46032

Street Address: Same

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Exhibit B

Complete for each state indicated in Exhibit A:

State: TX Name of Entity: Corporation Service Company d/b/a CSC-Lawyers Incorporating Service Co

Phone Number: 1-800-927-9800 Fax Number: 302-636-5454

Email Address: sop@cscinfo.com

Mailing Address: 211 E. 7th Street, Suite 620, Austin, TX 78701-3218

Street Address: Same

State: UT Name of Entity: Corporation Service Company

Phone Number: 1-800-927-9800 Fax Number: 302-636-5454

Email Address: sop@cscinfo.com

Mailing Address: 10 East South Temple, Suite 850, Salt Lake City, UT 84133

Street Address: Same

State: VT Name of Entity: Senior Health Insurance Company of Pennsylvania – Patrick L. Carmody

Phone Number: 317-566-7567 Fax Number: 317-566-7585

Email Address: pcarmody@shiplic.com

Mailing Address: 550 Congressional Blvd., Suite 200, Carmel, IN 46032

Street Address: Same

State: VI Name of Entity: Senior Health Insurance Company of Pennsylvania – Patrick L. Carmody

Phone Number: 317-566-7567 Fax Number: 317-566-7585

Email Address: pcarmody@shiplic.com

Mailing Address: 550 Congressional Blvd., Suite 200, Carmel, IN 46032

Street Address: Same

State: WA Name of Entity: Senior Health Insurance Company of Pennsylvania – Patrick L. Carmody

Phone Number: 317-566-7567 Fax Number: 317-566-7585

Email Address: pcarmody@shiplic.com

Mailing Address: 550 Congressional Blvd., Suite 200, Carmel, IN 46032

Street Address: Same

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Exhibit B

Complete for each state indicated in Exhibit A:

State: WY Name of Entity: Senior Health Insurance Company of Pennsylvania – Patrick L. Carmody

Phone Number: 317-566-7567 Fax Number: 317-566-7585

Email Address: pcarmody@shiplic.com

Mailing Address: 550 Congressional Blvd., Suite 200, Carmel, IN 46032

Street Address: Same

State: WY Name of Entity: Senior Health Insurance Company of Pennsylvania – Patrick L. Carmody

Phone Number: 317-566-7567 Fax Number: 317-566-7585

Email Address: pcarmody@shiplic.com

Mailing Address: 550 Congressional Blvd., Suite 200, Carmel, IN 46032

Street Address: Same

Resolution Authorizing Appointment of Attorney

BE IT RESOLVED by the Board of Directors or other governing body of Senior Health Insurance Company of Pennsylvania, this 3rd day of September, 2014, that the President or Secretary of said entity be and are hereby authorized by the Board of Directors and directed to sign and execute the Uniform Consent to Service of Process to give irrevocable consent that actions may be commenced against said entity in the proper court of any jurisdiction in the state(s) of Alabama, Alaska, Arizona, Arkansas, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Maine, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Hampshire, Nevada, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oregon, Oklahoma, Puerto Rico, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, U.S. Virgin Islands, Washington, West Virginia, and Wyoming in which the action shall arise, or in which plaintiff may reside, by service of process in the state(s) indicated above and irrevocably appoints the officer(s) of the state(s) and their successors in such offices or appoints the agent(s) so designated in the Uniform Consent to Service of Process and stipulate and agree that such service of process shall be taken and held in all courts to be as valid and binding as if due service had been made upon said entity according to the laws of said state.

CERTIFICATION:

I, Ginger Darrough, Secretary of Senior Health Insurance Company of Pennsylvania, state that this is a true and accurate copy of the resolution adopted effective the 3rd day of September, 2014 by the Board of Directors or governing board at a meeting held on the 3rd day of September, 2014 or by written consent dated 21 day of November, 2014.

Ginger Darrough
Secretary

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Exhibit 15

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.

- - -

MAGNA LEGAL SERVICES
(866) 624-6221
www.MagnaLS.com

APPEARANCES:
Counsel for the Statutory Rehabilitator of Senior Health Insurance Company of Pennsylvania:
COZEN O'CONNOR
BY: MICHAEL J. BROADBENT, ESQUIRE
BY: Dexter R. HAMILTON, ESQUIRE
One Liberty Place
1650 Market Street, Suite 200
Philadelphia, Pennsylvania 19103
(215) 665-2000
mbroadbent@cozen.com
dhamilton@cozen.com
CANTILO & BENNETT, LLP
BY: PATRICK H. CANTILO, ESQUIRE
11401 Century Oaks Terrace, Suite 300
Austin, Texas 75758
(512) 478-6000
phcantili@cb-firm.com

Counsel for ACSIA Long Term Care, Inc.: Global Commission Funding, LLC; LifeCare Health Insurance Plans, Inc.; Senior Commission Funding, LLC; Senior Health Care Insurance Services Ltd, LLP; and United Insurance Group Agency, Inc.:
CLARK HILL, PLC
BY: JOSEPH M. DONLEY, ESQUIRE
BY: SCOTT B. GALLA, ESQUIRE
Two Commerce Square
2001 Market Street, Suite 2620
Philadelphia, Pennsylvania
(215) 640-8500
jdonley@clarkhill.com
sgalla@clarkhill.com

Counsel for Anthem, Inc. Health Care Service Corporation; Horizon Healthcare Services, Inc., d/b/a Horizon Blue Cross Blues Shield of New Jersey; and UnitedHealthcare Insurance Company:

MORGAN, LEWIS & BOCKIUS, LLP
BY: HAROLD S. HORWICH, ESQUIRE
BY: BENJAMIN J. CORDIANO, ESQUIRE
One State Street
Hartford, Connecticut 06103
(860) 240-2700
harold.horwich@morganlewis.com
benjamin.cordiano@morganlewis.com
Counsel for Maine Superintendent of Insurance; Massachusetts Commissioner of Insurance; and Insurance Commissioner of the State of Washington:

RACKEMANN, SAWYER & BREWSTER, P.C.
BY: J. DAVID LESLIE, ESQUIRE
BY: ERIC A. SMITH, ESQUIRE
160 Federal Street
Boston, Massachusetts 02110
(617) 951-2300
dleslie@rackemann.com
esmith@rackemann.com
Counsel for National Organization of Life and Health Insurance Guaranty Associations:

FAEGRE DRINKER BIDDLE & REATH, LLP
BY: CARYN M. GLAWE, ESQUIRE
BY: JANE DALL WILSON, ESQUIRE
300 North Meridian Street, Suite 2500
Indianapolis, Indiana 46204
(317) 237-0300
caryn.glawe@faegredrinker.com

FAEGRE DRINKER BIDDLE & REATH, LLP
BY: D. ALICIA HICKOK, ESQUIRE
One Logan Square, Suite 2000
Philadelphia, Pennsylvania 19103
(215) 988-2700
alicia.hickok@faegredrinker.com

WITNESS INDEX

NAME	PAGE
Richard Cantilo	
Direct	14

EXHIBIT INDEX

NUMBER	DESCRIPTION	MARKED	ADMITTED
R1	Curriculum Vitae	15	___
R2	Second Amended Plan	95	___

P R O C E E D I N G S

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

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

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

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system; the lawyers representing the intervenors can come up as a group. There's plenty of social distancing at the Respondent table.

And with that, we will call Jessica Altman, the Insurance Commissioner of Pennsylvania, to begin her case in support of the Second Amended Plan of Rehabilitation of the Senior Health Insurance Company of Pennsylvania.

MR. BROADBENT: Good morning, Your Honor.

JUDGE LEAVITT: Good morning, Mr. Broadbent.

MR. BROADBENT: As the Court just acknowledged, my name is Michael Broadbent. I'm here with Cozen O'Connor on behalf of the Rehabilitator, Jessica Altman, and I will refer to Senior Health as SHIP throughout and I think everyone will do so as well.

I intend to keep the opening short, I think as Your Honor requested, primarily just to lay out the big picture things that we intend to present, as well as the evidence you

will hear from various witnesses.

Our goal is to present the Court with what we believe is the reasonable and thoughtful analysis of the Rehabilitator, ultimately reflecting the exercise of our discussion, properly designing a plan and intending to implement one that we believe will impact materially and position SHIP in a way that is highly beneficial for the policyholders.

So the central concept of the plan is to provide policyholders options that reduce or eliminate expensive, sometimes unwanted or unneeded benefits, thereby reducing the deficit but in a way that gives the policyholders a choice in allocating the loss for themselves. As the testimony and exhibits will demonstrate, the plan provides the policyholders with meaningful choices that cover their future benefits and premiums that they can collect on their own. We think it is a far better outcome than an immediate liquidation and we intend to show that it is fair, equitable and constitutional to approve the plan.

The Court knows that the current and

projected assets are insufficient to meet the liabilities and we make no mistake it will be difficult to fully restore SHIP to solvency or to effectively rehabilitate the plan, but we believe this is the way to do it despite the poor financial health of the company.

Really none of the objections we have heard, and we will address that in time, demonstrate that the plan should not be approved, that it is not fair and equitable, and it does not offer the policyholders what is truly beneficial to them, and that is choice in the outcome they will face in the insolvency.

With the assistance of Special Deputy Rehabilitator Patrick Cantilo and Oliver Wyman, an actuarial consultant, and other counsel, and we developed this plan and we intend to put on three witnesses in support.

The first is Mr. Cantilo, the Special Deputy Rehabilitator. In that role, he oversaw the development of the plan and its predecessors, the earlier stages of the plan. And as I think the Court knows, Mr. Cantilo is really an unparalleled authority on these matters, and we believe that the plan he

developed, in conjunction with the Rehabilitator and other consultants, should be approved.

I will give a brief overview of the testimony he intends to present today and tomorrow. He is going to briefly lay out the company's financial history and the history of the entity itself, explain both how we got here and the scope of the current LTC business and the deficit that should face us.

As Mr. Cantilo will explain, there is approximately 40,000 in force policies which have been vastly underpriced for many decades. The result of policyholders paying far less in premium than necessary, which is in part inconsistent rate approvals across the state and other factors, ultimately leading to the policyholders across the state paying those varying rates to receive their benefit coverage.

And on the subject of rate increases, Mr. Cantilo will provide the Court with a little bit more historical background on SHIP's increases as they were requested, they were approved, and to what degree that really

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has greatly impacted SHIP's current financial health, and why we think one of the reasons -- and that's one reason why we think the current plan and the way it sets rates in a seriatim basis hearing with the Court's approval addresses that issue and, ultimately, provides the best solution.

The result of all of this is that there is inequities in the way the policyholders pay premiums that subsidize some of the more valuable coverage that Mr. Cantilo will help the Court see how that plays out for SHIP's policyholders.

Mr. Cantilo will briefly address the efforts of the Department prior to rehabilitation, those things that the Department did to try and identify the problem at SHIP and encourage SHIP to cure the problem itself, ultimately unsuccessful, leading us to the rehabilitation.

After the background, Mr. Cantilo will turn to the plan itself, summarizing the key provisions and explaining the important details of the design and operation which, as I think the Court knows, will proceed in three

phases. Mr. Cantilo will address to the extent possible each one of the phases;

Phase 1, in which the policyholders are given a set of options using this new premium mechanism, which Mr. Cantilo will explain how that was adopted and the reason why that works here and the various options, how they will be presented to the policyholders, and what their choices are.

Mr. Cantilo will address further briefly, Phase Two and the idea of -- the flexibility of Phase Two and the way that's designed to address any remaining deficit as it appears at the end of Phase One.

Finally, Mr. Cantilo will turn to the reactions of the plan to the various parties and address some of the concerns that those parties have raised, specifically, a comparison of the plan to liquidation and help the Court understand why the rehabilitators concluded the plan is ultimately a better outcome than immediate liquidation.

I will pause there also to address the issue of state rate approval option -- Mr. Cantilo will explain it to the Court -- and the

reasons why this option effectively gives those states that do not want to have the Court approve a plan that sets rates through the Rehabilitator, those Courts are now in control of their own destiny -- those states are in control of their own destiny. They can choose to opt out of the plan and then decide for the policyholders, over whom they would otherwise have authority, what the rates will be and what the options will be.

After Mr. Cantilo concludes, we will offer Marc Lambright and actuary Oliver Wyman. Mr. Lambright is expected to testify exclusively as to the efforts of the Department prior to rehabilitation to understand the scope of the issue of the SHIP and to understand the actuarial analyses and ultimately, again, try and get SHIP to right itself. We expect Mr. Lambright's testimony will be brief and focus on these issues.

Following Mr. Lambright's testimony will be Vince Bodnar, again Oliver Wyman. Mr. Bodnar will provide significant testimony on the scope of the plan, the way that it operates, the options available, the

development of the plan, and he will, again, in supplementing what Mr. Cantilo has testified to, advise the Court as to why the rate structure that the Rehabilitator proposes to adopt not only addresses the deficit of SHIP but does so in a way that actuarially justified in effect consistent with the rate setting mechanism that the states themselves use across the country.

And Mr. Bodnar, like Mr. Cantilo, will conclude his testimony with analyses to compare liquidation and rehabilitation, ultimately leading to the same conclusion that we hope the Court will find, which is rehabilitation is better than liquidation in this case.

And I will conclude only by pointing out, as the Court knows, long-term care insolvency of this magnitude are not common. The Court is well familiar with Penn Treaty, but this is not Penn Treaty. We have limited opposition from the various parties, not as to the financial condition of the company or assumptions or projections and liabilities, but focuses exclusively on what we believe are

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narrow issues that the plan more than adequately addresses, in fact, in a way that is thoughtful and truly resolves any legitimate concern those parties may have.

And we expect that Mr. Cantilo and Mr. Bodnar will preemptively address some of those concerns and, of course, draw them out as necessary, on cross-examination.

So I will conclude what I promised would be short and was perhaps longer than I intended by calling Mr. Cantilo to the stand unless Your Honor has any questions she would like me to address now.

JUDGE LEAVITT: No. Thank you. That was just the right length.

MR. BROADBENT: It might be easier as well for me to question from --

JUDGE LEAVITT: That's fine.

PATRICK CANTILO, a witness herein, having been first duly sworn, was examined and testified as follows:

DIRECT EXAMINATION

BY MR. BROADBENT:

Q. Sir, can you please -- are you ready?

A. I'm sorry.

Q. Sir, can you please state your name?

A. Patrick Cantilo.

Q. Mr. Cantilo, I'm going to ask Mr. Martin to put what was marked as the proposed Exhibit 9 --

MR. BROADBENT: Your Honor, would you like a paper copy of this exhibit?

JUDGE LEAVITT: How many pages is this?

MR. BROADBENT: It's just Mr. Cantilo's CV.

JUDGE LEAVITT: Yeah, you can give one to them. Could you check to make sure his microphone is up.

Mr. Broadbent, do you have your microphone all the way up? I think that is as high as it will go. Thank you.

(Exhibit R1 was marked for identification.)

BY MR. BROADBENT:

Q. Mr. Cantilo, do you see what was previously marked as Rehabilitator's proposed Exhibit 1 there on the screen?

A. I do.

Q. What is this document?

A. That is my Curriculum Vitae originally.

Q. And it is true and correct as of the date it was prepared?

A. It is.

MR. BROADBENT: Your Honor, we would offer Mr. Cantilo's CV as Exhibit 1. And I will pause here for a moment. Also, on the remaining exhibits, Your Honor, we had spoken with the parties and stipulated to the admissibility of all exhibits offered by the parties.

JUDGE LEAVITT: Okay.

MR. BROADBENT: Everyone has agreed to that. We will make reference to exhibits throughout that Mr. Cantilo's testimony and the testimony of others without introducing them, but they will be available on the screen. And, of course, if there is something we need to examine further, we will do so.

JUDGE LEAVITT: All right.

BY MR. BROADBENT:

Q. Mr. Cantilo, can you please tell the

Court about your initial involvement in SHIP?

A. I was contacted by the Pennsylvania Insurance Department about SHIP sometime in late 2017 and was engaged in early 2018 as special RBC counsel to help the Department in understanding the financial condition of the company at that time.

Not long after that, we entered into a written agreement with the company that denominated me special representative of the department, and I continue in that capacity.

Q. Can you just define briefly RBC for the record?

A. I'm sorry, I'm having a hard time hearing you, sir.

Q. Can you briefly define RBC for the record?

A. Certainly. So insurance companies like SHIP are required to report to the regulators their risk-based capital, which is a formula that applies certain risk components to the capital held by the company and produces a ratio of the capital the company actually has to the total capital that it should have.

Q. I believe you testified that you

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entered into some sort of agreement with the department as a special representative?

A. Actually, that was an agreement with SHIP. In lieu of placing SHIP in supervision when the Department became concerned about its financial condition, it entered into an agreement, which I actually negotiated on behalf of the department between SHIP and the trustees who oversaw SHIP, and the main points of the agreement were to constrain the ability of the company to undertake certain types of transactions without department approval, for example, large possession of assets or large insurance transactions, things of that nature.

And also to appoint me as special representative and specify areas over which I would have authority which, basically, would be oversight of the company and prior approval by me of any extraordinary transactions.

And it also imposed an additional financial reporting requirement, some monthly reporting and some quarterly reporting, beyond what would normally be required statutorily.

Q. Are these, the limitations that you were just describing, are those standard in a

supervision of this type?

A. Yes. The limitations were typical of what you would find in an insurance supervision order in which the Commissioner appoints a supervisor, but does not go to court to place the company in liquidation or rehabilitation.

Q. Was the Department in control of SHIP at this time?

A. No.

Q. What did you do as the Department's representative?

A. My first role was to do what I could to drill down to ascertain the true financial condition, because members of the department and I suspected, from information available to us, that the statutorily filed annual statements and quarterly statements understated the company's reserve amounts and overstated surplus.

So I spent a lot of time communicating with management, outside counsel and the trustees, requested a lot of information from them, and the company was very cooperative in providing that, provided some of

that information directly to the department, some I analyzed myself and a lot of it was analyzed by the Oliver Wyman firm, which were our consulting actuaries, all with an aim to better understand SHIP's true financial condition.

In addition, there were a couple of transactions in which the company had engaged which were troublesome, and I worked with management and the trustees to extricate the company, to the extent possible, from those transactions.

Q. You mentioned Oliver Wyman. Do you recall with whom you worked at Oliver Wyman?

A. Yes. Initially, it was Marc Lambright, who had been engaged by the department previously as part of a special investigation the Department was conducting of SHIP, and that examination was focused on actuarial assumptions.

Later, the Oliver Wyman team expanded. Mr. Bodnar became involved, as well as Lara Chikhani and Mr. Oliveira, and I think there were other people involved but not as intensely.

Q. How long did you remain in the position of Department's representative for SHIP?

A. From February 2018 until January 2020 when the company was placed in rehabilitation and I was named as Special Deputy Rehabilitator.

Q. I would like to turn to the history of the company now. Can you just give a brief summary of SHIP for the Court?

A. Certainly. And I have a slide that we might put up that summarizes it. So as you can see, the company is quite old. It was formed in 1887 as the Home Beneficial Society. And about a hundred years later, it started selling long-term care insurance policies after it became the American Travelers Insurance Company.

In 1996, it was acquired by Conseco and became part of that group and was renamed Conseco Senior Health Insurance Company.

By 2003, SHIP had sold 645- or 646,000 long-term care policies around the country, and it continued the sale of new business as it realized that that business was

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not profitable.

So it went into runoff in 2003, still as a part of Conseco, and in 2008, in discussions with the Department, by which I mean the Pennsylvania Insurance Department, Conseco spun off SHIP, it was renamed Senior Health Insurance Company of Pennsylvania. It became owned by a newly formed trust, the Senior Health Care Oversight Trust, of which there were five trustees, four of whom were former insurance regulators and one who was a consulting actuary.

From that date, early 2009 forward, it was an independent company overseen by the Trust and, in January of last year. It was placed at rehabilitation.

There is a more detailed history of the company which appears in the plan itself and is on this next slide. That shows the various transactions on which the company engaged. The testimony I just summarized, I think, is a good overview. That slide, as I say, is Table 7 and the rehabilitation plan itself.

Q. Mr. Cantilo, I just want to pause

for an administrative question. I see at the bottom here, it says, source Rehabilitator's proposed Exhibit 55. I think everyone knows what that means. Can you just explain the citations?

A. Certainly. So I would be using some slides today, if the Court allows me to do that, to illustrate my testimony. Except when the slides are my own summary of events, whenever they are actual documents, they are part of or derived from exhibits. And for the sake of clarity, at the bottom left on each slide, I identify the exhibit or exhibits from which the slide came.

So this one comes from the proposed Exhibit 55, which is the Second Amended Rehabilitation Plan.

Q. Mr. Cantilo, I believe you mentioned certain trustees. Do you recall any of their names?

A. So as shown on Slide 5, the trustees were Julian Bower, who was former Massachusetts Insurance Commissioner; Thomas Hampton, who was a former District of Columbia Insurance Commissioner; John Morrison, who was a former

Montana Insurance Commissioner, and Gregory Serio, who was a former New York Superintendent of Insurance, and Cecil Bykerk, who was life and health insurance trustee.

These were the trustees at the time I became involved in 2018, and they continued in their tenure until January 2020 when the company was placed in rehabilitation.

They had served for several years before that, but there had been other individuals who served as trustees before, in some of these slots before that.

Q. Mr. Cantilo, how, if at all, has SHIP been affected by the Covid-19 pandemic?

A. In a number of ways. Like most other companies around the country, we began a work from home regimen in March of last year. We also ceased in-person visits to insureds and caregivers and started doing qualifications for benefits and monitoring of the benefits virtually, remotely.

As far as the actuarial strength of the company, over the few months since the pandemic began, we experienced a moderate increase in mortality, that is, more of our

insureds died than would otherwise have been the case and terminations, that is, lapses of the insurance policy because the policyholders discontinued paying premium or because they passed away.

I should specify with respect to terminations that, in many states, the insurance regulators imposed a hiatus on the termination of policies for nonpayment of premium. So insurers, including SHIP, could not simply cancel the policies of people who could not pay their premiums.

Those suspensions of the ability to terminate policies have mostly gone away by now and so there was a little bit of a buildup of policyholders who had not been paying premium for a while who were lapsed after that. Others resumed paying premiums.

In addition to the improvement -- I'm sorry, to the increase in morbidity and mortality, I should say, and in the terminations, we experienced a little bit of an increase in morbidity but, more importantly, we experienced a reduction in the yield that the company's invested assets were generating.

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That is an industry-wide problem. The broader capital markets have been depressed as a result of the pandemic, and so the assets, the money that SHIP invested in the capital markets yielded less money than it had before the pandemic.

All together, though, in the aggregate, all of these effects that I have just summarized are not material to the plan itself and have had a relatively moderate aggregate effect on the company's financial condition.

It is ironic that an increase in morbidity tends to be helpful to long-term care insurers because insureds tend to pass away before they can collect the benefits that were expected, so the increase in morbidity, the rate at which people became ill, was offset to some degree by the increase in mortality.

Q. I just want to clarify, you described the effects in the aggregate on the plan. I'm not sure that I heard what your answer was, but can you just tell us, were they material or not material?

A. They are not material to the plan,

and they have not, in the aggregate, been material to the SHIP.

MR. BROADBENT: Your Honor, I need to pause for what appears to be a technical issue.

THE WITNESS: Yeah. It is not on our end. Because my screen is showing the slide.

JUDGE LEAVITT: It is on mine. Not on that the one. I think the Court crier went to get help.

MR. BROADBENT: Should we proceed?

JUDGE LEAVITT: I think we can continue.

MR. BROADBENT: Thank you, Your Honor.

BY MR. BROADBENT:

Q. Mr. Cantilo, talking about the company as a whole, how many insurance policies does SHIP have in force, not just the LTC, all policies?

A. Right now that is approximately 85,000 policies, of which more than half, about 45,000 are non-LTC policies and about 39,000

are LTC policies. The 45,000 that are not LTC policies were transferred by reinsurance, although not notated to Conseco at the time that SHIP was spun off. So Conseco and their subsidiaries administer those policies and pay the expenses associated with the policies, including the claims, and for that purpose, established a Trust that we have been monitoring throughout the history of the independence of SHIP and which remains adequately funded.

So although most of the policies that SHIP has on the books are not LTC, in reality, they don't consume SHIP resources.

The 39,000 policies that are long-term care are fully the liability of SHIP. SHIP does not have any reinsurance attached to those policies.

And I do have a slide which, I believe, is Slide 10 -- I'm sorry, it's up. That just summarizes the history of the Trust I mentioned so that we can see that it has been fluctuating between 1 and 2 million -- I'm sorry, one and a half and $6 million over the last few years, but all in the positive.

JUDGE LEAVITT: Excuse me, Mr. Cantilo.

Ms. Gan, you see if we could get some help because I think people who want to do cross-examination are going to want to see these.

Just so I'm clear, Mr. Cantilo, we're talking today about 40,000, approximate, long-term care policyholders?

THE WITNESS: Yes, Your Honor. We have -- I think the last number I saw was 39,143, to be precise. But that changes every day. It goes down every day, I should say.

JUDGE LEAVITT: Yep.

BY MR. BROADBENT:

Q. While we're waiting for a slide, I can ask a slideless question. Mr. Cantilo, you just gave us a pretty detailed statistic, and I believe the last slide gave detailed statistics regarding SHIP's non-LTC business. How did you come across these numbers personally?

A. They are in the records of the company, and I also have that and Exhibit 55, which is the second amended plan, that details the non-LTC business and the Trust business

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that I just described. So what's up there now, slide 9 summarizes the non-LTC business for which I say Conseco is responsible. So that has not been an aspect of the rehabilitation.

Q. So Mr. Cantilo, I would like to focus on the long-term care policies that are the focus of the rehabilitation.

A. So, as I said, we have a bit over 39,000 of those out of the 645- or 646,000 that have been sold over the years with LTC. About 53 percent of SHIP's current policyholders are paying premium. The remaining 47 percent either have already taken a non-forfeiture option and do not pay premium or on premium waiver of one sort or another.

SHIP policies provide three kinds of premium waiver. There's a traditional claim waiver so that, on many policies, once the insured becomes ill and is qualified for benefits, he or she does not have to pay premium.

There may be a ninety-day waiting period for some policies and others that are right away, but so long as they continue qualifying for benefits, they don't have to pay

premium, so that's what we call a claim waiver.

Then what we call spousal waiver or dual waivers, those are waivers that allow the spouse of a policyholder on a claim to suspend premium payments so long as the spouse remains on the claim.

And the third kind are lifetime waivers, and those are waivers that are triggered, typically, by longevity with the company; after so many years of paying premium, you become immune from future premium payments.

If you add all categories together, plus the people who have taken the non-forfeiture option -- as I said, about 47 percent of our policyholders are not paying premiums today. Many of the policies at SHIP are the most expensive in terms of liability, they are the ones that have five percent compound inflation, unlimited lifetime benefits, the non-qualified triggers which allow qualification for benefits more easily, and short elimination periods.

The average age of our policyholder now is about 86 and the ones on pay are 89 years old.

Q. For the sake of the record, I'm just going to ask you to define a couple of things that you mentioned in there.

A. Sure.

Q. You mentioned non-forfeiture option. Can you explain what that is in the ordinary course?

A. Sure. Long-term care insurance policies, typically, have a feature that allows a policyholder to discontinue paying premium and receive continuing coverage that, in general, consists of the value of all the premiums paid in, less all the claims paid by the company, over the life of the policy.

Those, we sometimes call those reduced paid-up policies. So those policies are, typically, very modest in benefits because the amount of money I just described doesn't provide for a whole lot of benefit, but it's better than getting nothing.

So insureds that realize they are not able to afford paying premium anymore can request to NFO. Some policy forms require it, some don't. Some states require NFOs as an option and some don't, but SHIP universally

makes them available to policyholders who prefer it.

Q. Mr. Cantilo, on the slide here, there is five percent compound inflation riders. Can you explain what an inflation rider is, please?

A. Certainly. For many of the policies sold, especially in the late '70s and '80s and '90s, one of the features that a policyholder could select and for which, typically, a separate premium was paid was that the maximum daily benefit, that is, the amount the company would have to pay every day for care that qualified under the policy, would be increased annually by a stated inflation percentage.

For some policies, that was a simple interest calculation, and for others it was compounded. So that in Year 2, the increase was applied to the previously increased amount at the end of Year 1.

The most generous of those benefits were the five percent inflation, which, in the LTC industry, is kind of the worst of the bad boys. So it's five percent compounded annually and frequently results in a policy that started

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paying $100 a day in maximum daily benefit when it was issued, now having $650 a day in available benefits.

And complicating the problem is the fact that a lot of SHIP's policies are what are called indemnification rather than reimbursement policies.

Reimbursement policies require SHIP to reimburse the policyholder, as the name suggests, for the actual cost of care. For an average nursing home, that might be $350 or $400 a day.

An indemnification policy requires SHIP to pay a maximum daily benefit no matter what the cost of care is. So if you can imagine a policy on which the maximum daily benefit has been inflated to $650, and the average cost of care is $350, that policyholder would then qualify for benefits as getting additional $300 that is not required for the payment of care.

That is a feature that looks a little bit like a disability policy. And that is a big contributor to our overall deficit at SHIP. We lost the exhibit again.

Q. I did have one more slideless question, which will hopefully carry us to the projector working, which was, can you also define please elimination period?

A. Yes. Elimination period is a feature of long-term care policies that looks a little bit like a waiting period, or it is a little bit different. A policyholder has to qualify for benefits for the specified number of days. The most common is 90, but there are policies that have elimination periods as long as a year. And during that period, the policyholder has to actually receive the care and pay for the care, and after that period is expired, then the policy instructs further care.

For a policy to be tax qualified, that is, under the Internal Revenue Code to favorable tax treatment, the waiting period -- sorry, the elimination period has to be at least ninety days.

Q. So returning to the LTC business as a whole, in what states does SHIP have LTC business in force?

A. Now, it has business pretty much

everywhere. It was authorized to sell business in all but four states. The 39,000 policies in force, as we can see on Slide 12, the majority were issued in five states, with Texas leading the charge, Florida being the second. Then Pennsylvania was the third in terms of volume, followed by California and Illinois.

So those five states have the majority of SHIP's business in force.

Even though there are states in which the company was not qualified, like Connecticut, policyholders whose policies were issued in other states have moved to Connecticut since then, so we have business pretty much in every state.

Q. The total approximate 40,000 policies, are all of those policies in the same status with respect to being on claim or being on waiver?

A. No. In Slide 13, I provide a summary of their status. So we can see that the largest segment is policyholders that are paying their premium and not on claim. Those are the ones you want to have if you are a long-term care insurer.

The next largest category is the policyholders who are still not on claim but have taken a non-forfeiture option at some point in the past. So those individuals are not paying premium, but they are not on claim.

Then we have the group of policyholders who are not on claim but have premium waiver. Typically, that would be either a spousal waiver or a lifetime waiver.

And then we have a fair number of policyholders who are on claim and are not paying premium, and then some policyholders on claim who are paying premium.

So not every policy has a premium waiver and, as you can see on that slide, we have 914 policyholders who are on claim but still required to pay a premium.

The last is NFOs who are on claim.

Q. How much premium are the policyholders paying to --

A. It varies. On Slide 14, we provide a breakout of those premiums. That comes from Exhibit 33 or, I should say, proposed Exhibit 33. As you can see all the way on the left, the majority, the largest group of

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policyholders at 47 percent are not paying premium, and those are the ones I described a little bit earlier.

The category of policyholders paying premium between $1,000 and $2,500 is the next largest group, and about 22 percent or so of the policyholders are paying more than $2,500 a year in premium.

So we have some policyholders paying very high premiums, but the majority are paying less than $2,500 or no premium at all.

Q. Can you tell the Court a little bit about the demographics of the policyholders?

A. Certainly. As is typical in long-term care and life insurance companies, the group is predominantly female. As time passes, that skews more that way. So for SHIP, it is even more skewed than it was Penn Treaty, with 71 percent of our policyholders being female. The majority are in their 80s and 90s. We do have some policyholders in their 70s and 60s, and a few are a hundred.

The policies that we have in force, about 70 percent of them provide comprehensive coverage, meaning that they cover both home

health care and facility care, facility care being either nursing home or assisted living facility. And about 17 percent provide only nursing home coverage and 13 percent home health care only.

As I show on the right side of the slide, we have 47 percent of policies in force with inflation protection, that's a pretty high number.

Q. Do each of SHIP's policies provide for the same benefit period?

A. No. The majority of our policies, we have a large number that are -- our lifetime benefit is shown on Slide 17, all the way to the right, but the majority of our policies provide between one and four years in benefits.

Q. How is that time period determined?

A. The policy itself specifies for how long you qualify for benefits, so from the moment you go on claim, you start running the clock. If your policy has a four-year benefit period, that clock runs, and then when you stop being on the claim, the clock stops.

There are some policies that have restoration of benefits provisions, and which

if you're off claim long enough, it goes back to the beginning. So you have a four-year benefit period and you're off claim for six months after being on claim for two years, it goes back to four years. Otherwise, every period of claim reduces that benefit period. The lifetime benefit policies, there is no limit on the benefit period so you can be on claim for four hundred years if you're unlucky enough to live that long.

Q. Mr. Cantilo, you said there was maybe 646,000 policies sold and 39,000 in force. Can you spend a little more time in the detail of the history of those policies?

A. Certainly. So the company might peak just a few years before it stops selling business in the 1990s, when it had over 300,000 policies in force. As you can see on the curve on Slide 18, it then began a decline. In 2003, it stopped selling new business, so that decline steepened a little bit.

By the time the company was spun off in 2009, there were about 130,000 policies in force. And as I stated, by now, we are at about 39 ,000 and you can see that we are

projecting that curve to flatten a little bit as the number starts to diminish more rapidly in the next few years and then diminish slowly after that.

Q. What is the current trend with respect to the claims of the company?

A. Well, because the number of policies in force has declined so rapidly, so has the volume of claims. That's typical in a block of this nature. So on Slide 19 we see the projection through the end of last year. You can see, other than for some peaks and valleys, the general trend back from 2015 to 2019 has been a rapid decline in claims.

That has been the period after the company was spun off. Of course it has not been selling any new business in the last 18 years.

Q. How does the trend in claims compare to the trend in premiums?

A. Well, that's not a good picture. So the orange curve on Slide 20 is the projection of claims paid in the aggregate. The blue or, rather, green curve is the projection of premiums paid in the aggregate.

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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

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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

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period in question.

So the red bracket at the top is the period during which SHIP was selling long-term care policies. You can see at the beginning of that period, market interest rates were above 13 percent. It would not have been unusual or inappropriate for a SHIP actuary to project those kinds of investment rates for its invested premium. But you can see that the picture has been pretty disappointing since then. These are U.S. Treasuries. SHIP, like most insurers, invests in corporate bonds and is spread, usually treasury and corporate, between one and two points. That spread varies a lot with changes in the market, but what I am showing you is a picture of treasury. What SHIP was looking at when it sold those policies was a picture for corporate, which would have been, as I said, one or two points higher at least.

So even if you take that, and maybe we can go to the next slide, you take a very conservative estimate of this and assume that you are planning on seven percent interest rate, seven percent yield, what that table, and

that's the table I created, what that table shows is the drop in interest rate is very expensive.

On a $1 billion investment, that dropped from seven percent to three percent. That is a four point drop over a 20-year period will cost you over $2 billion in income on a $1 billion investment. SHIP was investing about $3 million at that time in excess.

So just a drop in market rate was devastating to SHIP and all other insurers that had progressive products.

Q. Let's focus on SHIP specifically. Were there any investment problems that arose for SHIP as opposed to other insurers?

A. Certainly. SHIP management, and by the management of another -- I'm sorry, my mic is cutting out on me -- made efforts to improve its yield to counter the impacts of the broader economy. Most of us know that that is usually a fairly frustrating exercise and was not any less so for SHIP.

They invested in two programs and, at the end of the day, we think might have cost the company between 150 and $300 million in

lost capital. And there were reasons for those exercises, one we call the Beechwood program and the other Roebling Re, were efforts to improve the yield on invested assets.

Q. How did SHIP's operating costs compare to other companies?

A. As I mentioned a bit earlier, they were higher. Of course, costs are a little bit of landscape. Companies that are very well capitalized can afford to have higher operating costs than others. But for a company in SHIP's condition, which is a runoff vehicle, the costs of accounting became very high, but we have been successful, and Mr. Robinson, the Chief Rehabilitation Officer, continues to be successful in sharpening the pencil and reducing those operating costs.

Q. Just two clarification questions. First, how do you know how SHIP's operating costs compare to other companies?

A. There is actually a lot of data available in the public, but I am also familiar with that subject from my time working on the Penn Treaty efforts, when we looked at market rehabilitation costs and availability of

vendors to provide administrative services to insurance company.

Q. You mentioned Mr. Robinson. Can you just give his full name and describe, again, his title and duties?

A. He is here so I am going to have to -- I'm talking about Robert Robinson, who was both the Chief Rehabilitation Officer for SHIP and the Chief Rehabilitation Officer for Penn Treaty.

Q. We have talked, Mr. Cantilo, about an inability to increase premiums. Can you explain that a little further?

A. Yes. So SHIP, like all long-term care insurers, is required to obtain the approval of the regulator in the state in which a policy is issued before raising the rates for those policies.

So on Slide 32, we have a graph showing the actual premium rates that SHIP charged from 2009 to 2020. On the next slide, Slide 33, I show what that would have been if the company had been successful in charging at least a new premium during that period.

The next slide shows graphically

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what that difference is. One of the aims of the plan is to eliminate that gap and bring all of our rates, as much as possible, to the if Knew level. But even if we are successful in doing that, just that gap during the period of time covered by this graph is about $300 million.

Q. Mr. Cantilo, we are going to spend some time, I expect, focused on this Knew Premium, but can you give the short explanation as to what that means?

A. Certainly. If Knew Premium is rate methodology which assumes that the current premium is what a company would be charging at this point in time, if it had known from the time that it issued the policy, how the liability would evolve over the ensuing years. Typically, when you sell a long-term care insurance policy, you are required to assume a specified loss ratio, generally between 60 and 65 percent, which is to say the regulators will only approve the rate if you are going to devote at least that much to payment of benefits rather than profit or something else.

So the If Knew methodology that we

use assumes a 60 percent loss ratio from inception to the current point. And, as I said, it assumes that the company will have been pricing that way all the way through, and the term is what the premium rate would be today.

That methodology is widely in use around the country. It is a methodology that a lot of insurance departments use to analyze increased applications.

It's also very similar to the methodology that the guaranty associations used in getting rate increases after Penn Treaty which was placed on liquidation.

The methodology we used does not have a component for the recoupment of past uncollected premium. There are variations to the methodology called the Texas and Minnesota approaches, which also add a component for recouping past uncollected premiums.

We haven't done that for two reasons. One is it would make the rates rise even higher and be more burdensome to our policyholders but, more importantly, it would cause our remaining 39,000 policyholders or,

actually, 20,000 or so paying premium to have to make up premiums that policyholders no longer in the company should have paid years ago, and that didn't seem very equitable.

Q. Thank you. Turning back to Slide 34, do you know whether, between '09 and 2020, SHIP became aware that its rates were too low?

A. Yes. SHIP --

Q. When was that?

A. Well, early in that decade, SHIP started sending rate applications to the various states, bearing in mind that SHIP had been spun off from Conseco, so it was now an independent company, it filed an application in 2010, 2011, 2012 around the country for various products.

Q. Let's turn to the 2010 requests.

A. As we can see on Slide 35, in 2012, the company filed about 429 requests, of which 58 percent were approved, 26 percent were partly approved, and 16 percent were rejected.

Then if we look at the next slide, you will see a similar picture for 2011, that the renewal rate went down to 39 percent, the partly approved rate went to 35 percent, and

the percentage of resulting in no increase went down from 26 to 10 percent.

My next slide shows the same experience for 2012 with, again, the majority being approved at three percent and then we have 35 percent partly approved at 22 percent that resulted in no increase.

Then in 2013, as shown on the next slide, inexplicably, the company concluded that it was doing great and didn't need any more rate increases, and so it stopped filing for rate increases. It didn't start again until 2016.

And then if we look at Slide 39 and Slide 40, we see the experience for some of the company's policies, and this is a particular block, this is the block of policies that have compound inflation for life. And you see the same kind of sparse approval of the rate increase, only 31 percent were fully approved, 33 percent were partly approved, 13 percent were approved but spread over several years, and then 23 percent, again, resulted in no increase at all.

On Slide 40 we have the experience

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for a different group -- I'm sorry, for the same group for a different time period. It is, again, comparable experience, although now you can see the municipal rate went up 49 percent. That is a much smaller -- not to belabor too much, Slide 41 and 42, I show a different policy. These are the policies that have zero elimination period. These are troublesome for insurers because it is much easier to start collecting money when you don't have to pay out of your pocket for 90 days or 120 days.

So the industry walked away from the that. But SHIP tried to get ready for these two, and as you can see from the 2018 to 2020, five percent of those were rejected.

There is a little bit of psychology that sometimes hurts troubled insurers that are regulators, and this is based on my experience that regulators around the country who fear that the insurers that making the rate increase request is going to end up in rehabilitation or liquidation, and if that's the case, why have rate increase, and I think that accounts for the high rejection rate for the 2018 to 2020 period.

Slide 43, I summarize a lot of experience in the same slide, and as you can see, the projection rates, which are the third line down, are pretty high during this period. This goes between 2016 and 2020.

And then even more indicative is Slide 44, where I have compiled all the information for all the states over the entire period, and that there are several things important about this data, and maybe it's easier if I show it in bar chart form, so we can go to Slide 45.

That slide, in each column, shows the percentage of requested rate increases that were approved over that period of time by each of the states. There are four states in which the company was not authorized to sell policies and, therefore, no rate increases were sought from those states.

But the others, you can see that there is a wide variance. For example, Florida, which is one of our largest states, has around ten percent approval rate, whereas other states, like Alabama and Alaska, have almost a hundred percent approval rate.

This is troublesome in at least two ways. One, of course, is, it provides less revenue to offset expenses. But more importantly, as I said earlier, it creates a kind of discriminatory or inequitable rate structure that has been the focus of a lot of criticism in the regulatory community.

So you have regulators in states, and I'm not saying they, specifically, do this because I want -- if you were in a state like Illinois, which tends to approve a lot of the rate increase requests, and you look at a state like Florida, which does not, you, as an NLR regulator, would become concerned that your policyholders are subsidizing the Florida policyholders.

And, unfortunately, one of the side-effects of that is that regulators who normally would be inclined to approve rate requests are more hesitant to do so because they think the money they are approving will go to offset the unwillingness of other regulators to approve rate requests.

That is a very big problem and one of the major targets of our rehabilitation

plan. And the use of If Knew agreements, as I will explain in a few minutes, is intended to put everyone on a level playing field going forward.

Q. The last few minutes you talked a lot about what regulators do or do not do or factors that may impact their thinking. How did you come by the understanding to which you just testified?

A. Well, I have been, for a long time, very active in the deliberations of the National Association of Insurance Commissioners, including groups working on long-term care issues, so I have a lot of personal discussions with regulators around the country about these issues.

Q. When SHIP collects its premium, what happens to those assets?

A. So SHIP, like most insurance companies, has a general pool of assets into which they deposit all of their premiums and all their investment income from which they collect and which they take all of their expenses and all of their claim payments.

So a dollar that I may pay as a

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policyholder will be combined with the $2 you will pay as a policyholder and the $3 Mr. Robinson will pay as a policyholder and that entire pool will become available to any part of our claims.

That means that when Florida only approves nine percent of the requested rate increase, it is making a much smaller contribution to that pool of assets than, say, Illinois, Virginia, Pennsylvania, Texas, one of the states that tends to get a lot of rate increase approvals.

The effect of not approving rate increases, in essence, is to -- not overtly, but inherently require other states to subsidize the policies issued in your state.

And I have illustrated that since they are in the room with us today, with our experience with Maine, Massachusetts and Washington. So if we look at Slide 47, that is an illustration of rate increases sought in Massachusetts, which generally has been favorable to SHIP in approving rate increases.

So as you can see, 90 percent of the rate increases sought by SHIP in Massachusetts

were approved, but ten percent were not. So for those claims, SHIP is going to have to find money from money collected from other states.

If we look at Slide 48, this is the same picture, but for the State of Washington, and here you see that Washington has rejected 37 percent of the applications, requiring that someone else step up for that 37 percent of the liability for the Washington-issued policies.

And then on the next slide, it will show you the experience for Maine, which is a smaller amount of policies but a really disappointing picture with which 89 percent of the approvals requested have been rejected, so that 89 percent of the burden has to be shifted to other states.

On Slide 50, I have aggregated that data for all the states and you can see that, over the period that we have been looking at, 2009 to 2019, the aggregate amount of rate increases that we have -- that SHIP has sought, I should say SHIP because I wasn't there at the time, has resulted in 312 million of that being rejected. That is $312 million that management thought they needed to pay the liability of

these policies that they did not collect.

If you add interest to that, and I don't mean projected interest, interest just for the period involved, that becomes $371 million, as you see on the next slide.

That is a big problem for SHIP, as it is for most long-term care companies.

Q. Mr. Cantilo, we looked at three charts of this type, and I just want to -- I want to understand, how were these charts prepared, where did the data come from?

A. So these were prepared by our consulting expert Oliver Wyman, from data that we have, in Seriatim, identified that has been available to all the parties from inception -- I shouldn't say inception, but quite some time. The Seriatim data file has a line that contains 360 fields of information for every policyholder. So it allows you to look at everything, including the rate increase history for every policy in force. And at my request, Oliver Wyman extricated from those tables this data to show me the experience of these three states.

I could have done that for any other

state but they are not in the room, so I thought it would be more appropriate to do it for the states in the room.

Q. Earlier you started to testify in a general way about the Department, the Pennsylvania Insurance Department's involvement with SHIP before the rehabilitation application was filed.

Can you describe those actions?

A. Sure. On Slides 53 and 54, I have kind of a sequence of those events. Starting with Slide 53, this is before I became involved, I kind of became familiar as part of my involvement, the company -- the annual statement for 2016 was filed in March 2017, and a review of that statement resulted in more intense concern by the department about the company's financial condition.

The Department believed, and I think we have since corroborated or confirmed, that SHIP had been engaging in optimistic cash flow testing assumptions, and that the claims experienced in the company had been experienced -- had been having was inconsistent with those assumptions.

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They also appear to be approaching inadequate claim reserves and have been apparently doing that for a few years, and the Department became aware of the Beechwood investments, which is one of the two programs I mentioned earlier, that the Department suspected were much riskier than the cash flow testing reports that the company indicated.

So the Department recommended to the company, and was assisted in doing so by the Oliver Wyman team that, in devising its morbidity improvement assumptions use more recent experience to develop morbidity and determination on assumptions, and develop alternative assumptions for a slower reserves resulting in a substantial decline in the surplus, as I say there, of $700 million.

To these recommendations, SHIP's general expense was, well, we're actually pretty good the way we are, we don't think we need to do all that. That dialogue continued until 2018, when I was appointed the special representative, at which point I was able to exercise a little bit more influence on management, and that resulted in the

restatement that I mentioned earlier in 2018.

And a lot of that was a result of the work done by the department and Mr. Lambright before in scrutinizing those assumptions. So by the time we got to 2018, the company had to record a $374 million premium deficiency that it had not recognized before, and had to recognize an additional $44 million in liabilities to the claim reserve that it had not realized, and then $176 million in losses on the Beechwood investment program.

And those are the major drivers of that nearly half billion deficit that the company reported for that year.

We continued our focus on the actuarial assumptions, and those were revised more in the next year, so about 2019, the deficit doubled as a result of revisions of those assumptions. As shown on that Slide 55, that resulted in an additional $400 million liability -- rather, deficit, recognizing the statement.

Unfortunately, management and the regulators all recognized that simply seeking rate increases wasn't going to help SHIP

because there is such a short premium runway left that is, as I said earlier, the average age of our policyholders is 86, they don't have that many premium paying years ahead of them, unfortunately, so other measures would have to be implemented to improve the company's financial condition.

And on the strength of these findings in 2018, we requested that the company prepare what is called a corrective action plan or sometimes called an RBC plan, which is a plan to restore the company to adequate capital and surplus level.

Management, in the event, turned out to be unable to do that so, as we now know, next year we asked the company be placed in rehabilitation, so January 29 of last year.

Q. Mr. Cantilo, I just wanted to bring us back to Slide 23. Just if you could take some of what you have been discussing, when did you become involved with SHIP?

A. In 2018.

Q. And at that point, had SHIP already reported a deficit of $466 million?

A. No. That annual statement was due

to be filed in March, and I started working with management in January and February --

Q. When you started working with management --

A. -- to make sure that their annual statement reflected proper reserve estimate.

Q. Did you have concern that the reserve estimate was incorrect?

A. I had concern even about the '17 annual statement. But for 2017, the company had pushed hard to get what's called a permitted practice from the Pennsylvania Insurance Department, and that is a dispensation from some of the reporting rules that -- the permitted practice they requested had to do with the maintenance reserve that the company was required to book for 2017, for SHIP, that was $192 million. And that's primarily a provision for fluctuating interest rates in the company's investments.

SHIP opined to the department since it wasn't selling new business, it really shouldn't have to comply with that. It also noted that property and casualty insurers don't have to post an INR and asked whether it could

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be allowed to be converted to a property casualty insurer so it wouldn't have to do that.

In any event, the Department allowed SHIP to take $190 million reserve into surplus, but to do that, the company had to recognize a deficiency reserve when the effect that the net increase in surplus from eliminating the interest reserve was actually $70 million.

So when I looked at the $13 million reported surplus for 2017, as shown on Table 23, I also knew that had it not been for the special permitted practice on the INR, that would have been a $50 million deficit in 2017.

And then as I summarized earlier, working with the actuary and management, we induced SHIP to recognize the deficiency reserve the next year. And so 2018, the company, not very cheeringly, but the company agreed to recognize the $467 million deficit.

And we continued working with the management after that time to further drill down on the actuarial assumptions. One on which there was a lot of back and forth had to do with morbidity improvement. The consulting

actuaries for SHIP management reported that its insured population would experience 1.6 percent improvement in morbidity year to year for the next -- well, initially, at F and I, and for the next ten years, we didn't think that the claims data that was made available to us on which they were basing those assumptions supported those assumptions. And in due course, the company and its consultant actuaries agreed to remove the vast majority of that. That made a big difference.

We also thought that their termination assumptions were too generous, that they were not experiencing lapses in terminations at the rate at which they were projecting them, and so they realized those assumptions as well.

This sounds a little black and white as I describe it. It's not. I had an old friend a long time ago who told me, very early in my career, that figures don't lie, but liars figure, and that may be a little bit of an exaggeration, but a lot of what happens when you are calculating these reserves is that you get to select the data on which you rely.

So, for example, you might say, I am only going to use the last five years of experience and base all our projections on that, or you might say, I'm going to use ten years, or you might say, I'm going to use five years 20 years ago and then five years more recently and the next five years. So if you select the data on which you are going to base your assumptions, you can drive your results.

A lot of our disagreements had to do with applicability of the data on which those assumptions were based.

Q. Mr. Cantilo, who, at the time of 2018, who provided actuarial consulting services to SHIP?

A. Milliman, Milliman was SHIP's consulting expert for most of it in the LTC.

Q. You may have explained this already, but did you raise the concerns about the assumptions and projections to Milliman?

A. Yes. We spent a lot of time with Milliman actuaries. It was not a contentious dialogue, but it was a frustrating one because we had a lot of pushback on our concerns about the assumptions.

I think in due course the Milliman actuaries realized that the data really wasn't supporting their assumptions so they made the changes, but it was not instant. And unfortunately, had all this been done ten years earlier without the interference of the Department, the company would have been able to raise rates much sooner and take other remedial steps that would have had much longer running to take effect.

Q. Mr. Cantilo, that third bullet under 2017 and 2018 requested a corrective action plan in 2018. Can you explain what a corrective action plan is?

A. That is a plan formulated by management to restore the company's risk-based capital to the level of one above, which is called the authorized control level, which is a level at which regulators step in.

So in common parlance, it's 200 percent RBC, so the company should have twice the required total adjusted capital.

Q. Where do those requirements come from?

A. They are promulgated in the

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insurance regulations, and the statute in Pennsylvania, just like other states. For SHIP at that time, that would have been about $15 million in surplus at a time when it was reported in 2017, $13 million in surplus, and 2018 almost a half a million dollar deficit.

Q. And I think you used the term "authorized control level"?

A. Yes. We're getting awfully close to areas beyond my areas of expertise, but the risk-based capital statute promulgates three levels of capital. There is the level at which the company doesn't get any regulatory intervention.

And then there is the authorized control level, which is a level at which regulators may but are not required to step in, which is, typically, half of the required capital or what some people call the hundred percent RBC level.

And then there is a mandatory control level, which is when the company's capital declines to 70 percent of the required total adjustment capital, at which point the statute requires the regulators take remedial

steps.

Q. Did SHIP prepare a corrective action plan?

A. So SHIP worked on a corrective action plan and presented their ideas to us, if my memory is right, in May of 2018. We had a meeting with representatives of the Department, Oliver Wyman, myself, representatives of Milliman, the trustees, and management, and without being intending to be critical, the consensus on our side of the table, so to speak, were that the ideas being presented were not going to be anywhere near adequate for restoring the company to solvency.

And so we then began, and I took charge, developing initially with the cooperation of management and the Milliman rehabilitation plan that has become today the Second Amended Rehabilitation Plan. It has gone through many iterations before that.

Q. Mr. Cantilo, I just want to make sure we covered everything before we move off of this topic. Have you identified all the actions in your recollection that the Department took with respect to SHIP prior to

January 2020?

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

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

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

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

So we knew even then in 2018 and

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

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

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

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

But the first really intense

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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

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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

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shows the difference between reimbursement and indemnification of these policies that I was referring to earlier.

So the blue bars are the indemnification benefits that policies provide. The orange bars are the actual cost of care for the same policyholders. You can see there is a pretty wide gap. On the right side, the gap on the right side accumulates that difference over time. And you can see, about 20 -- we are going to be paying about $400 million in benefits in excess of the cost of care under the policy.

That is, to me, low hanging fruit for a rehabilitation plan. If we can somehow peel that liability away, that is not money the policyholders received. We know by definition that is money over their cost of care. So it is not a fundamental long-term care benefit for them, but saving $400 million goes a long way to helping a plan.

This is an obvious one. There are a lot more difficult associated examples and other ways in which the coverage is probably not necessary, so a simple illustration of that

would be a benefit period. There are a lot of policies that have very long benefit periods held by policyholders, and I don't say this to be cruel in any way, but they reasonably don't expect to live that long. If you are 93 and have a chronic health condition, having an unlimited benefit period is probably not worth the money if your reasonable life expectancy is one or two years.

So we thought if we fashioned a plan that would enable policyholders to select that kind of reduction in benefits, and, as a result of that, forego a large premium increase or even face a premium reduction, that that would be attractive.

So those are the kinds of things at which we looked at putting the plan together.

Q. Did Oliver Wyman develop an actuary model for the plan?

A. They did. And they were able to do something that has been immensely helpful, which is to develop a Seriatim model. We can adjust every element of every one of our 39,000 policies individually.

So unlike what is normal, which is

to assign the policies to risk classes or categories or cohorts and you make the changes to the particular group all at one time, here, the plan can drill down to each individual policy and make the precise premium or benefit adjustment required to that policy and enable us, very importantly, to report to the policyholder, individually, the characteristics of the policy and how each option under the plan would affect their particular policy.

So they spent some months putting that model together. While they were doing that, we worked with Milliman Seriatim model, which allowed us to do a lot of that, but it made different assumptions than the Oliver Wyman model.

So we started working on the plan right away, but the plan really started making much more rapid progress after we relied completely on the Oliver Wyman model.

Q. You may have touched on some of these already, but collectively, what were the factors you considered in developing the plan?

A. So the first and most important factor, of course, is the protection of

policyholders, and by that, I mean not simply can we give them all the money in the world, what are the legitimate interests of the policyholders that are at stake in SHIP and how can we address those interests in a fair and equitable manner.

Obviously, reducing the company's deficit was a major role of the plan as well. And to the extent that we are going to be implementing modifications, the company's contacts, we wanted to do that in a way that was non-discriminatory either because of residence or state of issue or anything else.

So those were all key factors of the plan. We wanted the plan to be feasible and we wanted it to be susceptible of implementation in a relatively short period because of the advanced age of our policyholders.

And we have looked pretty carefully at the Court's opinion in the Penn Treaty case. We had a pretty good understanding of what we thought Pennsylvania law would be applicable to the plan, and we wanted to have a plan that would be the least likely possible to attract vigorous opposition, unlike Penn Treaty, which

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could not be described that way.
Q. Mr. Cantilo, you used the term "feasible." Can you explain what you meant when you said feasible?
A. Yes. I meant a plan that would be practical to enrollment and would have a material impact on the reduction of the company's deficit, obviously, while addressing the other goals that were already described.
Q. How did you come to that understanding of the word "feasible"?
A. Well, the Pennsylvania statute does not provide specific requirements for the components of the rehabilitation plan, but I think if you read the statute on when you should go from rehabilitation to liquidation, it compels that conclusion, because if a plan is futile, then that is one of the routes to going to liquidation.
We wanted a plan that would not be futile, and I converted that to feasible.
Q. If the plan does not eliminate the deficit, what impact will it have on the deficit for SHIP?
A. So it will not eliminate the deficit

unless the market turns and investment rates go up, but it will certainly reduce that deficit. We will talk more at some point during this hearing about the scenarios we have modeled on that, but we are hopeful we will at least eliminate half of the deficit. And there are definitely some areas under which we will do much better than that. All of them depend on policyholder behavior for which there is not a wealth of empirical data we can rely to make projections.
So as Your Honor will see, we have some projections and they project a fairly wide range of results. But even at the low end of the range, it's a material reduction in the deficit and a variable return on improvement in equity of the rate structure.
MR. BROADBENT: Your Honor, I am going to turn to the plan itself and start to dig into its operations and its terms, and I happen to know we were around 12:00. I just want to know if you want to keep going and dig in or pause and then move on to the other topic later.
JUDGE LEAVITT: We can go off

the record for a couple of minutes.
(Discussion held off the record.)
(Lunch recess taken from 12:00 until 12:45 p.m.)
MR. BROADBENT: Your Honor, there were two housekeeping items before we begin again. The first was, we began this morning, I think the goal was to get started as quickly as possible, and I discussed Mr. Cantilo's CV and history and we drew out some of the bases for his conclusion in areas of expertise, but we didn't formally proffer him as an expert in rehabilitation insolvency and long-term care insurance. We would like to do so subject to reserving the right to do some Voir Dire, if that's necessary if any party objects, which we don't expect they will, but we just wanted to raise the issue because I hadn't raised it before he got on the stand.
JUDGE LEAVITT: All right. At this point, we have an offer to have Mr. Cantilo qualified as an expert to testify in rehabilitation of long-term care insurance companies or maybe other companies. I'm not

sure of the extent. But I think we all understand what the offer is.
Would anyone like to conduct Voir Dire? Does anyone object? All right. He is so qualified.
MR. BROADBENT: Thank you, Your Honor. The second was whether -- we noted in reviewing our notes that none of the other counsel had appeared on the record, I think when we opened the record earlier today, and we weren't sure if the other counsel needed to enter formally on the record their appearance or not when we proceed with the remainder of the testimony.
JUDGE LEAVITT: That's a good point. Have any of you filled out entries of appearance and submitted them to the crier?
MR. LESLIE: Yes, Your Honor.
MR. DONLEY: No, Your Honor, we have not.
JUDGE LEAVITT: If anyone has -- why don't you each address the Court at the podium, state your name, who you represent, and whether or not you filled out an entry.
MR. DONLEY: Good afternoon,

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Your Honor. I am Joe Donley with Clark Hill. We represent the agents and brokers in this matter. With me is my colleague, Scott Galla. We have our entry of appearance of record, of course, Your Honor, but we have not given it to the Court crier. I can do that at a break.

JUDGE LEAVITT: Yes. That's fine.

MR. LESLIE: Good afternoon, Your Honor. David Leslie, and I represent the intervening state insurance regulators. We have noticed our appearance and we have completed the forms, myself and my partner, Eric Smith.

JUDGE LEAVITT: Thank you.

MR. HORWICH: Good afternoon, Your Honor. Harold Horwich from Morgan Lewis & Bockius. I am here with my partner, Benjamin Cordiano. We represent the health insurance companies as intervenors. We have, in fact, filled out a form.

JUDGE LEAVITT: Thank you.

MS. GLAWE: Good afternoon, Your Honor. Caryn Glawe with Faegre Drinker Biddle & Reath for NOLHGA. I and my

colleagues, Jane Gall Wilson and Alicia Hickok, also with Faegre Drinker, have noticed our appearance and we have filled out the forms.

JUDGE LEAVITT: Thank you.

There are some policyholders. They apparently did not understand that we were told at the prehearing conference that this was not going to be a televised proceeding. Mr. Fink has been in touch with them. They will be participating, nevertheless, by Webex at the appropriate time in the proceeding.

Okay. Anything else before you --

MR. BROADBENT: No, Your Honor, we are ready when you are.

JUDGE LEAVITT: All right. We're ready. Thank you.

BY MR. BROADBENT:

Q. To avoid standing up again, momentarily, I am going to ask Mr. Cantilo to turn to the plan itself. I will just hand a physical copy up.

A. I have a copy.

JUDGE LEAVITT: We will have this marked as Rehabilitative 1.

(Exhibit R2 was marked for

identification.)

MR. BROADBENT: I believe, Your Honor, Mr. Cantilo's --

JUDGE LEAVITT: You are right. This is R2.

BY MR. BROADBENT:

Q. Mr. Cantilo, just to reorient us here, the current plan, the second amended plan, you started to testify as to how it came about, including on the essential concept of the plan, which you have before you.

Can you describe briefly again the driving principle of the plan before we get into its terms?

A. I'm sorry, I didn't hear the last part of your question. You want me to tell you what the plan is or how it came about?

JUDGE LEAVITT: The essentials.

BY MR. BROADBENT:

Q. The essential concept of the plan, which is what this line says, just to reorient with some testimony as to the driving principles, philosophy of the plan, before we get into some terms.

A. Absolutely. So I did put together a summary of that on Slide 60. And, as I mentioned a little bit earlier, the plan assumes a deficit in the insurance company of $1.2 billion. That's a fluctuating number, and the plan is completely scaleable, meaning the elements of the plan are designed to be the same whether that deficit is half a billion or two billion.

So the fact that we are assuming 1.2 billion by itself is not particularly significant. But it does give us a sense of scale of what we need to accomplish.

Its principal goal is to reduce the funding gap, the deficit. The difference between the potential -- protect the liabilities for the company and the assets and projected premium available to fund those liabilities by a combination of policy modifications. And the modifications will fall in two categories; either premium increases or benefit reductions.

The plan is structured to occur in three phases, the first two of which envision that the policyholders be given an array of

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options for modification or retention of their policies, and allowing the policyholders with adequate information to select from among those options.

In the first of the two phases, the options are based on the If Knew premium that I talked about earlier today, and the second of the two phases, the modifications are based on self-sustaining premium.

The third phase is to take place after we have completed Phases One and Two, and that's the phase with which we address general creditors and the wind-down of the company. So that's not a rehabilitative phase; that's more of a windup phase.

We understood as we launched into the design of a plan that how big Phase Two would be would be completely dependent on the effects at the end of Phase One. So it's hard today to predict exactly how Phase Two is going to turn out. There could be a large deficit remaining after Phase One, in which case Phase Two will be very material, but it could be a smaller deficit, in which case it will be less important.

And we did leave room in the description, Your Honor, for flexibility in changing the terms of Phase Two.

So I envision, we haven't answered this, but I envision that we will be coming back to Your Honor after Phase One reporting the results of Phase One and describing to the Court what we envision for Phase Two. The Court may decide that we don't need to do that. I don't presume to tell the Court how Your Honor is to conduct the proceeding, but that's what we have in mind, and there is flexibility in there for that.

That having been said, as we see it right now, the structure of Phase Two is very similar to Phase One. The options are very similar. The election process is very similar. It's just the rate methodology that's different and the anticipated number of policyholders will be much smaller, and I will explain why in a few minutes.

Q. Just to dig into the details of the plan, can you explain to me what you mean by modifications there in the third bullet?

A. So the policies that are in force

now each have a combination of many benefits. Delivery of some of those benefits is very expensive. Delivery of others is not. We have spent a long time developing a small, and we think manageable, number of options for policyholders that take into account the differences in the characteristics of these benefits.

And we have tried to package these options so that we can address as many individual circumstances as possible with a manageable set of options.

And I should say here, Your Honor, we did consider a plan with many more options, but our conclusion in the space of experience that we had with Penn Treaty is that for a population like SHIP's population and their age, the more complicated the plan, the less likely it is that they are going to be engaged in selecting the options, and we don't want the default option to be the option that applies to everybody.

So it was important to us that we reduce the number of options to a handful, that we could describe in the way in which it could

be understood, and that can actually be understood by the policyholders.

We have four options and a variation of the theme for one of the two. So it's a total of five options. But as Your Honor will see as we describe them, we think that these options, albeit that they are small in number, are wide enough in scope that they allow each policyholder to have something responsive to his or her individual circumstances.

And that was a key point of this. Commissioner Altman giving policyholders the requisite information and then allowing them to select from among meaningful full options was a really important aspect of the rehabilitation. You could have had a plan which you could just have told us about the monetary modifications, but in this case, the philosophical underpinning is that our 39,000 adult policyholders ought to be able to make their own decisions. So that's a hallmark of the plan.

As I said, the options are few in number and we strive to make them simple, but we -- I'm not sure we succeed in making them

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

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

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

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

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

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

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

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

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

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

Q. The summary mentions two of three plan phases. Can you elaborate on the phases, please?

A. Yes. As I think I just mentioned, they are similar in structure which each of the policyholders given roughly the same choices but different in participation, with Phase Two having many fewer policyholders affected, and then the premium rate methodology, If Knew being applicable to Phase One and self-sustaining being applicable to Phase Two.

Q. Do you know how long the plan will take?

A. I do not. And there is not a deadline for the plan. The way the plan is structured, it could become a long-term runoff until the last policy lapses or terminates, but the actual implementation of the measures to accomplish that will probably happen within the next two to three, maybe four years.

And then after that, and I know this sounds simplistic, but the plan will kind of be an automatic after that.

Q. Does the plan depend upon meeting any specific milestones?

A. No, there are no articulated milestones, although given the age of our policyholder group, time, obviously, is important. You asked about the timeline, and I saw you had it up on the screen, something I had given of the timeline, but the timeline itself does not currently have specified milestones other than to describe, and I am referring now to Slide 62, which is Table 3 in the plan, that describes the sequence of events for the plan.

But as you will note immediately, for most dates, I have TBD. So there are no specified milestone dates for those steps. That's just the sequence in which we anticipate they will occur.

Q. What are the goals of the plan?

A. First, we reduce or eliminate the funding or the deficit.

Second, eliminate the inequitable and discriminatory rate structure that's currently in place and eliminate the subsidies, across policyholders subsidies, prospectively. The plan does not ascribe to do anything about the subsidies historically. I don't think they

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have any tools for that. But going forward, we want all policyholders to be on a level playing field and pay the same amount for the same amount of insurance.

Those are the goals. Obviously, we want to get out things like the Beechwood program and the Roebling Re program. Those are significant, those two key holds.

Q. You touched on these things before, but just to bring it all to one place, what are the key attributes of the plan?

A. Well, we think that the flexibility and the scaleability of the plan is one of its most desirable features.

The plan is focused on respecting the rights of individual policyholders to determine the terms for themselves, what is the most valuable aspect of their coverage, but it is self-calibrating, meaning that the decisions of the policyholders will determine what is the next step in eliminating the deficit.

It was important to the Commissioner and so the plan incorporates respect for the importance of letting the policyholders have meaningful choices about what's going to happen

to their coverage going forward. We thought it was important to give each policyholder at least two options. One is retain their current coverage, if they are willing and able to pay whatever that takes, and two, retain their current premium. That is, if they cannot pay another penny, let them have their current premium and adjust the coverage to that amount that they are paying today.

And between those two options, we have other options. One is, and I will describe it in more detail, one is a non-forfeiture option, although the one in the plan is more generous than the one I described earlier in the industry, and then two, versions of a basic policy that provide fundamental long-term care coverage but not a lot of bells and whistles and produces a much more affordable plan.

Q. On the question of premiums, Phase One, if Knew premium, can you explain what that is?

A. Yes. As I said earlier, this is a premium methodology, widely in use around the country, that assumes the current rate would be

-- is what it would be if the management of the company had known how the liabilities would evolve and priced the premium that way to produce the stipulated loss ratio, say 60 percent, all the way through until the current moment.

Q. Item 1D on this slide, the plan does not incorporate provision for recovery of past uncharged premium, why not?

A. In a nutshell, because we have too few policyholders left and it would be unfair to make those policyholders pay premium that should have been paid by someone else in years past.

Q. Why did you select If Knew premium for the plan?

A. There are several reasons. One is that it is widely in use around the country and we thought, naive as we are, that it would not engender much opposition.

Two, it is because one of the key goals of the plan is to put policyholders in no worse a position than they would be in in a liquidation, and based on the only experience that exists today, which is the Penn Treaty

case, that's the methodology I believe was raised rates in the liquidation. So it would be the same rate increases subject to the caps, of course, and the guaranty association coverage.

Three, we think it is an easy rate methodology to explain. The Court may recall the very complicated rate methodology that was used in Penn Treaty that challenged most of us to understand. This one is not. This is pretty easy.

I can tell a policyholder, we want to set a premium that generates 60 percent loss ratio. And if we haven't done that historically, we will adjust the next premium portending we will have done that historically, and determine what the premium would be today.

I understand that sounds still like an insurance technical jargon, but I think it's considerably easier to explain it.

And the last reason is that it's a very good way of putting policyholders on a level playing field. It's not very hard for us to determine what the if Knew premium would be on a Seriatim basis, that is, on a policy by

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policy basis, and then adjust every policyholder to that level so there are no policyholders being compelled to subsidize another going forward.

Q. In Phase One, what kind of rate increase will result from the use of If Knew premium?

A. So, as demonstrated on Slide 66, about 63 percent of policyholders will face from zero to 50 percent in rate increases, and 38 percent of that group will face no rate increases, as I said a little bit earlier.

Then we have a slew of about 15 percent that will face up to doubling of their premium, and the remaining 22 percent will face more than doubling of their premium. This would be the premium they would have to pay to retain their current coverage.

Of course, all of these policyholders that have a rate increase shown on this table will have at least one or two options that allow them to pay no increase or moderate rate increase.

But if they wanted to keep their current policy, our rate methodology would use

this kind of rate increase.

Q. How does this process differ from Phase Two?

A. So Phase Two is in some respects a cleanup phase. So we will determine what the remaining deficit is at that time. And unlike this backward-looking methodology, because If Knew premium is looking back at the history of liabilities, self-sustaining premium is a forward-looking methodology. It looks at what remains to be paid and how much money do we need to make those payments.

So it calculates for each policy a shortfall amount, which is the difference between the present value of future benefits and expenses are actuarially determined to be necessary for that policy, less the projected future premium and some portion of the existing assets.

And the assets will be allocated among the policies in proportion to premium paid historically. So a policy that has paid more premium, for example, because more rate increases have been approved for that policy, will get more assets and, therefore, require

less premium going forward.

Whereas a policy issued in a state that hasn't given a lot of rate increases will get less allocated to it and will have to have a larger rate increase going forward; that, along with our new methodology in Phase One, are elements designed to remedy the historical subsidy or rated inequity problems that I have described a couple of times today.

So we will calculate that shortfall for each policy and calculate the premium required to eliminate that shortfall, and that will be the self-sustaining premium for that policy.

MR. BROADBENT: Your Honor, I planned at this point to move to the options that are available at the plan, but I wanted to pause here on the rates if there was anything else Your Honor would like Mr. Cantilo to cover. We also have Mr. Bodnar, who will offer further testimony. But if there is anything specific, Mr. Cantilo is happy to answer your questions on the rates.

JUDGE LEAVITT: No. I'm following right along.

BY MR. BROADBENT:

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

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

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

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

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amount is adequate on an If Knew basis.
So, say a policy is paying a thousand dollars a year in annual premium, but for the benefits that policy offers, we calculate the If Knew premium would be $1,500, we have a program that would reduce those benefits to a thousand dollars on an If Knew basis, so that now every policyholder is on the same basis. That's like we are all paying the same rate for each pound of potatoes.
The second option is what we call the basic policy endorsement. We have selected what we think are the key components of long-term care that people want to have, if they can't afford everything, these are the things they want to have.
And we created an array of those that we think will generate affordable premiums. And so there are some limits on what we're going to do with those options. We're going to have a maximum benefit period that is no greater than 80 percent of the current premium or four years. For most people, we think four years of benefit period is a basic long-term care insurance policy. Sure, if you

have the money and you would like to have a longer period, but four years is a pretty reasonable benefit period.
We are doing the same thing with the daily benefit. We're going to take 80 percent of the current daily benefit or $300 and use the lower to -- as a basic daily benefit for that policy.
There will be an inflation component if there is one in the policy already, but it would be capped at one and a half percent, not five percent. There is a variation on the policy that we, again, very creatively call 2A, and the differences are that you can take a benefit period out to five years and the inflation to two percent, and you'll pay a little more premium for that variation.
Q. Mr. Cantilo --
A. One very important aspect of the basic policy is if you select this option, you will not be affected by Phase Two. It is what we call a one and done option, which makes it, we think, very attractive to policyholders.
Q. How did you and the other team members working on the plan identify what

should be included in the basic policy?
A. So we are lucky because there are several members of our team that have a lot of industry experience, and I and others also have a lot of experience where we did a lot of policyholder outreach.
So we are basing those judgments on what we interpret to be the opinions expressed by policyholders throughout the country about what they find valuable in their long-term care insurance policies and which are the things they are willing to give up.
Now, it's not a perfect world. So some of the things they find valuable are the most expensive and we're not necessarily going to retain them in the policy, but I think the fundamental coverage responds to those policyholders around the country.
The next option, Option 3, is a paid-up policy or a non-forfeiture option. But unlike the one I described earlier that is common in the industry that just takes accumulated premium less claims, here we are putting a floor on that policy of two and a half years of benefit period, unless your

policy already has less than that. We are not going to lengthen your benefit period. But if you have a five-year policy, even if you take an NFO, you have to have at least 30 months of coverage. That makes that option, Option 3, very attractive, because unlike the typical NFO that gives you at most months of coverage, here you have two and a half years, which is a pretty reasonable period of coverage.
We also floored the maximum daily benefit at 80 percent of the current level of $300, which, again, is a reasonable maximum daily benefit. So not a luxurious policy, certainly not what anyone would call a Cadillac policy, but I think this is a solid Chevy policy that we're offering as an alternative. And I don't mean to be pejorative about Chevys when I say that.
And then the last option is the option that we hope the fewest policyholders will select, but it's out there, and that is pay whatever it takes to keep your current policy.
Q. A policyholder electing Option 1, does he or she get to decide which benefits to

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downgrade to get to the new premium?
A. No. That is an important point. We did think at one time about giving policyholders a menu of benefits and other provisions that they could select for themselves.
If the Court may remember, we had a construct like that in Penn Treaty when we did that plan. That is too complicated. When we did the focus groups in Penn Treaty, most people said, please tell us how I should do this. That's not an effective way of giving people their best choice.
So we had the algorithms I described earlier, that is, ordered the key benefits as I've shown on Slide 69. There are other policy provisions that I will mention later that are untouched, but these 11 are the levers we will use to reduce the cost of the benefits to what the policyholder is paying and they will be done in this order.
Now, not every policy has all these. So, for example, if the policy at which we are looking at a time does impact restoration of benefits, then that will not apply to that

policy.
We will go down this list until we have reached construct of benefits, the If Knew premium of which mentions the current premium.
Q. Mr. Cantilo, does the plan describe the policyholder options?
A. It does. There are long sections in the plan that describe it, each one in detail. And then for simplicity, on Slide 70, I have shown Table 6 of the plan, which summarizes all the options on one page and summarizes the options, depending on circumstances.
This is probably the point at which I should explain that what I have been saying so far is probably a little bit of an oversimplification. We have policyholders in a lot of different circumstances, so the options vary a little bit, depending on whether the policyholder is on claim or not and whether or not he or she is paying premium or not. So this is probably one of the most important distinctions and one that has drawn some criticism from the regulator intervenors.
For policyholders who are currently not paying premium, some of the options require

them to pay what we call a differential premium. And the rationale behind that is that we thought it would be unfair to have those 13 percent of our policyholders immunized from the effects of the rehabilitation, thereby requiring the other 87 percent to subsidize those 13 percent.
So if a policyholder is currently on premium waiver, he or she can keep that premium waiver and not pay any more premium, but the benefits of that policy will be reduced to the premium amount.
If they want to keep the current benefit structure, they will have to pay the difference between the premium that is on waiver that they are not currently paying and the If Knew premium for those benefits.
So if they have a policy that offers a set of benefits for which they would be paying $1,000 but for the waiver, but the If Knew premium for those benefits is $1,600, they will pay a $500 differential premium.
We think that is fair. That is a way of having everyone have some of the loss apportioned to them and not just a subset of

the policyholders.
Some policyholders are not on claim but they are on waiver because their spouses are on claim and so they will face the same circumstance.
And as I say, on -- in Phase Two, even though it's the same options, they are based on different premium methodology. I should also say that we have a couple of options that are floored as the guaranty association limits that policyholders always have an alternative that gives them at least as much coverage as they would have -- they can choose less if they want to pay less, but they can have an option that gives them at least --
Q. Mr. Cantilo, in the blue box at the bottom, there is an asterisk with default option. Can you explain what the default options are?
A. Yes. We hope not to use it very much, but there will be some policyholders who will not make an election. Either they will make an election and effectively say, by choosing two options on the form, or just not do it at all. The plan can't come to a halt at

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that point. So if a policyholder does not select an option by the deadline, the plan automatically selects one for that policyholder.

In general, for policyholders on premium waiver, the default option is a boundary, Option 1, and for policyholders paying premium, the default option is the basic policy endorsement.

But the two defaults are structured to minimize the impact on the policyholder. I'll talk about this in more detail in a few minutes, but we will engage in a vigorous effort to reach out to policyholders. So we have materials that we think are friendly. We are going to call the policyholders from whom we don't hear. We are going to send them communications, probably not a lot of E-mail because a lot of them don't have E-mail, but we will send postcards or letters and reach out by telephone.

We have a goal, and Mr. Robinson and I like to joke about the fact that we might not meet our goal, but we have a goal of 100 percent return on the election forms. That is

what we are working towards.

Q. What happens if a policyholder is unwilling or unable to pay differential premium?

A. They have options under which they can keep the currently waived premium and have their benefits reduced to that level.

Q. Other than the two different methodologies for calculating rates, are the options the same in Phase One and Phase Two?

A. Yes, with the exception that, I think I already described the slide, so -- but the big exception is that anyone who has taken Option 2 or Option 3 in Phase One will not have to make an election in Phase Two. They can if they want. If they made an election in Phase One that they now regret and they want to do something different, they can change. But in general, anyone who has taken Option 2 or Option 3 -- yeah, Option 2 or 3 in Phase One, they don't have to make an election in Phase Two. They are done.

Also, anyone whose policy is completely covered by a guaranty association, they don't have to make an election in Phase

Two. They are also done.

So we are going to have a fairly small number left. The last category that will not be affected by Phase Two are those who are already paying self-sustaining premium. That's not going to be a whole lot of them, but anyone in those four buckets that took Option 1 -- I'm sorry, or Option 2 or Option 3 or that are covered by the association or are self-sustaining, they are not affected in Phase Two.

So these, you have up Slide 72, I said a few minutes earlier that there were parts of the policy that are not affected and our benefit reduction model, these are 15 policies that will not be reduced or eliminated by the plan.

So if a policy currently has these features, they will continue after the plan is implemented, unless, of course, the policyholder terminates the policy. But we don't anticipate a lot of people doing that. Even if you don't want to pay another penny, the NFO is a pretty attractive policy, and you would never pay another penny.

MR. BROADBENT: So Your Honor, as I did a few moments ago when we moved from the rates to the options, I'm pausing here. I plan to ask Mr. Cantilo about the elections process. And although Your Honor is, of course, free to ask him any question at any time, if there is anything specific on the options now, I just wanted to pause to make sure we address that.

JUDGE LEAVITT: Thank you. We can keep going.

MR. BROADBENT: Thank you.

BY MR. BROADBENT:

Q. Mr. Cantilo, is every SHIP policyholder required to make an election in Phase One?

A. No. Policyholders who are already paying If Knew premium who, as I say, are about 38 percent as of the middle of last year, probably about the same number today, they will have the option, if they want to change their policy, of selecting another option, but they will not be required to.

It's worth noting that policyholders that are already paying self-sustaining premium

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would never want to choose Options 1 or 4 because they make no difference. It would have no effect on their policy.

But if they wanted to reduce their coverage to reduce their payment, they could take Option 2, Option 2A or Option 3. That is strictly voluntary. They are not required to return an election form and we are going to spend less time trying to track them down than the people who are required to make an election.

Q. Why would a policyholder already paying If Knew premium choose a different option?

A. To reduce their premium or change their coverage based on their individual circumstances. For example, they may decide that they no longer need the long benefit policy because, unfortunately, they don't expect to live that long and so they may want to save money by shortening that and taking one of those options.

I know it sounds cynical and cruel when I say that, but that's real life. There are people out there in the last days of their

life for whom budgeting is important and who are cognizant of their individual circumstances and would appreciate the opportunity to give up some coverage they will never use to save some premium that they would rather not have to pay.

Q. How will the policyholders actually make the elections from amongst the options available?

A. We will send every policyholder a packet of information. Now, what we have on Slide 74 here is the collection of the information that will be in that packet. This will not be the form we are going to send them because it is a little bit intimidating, but it is important to explain to the Court the information we will be providing the policyholders.

So I have broken up this, what we call the policyholder guidance page into three sections, and if we can go to the next slide.

This top section describes the current policy. So every policyholder will be able to tell on their plans, of course, whether or not this is their policy, but also what is the applicable guaranty association limit on

the policy and, very importantly, the policy value for their policy.

So that's kind of policy limits. If you use up all the benefits available under your policy, for this hypothetical policy, that would be $395,961.

You would see that that is 95,000 over the applicable GA limit for this policy. It also tells you in advance whether you have inflation, and, of course, the current fee that you're paying.

The next section, if I can go to the slide, this is kind of where the rubber meets the road, this section describes how the current policy works, that's the first column that says current, about halfway down the page, and then how each option available to that policyholder will work.

So for this policy, if we look at Line 1, it tells the policyholder that her current premium is $6,306. That would also be the premium for that policyholder under Option 1.

But you can tell by looking at Option 4 that policy is badly underpriced. For

the benefits that policy provides, the premium should be, on an If Knew basis, $10,727.

So this chart shows a policyholder that they can take Options 2 and 2A at somewhat less of a rate increase and still have a decent amount of benefits, or they can keep their current premium, but then they will be facing a material downgrade proportionate to the $4,000 underpricing of the policy.

Or, and this is one of the things that we think is attractive about the plan, that policyholder could choose Option 3, the NFO, pay no premium, and if you go down to Line 5, you see I have the maximum policy value, the limits for each policy listed, that Option 3 is still a $247,000 policy. That's not chicken feed.

And if you look at Line 3, that is a two and a half year benefit period for that policy. And the policyholder can look at all the others as well. They can see that if they wanted to downgrade their current policy to keep their current premium, their benefit period will go down to less than a year, as shown in the option column under Line 3.

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On the other hand, our basic policies will offer three years of benefits, NFO offers two and a half years, and, of course, pays the required premium to keep their current policy, that becomes three years as well.

And the chart shows the same things for the other components, like the premium increase, the daily benefit, the inflation protection and so on.

And at the bottom, we explain to the policyholder, if the company were to go into liquidation, what portion of the policy they chose would be over the cap. So in the current and in Option 4, that would be the 95,000 difference. With the downgrade in the Option 3, there would be no uncovered benefits for that policy. But with the two basic policy options, there would be some.

So the basic policy is about $2,600 and the enhanced basic policy is closer to $5,000.

This information will be provided individually, not in this form, but individually to each policyholder. And then if

I may see the next slide, we are also going to provide -- most of this slide is disclaimers and explanations, but there are two key pieces of information there we will also provide policyholders.

The first one is what we think the policyholder would be asked to pay in annual premium and liquidation based on the Penn Treaty experience.

So policyholders will have some guidance as to what their liquidation premium would be. The lower number is what the self-sustaining premium would be for that policy if set today.

The reason these two numbers, we think, will be important to policyholders as they choose among the options, and especially if they consider whether they want to be subject to Phase Two by selecting Options 1 or 4, we want them to have some guidance of what kind of burden they might face in Phase Two.

Now, we cannot actually predict today what the Phase Two premium will be, so here, for this policy, we say $18,000. That's if it were determined today. That will change

with the passage of time. It will go down with the passage of time most likely.

So we don't want a sticker shock. We don't want a policyholder to select Option 4, take a 70 percent rate increase for Option 4 and say, I can afford this, no problem, and then when option -- when Phase Two comes around, they are faced with an $8,000 rate increase and they're wondering what the heck happened.

So it is an effort to provide information that we think will be material to policyholders in making these selections.

JUDGE LEAVITT: Could we go back to Slide 76. Mr. Cantilo, the Phase One premium for Option 4 that you're showing is $10,727?

THE WITNESS: Yes, Your Honor. That's the If Knew premium for the current policy.

JUDGE LEAVITT: Does that number include the age of the policyholder, the medical condition of the policyholder, or is that the premium that should have been set when this policyholder purchased the policy?

THE WITNESS: It's what the premium would be today if the company had been charging If Knew premium all along. So that -- the medical underwriting is done 40 years ago when the policy was issued, so we don't do more medical underwriting today. So changes in health and age, those are not taken --

JUDGE LEAVITT: Those are not factors?

THE WITNESS: What is factored is what should the premium have been when the policy was issued based on the facts then.

JUDGE LEAVITT: Whenever it was issued?

THE WITNESS: Yes, and how it would change over time, again, not due to health conditions --

JUDGE LEAVITT: Right.

THE WITNESS: -- because, as Your Honor knows, that's not --

JUDGE LEAVITT: Claims experience before everyone with this product.

THE WITNESS: Exactly, Your Honor, and the collapse of the capital markets, which are already factored.

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JUDGE LEAVITT: Okay. Thank you.
BY MR. BROADBENT:
Q. Mr. Cantilo, can I ask you to look at -- the coming slide shows a policy already paid If Knew premium just for comparison sake.
A. So in this case, the current premium is 2995, and if we go to the next page, you can see that the newly imposed policy is also 2995. So this is one of our 38 percent policyholders who is not required to make an election but know, for example, that if this policyholder wanted to cut his premium or her premium in half, they could do that with Options 2 or 2A.

And that may be important. This policy right now has a five-year benefit period. Taking Options 2 or 2A only reduces that to 4.8 or unchanged benefit period. So that's not a big giveup.

There will be a little bit more of reduction in maximum daily benefit. So the current daily benefit is 205. If they cut their payment in half, their daily benefit will be $164. That may still be within what they want to realize from the policy.

And then on Line 5 you can see what the maximum policy value will be and, again, Options 2 and 2A provide substantial policy value, of 300 or 317,000 compared to 432,000 today. That, all of which is to say, Your Honor, that a rational policyholder who is not required to make a change may look at this and say, hey, I can cut my premium in half and still get what I need.

JUDGE LEAVITT: Could you remind the Court what the enhanced basic policy is?

THE WITNESS: Yes, Your Honor. Instead of a four-year benefit period, it's a five-year benefit period, and instead of one and a half percent inflation, it's two percent inflation.

JUDGE LEAVITT: Okay.

THE WITNESS: This, actually, is a -- I'm sorry, this is a good opportunity to explain some other feature that is not obvious here. You will see that in Option 2 for this policyholder, the benefit period is not four years, it's 4.8 years.

JUDGE LEAVITT: Uh-huh.

THE WITNESS: The reason for that is sometimes when we adjust benefits to the If Knew premium, the product overshoots, meaning it cuts too deep and produces a lower premium than we intended, and so we built up the benefit period to compensate for that so that no one gets inadvertently cheated. And I don't mean cheated in a bad way but so that the program doesn't take benefits away unfairly.
BY MR. BROADBENT:
Q. For the policyholder already paying If Knew premium, how does that relate to a self-sustaining premium?
A. Well, unfortunately, it's impossible for us to predict today what the self-sustaining premium will be when Phase Two is implemented, but we do know, and that's why I show those numbers on -- I don't remember the slide number, but you can see them again on Slide 8, why we show what we project the self-sustaining premium to be today.

We do think that for a substantial number of Cadillac policies, for lack of a better term, the ones with the five percent inflation and all that, for some of those, the

self-sustaining premium can be very substantial. You saw in my earlier example an $18,000 premium, that's not going to be extraordinary. There will be several in that category.

And so the If Knew premium may be a moderate increase but the self-sustaining premium may be a very large increase.

The other example that we looked at, as I recall, that jumped from current to If Knew was from 6,000 to 10,000, but from If Knew to self-sustaining it is over 8,000, so it's a pretty big jump.

Q. It kind of leaves a lot of information to attempt to process. So how will the average policyholder who you have testified is 86 years old --
A. This is my favorite part of this.
Q. -- understand the information?
A. We have spent a lot of time, Your Honor, trying to figure out how do we make this understandable. So we have engaged some consultants --

JUDGE LEAVITT: 86 doesn't look that old to me.

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THE WITNESS: To me either, Your Honor, but I am thinking about the way my kids would look at it.

JUDGE LEAVITT: All right.

THE WITNESS: So we have some consultants who specialize in doing Medicare supplement materials, very similar population. And as Your Honor will see on this slide, we are going to convert that daunting piece of information that I showed you a minute ago into more user-friendly materials. This is only a first draft. So we're still working on it.

But they will be intuitively presented with graphics, where even, Your Honor, working on a video, people can look at online or download that will walk them step by step through the election form.

We are striving to make this, as I said, Your Honor, our goal is a hundred percent active selection, not default selection on the policyholders, and that doesn't happen unless we can make it friendly to them.

So we will continue working on that, and by the time -- I am hoping Your Honor will approve the plan -- by the time we launch the

plan, we will have materials and we think it will become the industry standard on how to communicate, but this doesn't exist right now. There is no company doing it this way, no.

BY MR. BROADBENT:

Q. Mr. Cantilo, 100 percent is a laudable goal, but how do you ensure that that 100 percent -- the integrity of the elections?

A. Well, so, very important. It's not just about not getting the elections in, but respecting them, that is, processing them accurately. So we have a dual audit process summarized in this confusing chart that I am not going to try to explain, but the end result of which is every policyholder election will be reviewed twice before we implement it individually, every one, to make sure we properly record the policyholder's election.

You can skip that. That is more detail on the same slide. Now we come to the least favorite, my least favorite portion.

Q. Again, at a high level, Mr. Cantilo, does the plan address tax issues?

A. It does. This is not atypical of insolvent insurers. The company has

historically posted tax reserves and has deducted reserves, tax reserves from its taxable income, as is permitted under the Internal Revenue Code.

If the company is unable to pay the claims to which those reserves correspond, and we do nothing, the Internal Revenue Service will interpret that as taxable income for cancellation of indebtedness, the same problem we had in Penn Treaty.

So we're going to engage in a tax strategy pretty similar to the one we implemented in Penn Treaty, so we are not going to reinvent the wheel, in which we bifurcate our policy liabilities after the plan becomes effective but before policyholders make selections between the portion of the liabilities for which we have money or expect to have money, which we call the initial funded restructured policy value, and I should quickly explain that our tax lawyers came up with that term, not me, and the portions we will not be able to pay, which we call the unfunded benefit liability.

And what will happen is that on our

books, for tax purposes, the liabilities will be bifurcated that way, but insofar as policyholders are concerned, this will not affect them. It will not affect their options, it will not affect their contract rights or their benefits or anything else.

But at the end of the day, if the amount we set aside is the unfunded benefit liability, meaning the portion of the liability that we booked as probably not going to be able to pay, if that remains, if we come back to the Court and ask the Court to discharge that as a matter of state law because we can't pay it, and once we get the Court's discharge order, we're going to go down the street to the IRS and seek to exclude that from our taxable income under Section 108 of the Revenue Code.

Apart from that, Your Honor, we probably -- we're still working on this, but we're probably going to come back and get a private letter ruling from the IRS, like we did in Penn Treaty, to assure policyholders are not being affected adversely by the plan.

The most important thing is we don't want any of the elections to result in a mean

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exchange by a service that returns the basis to zero.

Q. I apologize, Mr. Cantilo, if I missed this part of your testimony, but when will the restructuring occur?

A. That is very tricky. So we are going to do the restructuring after the plan becomes effective, but we want to take policyholder elections into account so that our unfunded benefit liability is as precisely measured as possible. So what we are going to do is wait until the election results are in, but not until they become effective.

So we will let all the election results come in, then we will do the restructuring, then we will let the election results become effective, and only then will the policies be modified.

That's actually fairly astute because it allows us to predict the unfunded benefit liability with great precision because we have the election results. Again, I take no credit for that. We have actuaries and tax lawyers who do that.

Q. Will policyholders be advised of the

calculations?

A. No. The bifurcation between the IFRPV, the Initial Funded Restructured Policy Value, and the unfunded benefit liability will never be explained to a policyholder, other than in the plan itself, which explains it in great detail, but we are not going to provide them their individual numbers. We are not actually even going to calculate it on a policy by policy basis. We are calculating it in the aggregate and keeping it on our tax books in the aggregate, but it does not affect policy choices.

As you can see from Slide 86, if the gods are looking favorably on us when we do this, the amount of the unfunded benefit liability should match, approximately, the amount of benefit reduction that results from the policyholder elections. That is the balance for which we are striving.

Q. Mr. Cantilo, we would like to ask you about the reactions to the plan, and I will first back up and ask, what steps did you take to send information to the affected and interested parties?

A. Even before a decision was made to come to the Court for an Order of Rehabilitation, it was important to the Commissioner that, the fact that she was looking seriously at SHIP's financial condition and considering remedial action being well understood by the regulatory community, so for quite some time department representatives have appeared in front of the NAIC to brief regulators on the commission of SHIP.

Later, as we began focusing on either a corrective action plan or rehabilitation plan, we began extending our descriptions to those efforts and, as the plan started taking shape, apart from the regular NAIC meetings, we organized a number of all state conference calls, typically, they were attended the by 200 or 300 people, at which every department had the ability to first listen to a briefing, most of which I provided, on our enrollment of the plan, and then to either offer comments or ask questions.

And our role here was to anticipate as many concerns as people had and people would have as possible so we could incorporate them

in the design of the plan. So we have probably had, I would say, about a half a dozen all state calls and many more times that individual calls with representatives of the various insurance departments.

We have also distributed various submissions of the plan along the way to all the departments and the -- one of the most important amendments between the first and second version of the plan, the one affecting issue state rate approval, we sent that separately to all the states apart from the plan itself, so they could look at that and understand it and weigh in on it.

So all together, we spent hundreds of hours communicating with other regulators and other interested parties as well. Apart from sending materials to policyholders, we probably received about a hundred comments from policyholders.

And at Slide 90, so this is a summary prepared by the SHIP staff on the policyholder comments. They did it primarily by subject. So you can see that the comments about questions and benefits under the plan,

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that's a predominant category, about 28 percent of the comments received, whether that's being questions about the rate increases -- not a surprise, those are the things you would expect to see.

The surprise, and we don't factor it this way because we were trying to be more focused on the subject, not the color of the comments, but the surprise to us, especially after the Penn Treaty experience, is how many policyholders were supportive of a rehabilitation and the plan that we have described to them.

But this summarizes the policyholder concept. As I said, it has only been about a hundred, far fewer than we had on the Penn Treaty case, which is a bit of a surprise to us.

Then we have formal comments from representatives of the Maine, Massachusetts and Washington insurance departments and from the Wisconsin and Maryland insurance departments as well, and then formal comments from some policyholders from the agents, from the health insurers, and from three companies that had

ceded business to SHIP by reinsurers.

And then apart from the intervention in this proceeding from Maine, Massachusetts and Washington, I think we reported to the Court separately that lawsuits have been filed against the Rehabilitator, and in one case me, and Louisiana and South Carolina, to try to stop the plan.

The key issue raised by both of those lawsuits is the rate approval issue, and we have filed motions to dismiss the cases. They are both briefed but no decision has been made on either one.

Q. Mr. Cantilo, during the course of the litigation, what efforts did the Rehabilitator make to provide the parties in this matter with sufficient information to assess the plan?

A. I'm sorry, you mean during the course of the rehabilitation?

Q. During the -- yes, the rehabilitation proceedings.

A. We did. We engaged in communications that I described. We also created what we called the secure data site,

which is a box, by which I mean Microsoft box facility, that can be accessed by anyone, potentially by us, anyone to whom we give a user name and password, and on that site are all of the things that are exhibits here, but more importantly, the key actuarial files. So the Seriatim file has been available to every state for quite sometime for every policy. So every state not only had their own policies, but the policies in every other state.

We also have Seriatim files that were tailored, specifically, to our concept of the plan. Those have been available to everyone. We generated for each state an individualized report that we did give the Phase One rates for their policyholders and we sent every state an individual report explaining that so that they would know how their policyholders would fare under the plan, and we provided a lot of other documentation including the plan itself, the trial memorandum supporting the plan, the actuarial assumptions supporting the trial memorandum, and a number of other collateral documents all to anyone interested in the plan.

That side has gotten a lot of use, hundreds of uses. I don't know exactly who is using it how many times, but I do know there are in the aggregate, I would say, many hundred of visits to that site.

Q. You mentioned the regulators from Maine, Massachusetts and Washington. Can you summarize the objections as you understand them that those regulators have raised to the plan?

A. I'll give it my best shot. I'm sure Mr. Leslie -- as I understood them, those three regulators were concerned about premium rates for policies under the plan being set by the Rehabilitator with this Court's approval as distinguished by being set by them.

They also assert that liquidation would go to rehabilitation and they expressed skepticism as to whether the plan was feasible, primarily because they don't believe, as I understand it, that it will sufficiently reduce the deficit.

In addition to those three objections, I should point out that before we had amended the plan, we had also received objections from other states, not those three,

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about our earlier proposal to treat the reinsurance assumed as the right business. Those four objections were the -- are of the four principal objections that the regulatory community has developed in their plan.

Q. Let's focus on the one, the treatment of the reinsurance assumed. Can you elaborate on the change in the treatment of the reinsurance assumed from the initial plan to the current plan?

A. Certainly. So SHIP has a bit over 2,000 policies, long-term care policies, that were originally issued by the companies mentioned on Slide 93, American Health & Life, Primamerica, TransAmerica or the predecessors of those companies. So, for example, the TransAmerica policies were originally issued by J. C. Penney Life and eventually became TransAmerica policies.

So the predecessors of SHIP, Transport Life and Travelers Life, entered into agreements with the predecessors of these companies to reinsure these long-term care policies, not to assume them or debate them, but to just reinsure them. And as part of that

relationship, SHIP also agreed to administer them. So as the company went into rehabilitation, it was administering and paying the claims for these 2,000 policies.

For one of the three blocks, the one, the largest, the TransAmerica block, the original agreement had required American Travelers to establish a Trust account which then went to Conseco and is now SHIP's, to axe out those liabilities.

And that is an account funded with SHIP assets or the predecessor of SHIP, but can only be used to pay the claims arising under those TransAmerica policies. The other two, the American Health & Life and the Primerica blocks are not supported by the Trust account.

In our original plan, we proposed to treat this as if they had been directly issued policies, that is, in the same way as all the other policyholders, because largely that's the way they have been treated historically, but that resulted in some pretty vigorous objection from some states on what I think is a proper theory that, typically, in a liquidation, reinsurance is a general creditor liability,

not a policyholder liability, so we shouldn't be elevating it in a plan.

So with the amended plan we filed in October, we reversed course. I will take the blame for all this, but we reversed course and we are now treating the reinsurance assumed exactly that way.

With respect to TransAmerica policies, that means those are being paid out of the Trust, not SHIP assets, but we cannot touch that until all the premiums have been paid in full.

With respect to the American Health & Life and Primerica policies, what we are asking the Court to approve is that those companies be required to make their own claim statements out of their own money and then file a claim against us for breach of contract for the claims we should have paid, which is the way reinsurance would, typically, be treated in insolvency.

In the case of TransAmerica, we did come to this Court earlier for approval of a recapture agreement that we negotiated with TransAmerica last year. So, as of December, we

pretty much have nothing to do with liability, although SHIP continues to provide administrative services for a fee to TransAmerica for those policies.

Q. What --

JUDGE LEAVITT: These are a hundred percent --

THE WITNESS: Yes.

JUDGE LEAVITT? Quote per share?

THE WITNESS: All three were a hundred percent. That's pretty common in long-term care.

BY MR. BROADBENT:

Q. What effect do these changes have on the plan and on SHIP?

A. So we have, I think -- in a nutshell, the projected liability for these policies is removed from our liability, but the Trust is removed from our assets.

And so you will see on the exhibit -- I'm sorry, Slide 94, that on the left side of the page, we have a column, which is a year-to-date, as it is, then the effect of the reinsurance and the pro forma taking the

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reinsurance -- I'm sorry, not the reinsurance, so the total assets go from a million -- I'm sorry, I misspoke.

The last column is what happens after giving effect to the removal. So the assets go from a million seven -- a billion seven to a billion four because we remove the 300 million that were in the Trust, 325 million, but we also removed 324 million in liability shown further up on that page.

So the liabilities went from 2.7, maybe 9 to 2.624. And the difference between those two numbers is the overfunding of the Trust, which we hope to recoup once the liabilities are run off.

So in terms of the impact on the company's capital and surplus, the left side -- or right side of the sheet, you see that the surplus before, given to the fact that previously it was a billion dollar deficit and after was a billion two deficit, and that difference is primarily attributable to the overfunding of the Trust.

Before all this happened, Your Honor, SHIP reported financial condition as a

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

JUDGE LEAVITT: Okay.

BY MR. BROADBENT:

Q. When will these changes take effect?

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

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

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

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

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

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

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

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

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

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

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

But that's my understanding of that principal objection.

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

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

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

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

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

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

Q. In a receivership, why wouldn't you

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

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

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

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

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

Q. Does the plan address the issued state rate?

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

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

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

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

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

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

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

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

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rehabilitation context, could a policyholder adjust the benefits available under the policy outside of the rate setting process that the state applied?

A. No. The contracts don't provide for that. In fact, that, I think, is one of the advantages of the rehab plan is it gives policyholders more flexibility than they normally find.

What typically happens is when a company seeks rate increases, it will offer options to policyholders, but it's only when they are seeking rate increases. And those options are typically fewer in number and less varied than the ones we have been describing here.

Q. Mr. Martin has pulled up Slide 100. I would like to ask you about the deem denied period of 60 days. Why is that important?

A. I should have said that when we file our rate increase application with each of the opt out states, we will make clear that if the state doesn't pass on the application, approve it, partially approve it or reject it within 60 days, we will deem that application to have

been denied in its entirety.

And that is necessary so that the plan is not ground to a halt by inaction, as has happened so long -- so often in the past, inaction on state rate increase requests.

The other point made on the slide which is, perhaps, even more important is, we will be filing the rate increase application on a policy by policy basis, on a Seriatim basis, so we will tell opt out state X, for each of your policyholders, this is the rate we want you to approve, and that's going to be the If Knew rate, again, to eliminate the subsidies and restore a level playing field.

A lot of states don't approve rates individually. They approve them by groups. And that's a problem. And that's a problem because, I mean, take a simple example, assume three policyholders and we send state X an application to increase Policyholder A by 25 percent, Policyholder B by 30 percent and Policyholder C by 35 percent, because that's what the If Knew rate will require.

If that state says, we're just going to average that and give everybody 30 percent,

that's going to disadvantage two of the three policyholders. So the one for whom we only sought a 25 percent rate increase is now going to be paying an extra five percent just for the convenience of that state.

The one for whom we sought a 35 percent rate increase will now face a five percent downgrade because the state only approved 30 percent instead of 35 percent.

So in the materials we distributed to the states a couple of months ago about the issue state rate approval process, we emphasized that in deciding whether or not to opt out, a state ought to bear in mind that if it is unable to process the rate increase request application on a policy by policy basis, there could be adverse results to the residents of that state from application of new decisions on the rates.

And we thought it was important to make that point because some states may decide we don't want to do that so we'll just let the Rehabilitator set the rates one by one rather than we set them by group. Other states may say, no, we always set them by group, we'll

continue to do that.

But at least the cards are on the table, so to speak.

JUDGE LEAVITT: If the state is reviewing the rate filing in an opt out state, on a group basis, won't they just be looking at the If Knew premium for all the policies of a certain type? In other words, I mean, all they have to do is -- do we agree, actuarially, that it's a 60 percent loss ratio or whatever?

THE WITNESS: Our application, Your Honor, will have every policyholder listed and specify their rate increase for every policyholder and it will not be the same number.

JUDGE LEAVITT: I understand that. But, ultimately, in the aggregate, the rehabilitator is looking for an If Knew premium that's across the board; correct?

THE WITNESS: Correct. So if we send an application, say, Your Honor, we send an application for a hundred policyholders and they are all different, but in the aggregate, if you took the aggregate amount, it

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would be a 47 percent rate increase.
So Your Honor is asking why couldn't we just break up the 47 percent and say, we're going to apply it to Policyholder A at 60 percent and Policyholder B at 40 percent and so on, because, Your Honor, we are letting the state set the rates for its policyholders. If we did that --
JUDGE LEAVITT: I see. So it's not giving them another opportunity to review your actuarial analysis that --
THE WITNESS: They would have. We will file a conventional rate increase application with the exception that instead of being, give us 20 percent for all of our policyholders, we are going to say, give us 13 percent for --
JUDGE LEAVITT: For A, okay.
THE WITNESS: And so on.
But each of those, Your Honor, we will have actuarial support for the fact that whatever that number is, it's an actuarially justified rate for that policy.
BY MR. BROADBENT:
Q. Mr. Cantilo, there's four

policyholder options here, A through D. Will you offer the last option, even if it's not approved by the Commissioner of the opt out state?
A. That was a late addition to the issue state rate approval section. The original contract only had the first three options. And, as I discussed this informally with the regulators in other states, one of them, that I will not identify, suggested that -- this is not an unusual problem. They, actually, don't oppose philosophically our setting the rates, but they are bound by a statute, in their state, that limits how much rate increase they can approve.
And what this regulator suggested to me is, we don't want to punish our policyholder because our statute doesn't allow us to approve a higher rate, so long as you allow us to pass on your rate increases and reject them or approve them or whatever, but in compliance with our statute, we don't mind if you also let policyholders pay such additional rate as they are willing and able to pay to keep their policy, even though it doesn't comply with our

statute.
We won't be approving that, but we're not going to block policyholders from doing it voluntarily. I thought that was a persuasive argument, so we included that as an Option B in the program.
Q. Do policyholders governed by the opt out states have Phase Two of the plan?
A. Yes. And, again, just as for opt-ins, Phase Two will be very similar for opt out states. Again, we will file rate increase applications in each of the opt out states, but on a self-sustaining basis, individually, Seriatim again, and again, they will have the ability to approve them individually or in groups.
Q. Have you received a reaction from state regulators, generally, to the issue state rate approval option?
A. The only formal reaction has been the filing by the state regulators in this case that that doesn't satisfy them. I think there was a passing comment on this in the Louisiana case but really not germane to any of the issues in that case.

Other than that, I had informal conversations with a number of regulators who think this is creative and a good way of slashing the cat, so to speak, or whatever the expression would be.
A lot of people are not going to come out in public and say that because it would mean surrendering to the Pennsylvania Insurance Commissioner the ability to set rates, and that has become a very contentious issue.
But in terms of harmonizing their concerns with the exigencies of SHIP's circumstances, they think this would create an effective solution.
Q. Is all of this explained in the plan?
A. Yes.
Q. Will states opting out hurt the plan?
A. No. Ironically, we anticipate, we can be surprised, but we anticipate that the results of states opting out will be a deeper reduction in benefits because of more rate approvals.

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

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

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

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

JUDGE LEAVITT: No, I'm fine.

MR. BROADBENT: Thank you.

BY MR. BROADBENT:

Q. Mr. Cantilo, one other issue raised by the intervenor state regulator is the suggestion that the SHIP policyholders would be better off if SHIP were immediately liquidated.

Have you examined this issue?

A. Yeah, at quite bit of length. Early in the process of this and before we even set down the elements of the plan, the threshold issue is are we better off at rehabilitation than liquidation, and the conclusion unanimously among the group was that rehabilitation would offer policyholders more meaningful options and potentially better outcomes under the circumstances than liquidation.

In addition, the decision to go to rehabilitation was driven in part by the recognition that a key problem that SHIP faces is this great inequity issue.

Liquidation is unlikely to be able to fix that, and without it being fixed, we're going to continue perpetuating the subsidies that have plagued SHIP and the industry for so long.

So we think that one of the key

contributions this plan makes, which would not be possible in liquidation, is to eliminate the subsidies prospectively and put the policyholders on a level playing field.

In addition to that, in candor, we were not persuaded that we could justify, in good faith, compelling the guaranty associations and eventually the taxpayers to enable policyholders to continue getting Cadillac policies at VW rates. In fact, some Cadillac policies have VW rates, other Cadillac policies have Chevy rates and so on.

We think it's reasonable information to fulfill the contractual obligation on, but we also think it's reasonable to take into account when those obligations are upside down. By way of illustration, if SHIP had issued a thousand $1 million dollar face amount of life insurance policies to everyone with diabetes for a dollar each, I don't think anyone would pretend that when the company went down because a dollar in premium is grossly inadequate, the guaranty association ought to be made to step up and fulfill that million dollar life insurance policy.

And although the degree is different, I think the principle is the same in the context of long-term care insurance.

Q. Are you familiar with the intervening state regulators' arguments with respect to what they call the carpenter test?

A. Yes. So the carpenter test, that's a term used widely in the insurance insolvency industry, is a test that arises from the 1930s case, Neblett versus Carpenter, and, basically, holds that a rehabilitation plan does not fail constitutional muster if it puts policyholders in no worse a position than they would have on liquidation.

The Court, in that case, analyzed it in terms of distributing the assets proportionately on policyholders. That clearly doesn't make sense in the case of long-term care insurance. But I think people who work in this phase and the insurance rehabilitation phase, generally, understand Carpenter to mean no worse off.

What I understand the state regulators to suggest is that, based on their actuarial analysis, more policyholders fare

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worse under the plan than better. We don't agree with that conclusion. But on the strength of that, they believe, or at least they suggest to this Court, that the company should be liquidated and not rehabilitated.

Q. Are you aware of any required quantitative measure for the Carpenter analysis?

A. I am not. As I said, the Court itself, the Supreme Court and the California Supreme Court, in the Neblett case, looked at that as a distribution of assets proportionately among policyholders as the liquidation value. I don't think that, as I said, makes sense in the case of long-term care insurance.

In the property and casualty insolvency arena, typically, it's done the same way. It's a measure of distribution of assets proportionately on policyholders. But neither the statute, nor any regulations of which I am aware anywhere in the country, promulgate a test for when a plan leaves policyholders better off or worse off than liquidation and rehabilitation plan.

And, of course, the Pennsylvania statute doesn't even mention that test.

Q. Have you considered the analysis of the intervener regulators in proposing the plan for approval?

A. Yes, at some length. Their analysis is based on a measure used to establish a company's liabilities, which is the present value of the future benefits less the present value of future premiums, which they use -- they shorthand define that as the Carpenter value.

They are not the first to say that. Other people have used that term in the industry, although the term has been used for a bunch of different measures, but you can certainly use it as they have, but I don't think it's a fair measure.

So the measure we used to place on value of future benefits less present value of future liabilities is completely a projection measure. It's an estimate of future numbers. It doesn't tell you anything about today's numbers. And, as we will see, it's a number that policyholders never see.

But their suggestion is that we ought to analyze each policyholder under the plan and determine whether the options under the plan present a greater or lesser present value future benefits less present value future premium than would liquidation.

So if we use that test, they would rank the options, and if liquidation is a better option for the specific policyholder, then they would say the plan fails the test.

If we could put up Slide 102. This is an illustration of one reason I think this completely fails. This is an actual policy, actual SHIP policy. This 92-year old policyholder, if you look at the very bottom line, I state here what their measure is of present future -- present value of future benefits less the present value of future premium, so using that measure, you can see a liquidation would give this policyholder a value of $33,890. That is higher than any of the plan options. So if you use their analysis, you would say, that's the highest number, liquidation, game over.

But look carefully at what Option 3

is. Option 3 only has a value $340 lower than the liquidation value, but now look at the premium. The premium for Option 3 is zero. The premium for their test is $11,520.

So by paying 34 times the savings, the $340 every year, the policyholder can have the additional $340 in value. I submit, respectfully, Your Honor, that that is not a rational choice for the policyholder. This is not exceptional. There are many cases where the raw projection of future benefits less future premium don't really tell you what the real value of the policy is.

Q. Mr. Cantilo, I --

A. I do have another example, but it's probably not worth belaboring, but here is another case where you see a much higher value using their measure for this policyholder, but, again, you have other options that offer material coverage at a much lower premium. So the policyholder may not want to pay the $4,379 to get that $25,000. For $6,000 less in benefits, they pay no premium in Option 3. But for half that amount, they get $12,000 in present value in Option 2A and so on.

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Q. Mr. Cantilo, I would like to return just briefly to the previous slide.
A. Yes, sir.
Q. You drew a comparison with Option 3, the enhanced RPU, in terms of the present value analysis proposed by the regulators.
How does the liquidation option compare to the basic policy for this policyholder?
A. Well, so the basic policy has about half the premium of the liquidation policy. But if you look at the maximum policy value, which is the line just above the measure they recommend, it has the same value.
So the policy limits on both policies of $300,000, but the premium is half as much in Option 2 or Option 2A as in the liquidation.
Q. So in your view, is this a rational choice for a policyholder?
A. My view, first and foremost, is that I want to give every policyholder all the information and let each one select what is best for him or her. But if it were my grandmother and she were faced with these kinds

of options, I would tell her to think carefully about whether she wants to spend the extra $6,000.
You have no additional coverage because the maximum policy value remains the same, but in actuarial protection, that's twice as large.
JUDGE LEAVITT: May I -- I'm having a little trouble with Slide 102. Why is the liquidation premium $11,520? Where does that number come from?
THE WITNESS: It is the application of the If Knew premium to the benefits of the current policy subject to the guaranty association cap.
JUDGE LEAVITT: I see. But the guaranty --
THE WITNESS: You see the number in the column just before that and the column for Phase One premium, the actual Phase One premium for that policy is $13,564. But in a liquidation, we expect the guaranty associations would only charge it on the cover portion.
So we are contemplating it to be the

300,000 --
JUDGE LEAVITT: Okay.
THE WITNESS: And so for this policyholder, Your Honor, I would not recommend Option 4 because Option 4 is a higher premium, and I think that's the whole point about the benefit of choice under the plan.
JUDGE LEAVITT: So the column labeled current shows the annual premium of $2,760.
THE WITNESS: Right, Your Honor. That would be one of those ones I mentioned earlier that is vastly underpriced.
JUDGE LEAVITT: Right. I see. Okay. I got it.
THE WITNESS: Well, apart from this aspect of their measure that I think is a little bit oversimplified in their analysis, there are other ways of measuring the value of each of these options. On Slide 104, I know some of them are obvious ones.
So one they suggest is the present value future benefits less the present value future premiums. You could also take the present value future benefits over annual

premium, what some people call the bang for the buck measure, how much insurance are you getting for each dollar.
But with respect to both of these measures, Your Honor, what you are looking at are projections. We don't know those numbers. And if I gave you the numbers today, they would be wrong tomorrow. Every day, those projections are going to change.
The third option that I have up there is not susceptible to that problem. That is a maximum policy value. That is not going to change. That is the product of that policy's maximum benefit period times its maximum daily benefit. Unless you modify the policy, that's a static number and it will be that way until the policy ends.
The other part of that formula is annual premium which, again, does not change. That's not a projection. So if you are going to give policyholders guidance, I think you should give them guidance at a static, not that you know it was wrong the day after you give it to them.
The fourth measure is another bang

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

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

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

Just for the sake of illustration of

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

BY MR. BROADBENT:

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

A. You want me to stop talking?

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

A. Yes.

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

A. No. Of course not. Every policyholder is going to have subjective circumstances that differ from one to the other. We did put on Slide 111 -- it's hardly legible -- some considerations that are not in these formulas and which I think are critically important. So when we focus on better off using just present value benefits less present value of premium, we are ignoring things like the value of choice.

I think for policyholders the ability to right size their policies can be very important. I can't assign a dollar and cent value to that, but I know it's not zero and it is zero in their calculation.

The fact that we offer, in the plan, an enhanced non-forfeiture option that would never be available in liquidation, I think that's valuable. I think that's a reason to support the rehab over liquidation. Those are options in which policyholders never pay another penny in that material coverage.

I think the ability to retain their current policy, paying whatever the premium is for that policy is going to be very valuable to

some policyholders, not available in liquidation. In liquidation, no policyholder will have the ability to pay the full premium to keep their current policy which provides benefits above the guaranty association limit.

And there are other things that are less obvious but which we think are also valuable and militate in favor of the plan. As I said, the non-forfeiture option that we offer is better than the one in the industry.

The plan, if Your Honor approves it and it's implemented, will reserve the guaranty association limits for our policyholders. They are not giving that up. They will be right sizing their policy.

And I submit, Your Honor, that that's fair. But if we have to go into liquidation in three years because the plan is not as successful as I hope it will be, they will have a full 300,000 or whatever the guaranty association limit will be in another state. We are not opposing that with our plan.

Q. Mr. Cantilo --

A. And, again, I think the value of eliminating subsidies is something not taken

into account but incredibly important. Sorry.

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

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

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

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

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

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plan will reduce SHIP's deficit?
A. If a plan is implemented, it will reduce SHIP's deficit. What I can't tell you is whether it will eliminate it.
In all likelihood, it will not eliminate it. In all likelihood, it will just reduce it materially.
We have actually done some modelling of that very important issue, and so if you look at Slide 113, here are 11 scenarios. I will be clear, Your Honor, that these are artificial. We cannot pick what policyholders will actually do, but each of these columns represents a particular hypothetical take rate for each option under the plan, and those take rates are in the yellow boxes below that.
So, for example, Your Honor, in Scenario 1, we assume that seven percent of the policyholders will take Option 1, four percent Option 2 and so on, and that the vast majority, 81 percent, will take Option 4, pay whatever it takes to keep my policy.
If that were the scenario that occurs, Your Honor, we will reduce the deficit by $525 million as shown above the bar there,

which is a little bit less than half of the deficit.
Scenario 2 moves more people away from Option 4 to the other options and increases the reduction of the deficit and so on. If you go all the way to the right, Your Honor, to Scenario 11, where a very small number of policyholders elect to pay the high premium and keep their policy and the rest are spread evenly among the other options, that wipes out the deficit.
Now, I hasten to add, Your Honor, we are not predicting Scenario 11. This is a demonstration that the policyholders will be the masters of the fate of the company here, and if they stubbornly decide to stick to their expensive policies, probably the most we can hope to accomplish is cut the deficit in half.
But we worked hard in making the other options attractive and hope fervently that policyholders will select the other boxes.
The next graph will show why that is so important. On this chart, Your Honor, we show how effective each individual option is in reducing the deficit. So on the left side is

zero, meaning zero percent of policyholders take that option, and on the right side is a hundred.
If a hundred percent of the policyholders chose Option 4, which is the bottom of the curve here, the one that ends at 227, if every policyholder says, I will pay whatever it takes, don't mess with my policy, we're only going to eliminate $227 million of the deficit.
On the other hand, Your Honor, if 100 percent of the policyholders decide to take Option 3, we would create a $136 million surplus. And you can see in between where the other options fall on this analysis.
Again, no one of these options is going to get a hundred percent take rate. So if you wanted to predict, you would move your marker to the portion of the line for each graph and add them up, and that's what we did in the prior slide.
We attempted one more way to try to figure out which way things would work out with the plan, and that is Slide 115, which makes the assumption that every policyholder will

select the economically rational policy. That is an assumption that is much more sympathetic to the U.S. policy by the state regulators. It's probably not realistic because I think, Your Honor, they ignore subjective factors.
But if you did that, you can see that those take rates would produce deficit reductions in the $750 million range. And the exact assumptions are spelled out in that blue box just to the right.
Q. Mr. Cantilo, do any of these scenarios take into account for Phase Two?
A. They do not. We, as I said, we have not projected Phase Two yet. But as I also suggested, if we do Phase One, chop $700 million off the deficit and then decide we have to liquidate, we're in better shape, especially with right sizing the policies, than we are today.
Q. I'm going to change topics here and ask, Mr. Cantilo, why does the plan propose to suspend payments on accrued commissions to stop the accrual on the policyholder election date?
A. The basic reason is we don't think the plan should put agents in a better position

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than they would have in a liquidation at the expense of policyholders. So if SHIP were placed in liquidation, as happened in Penn Treaty, we would suspend the accrual of commissions and suspend the payment -- stop the accrual of commissions and suspend the payment of commissions until such time as policyholder liabilities have been paid in full or at least provision has been made for them, and that's what the plan proposes.

The plan proposes to suspend agent commissions until provisions have been made for all the policyholder liabilities as regards to commissions already approved, and to stop accruing commissions once the company is in the rehabilitation plan.

Q. Finally, Mr. Cantilo, can you explain in sum, for Judge Leavitt. The rationale for the plan?

A. Again, the key is to right size the policies that we think the sporadic pricing or the widely varying results to rate increase requests has created both a giant subsidy and a giant deficit column. So getting to have policyholders pay a fair price for the coverage

that they are getting is a big goal and we hope a benefit of the plan, that the subsidies that have been the lightning rod for so much regulatory angst in the last few years would be eliminated under the plan prospectively, although we can do nothing about them retrospectively. But we think that's essentially going to create equity for the policyholders.

I think a plan that continues having one policyholder pay Cadillac prices for a Cadillac policy and another similar policyholder paying VW prices for that policy, I don't think it's a fair and equitable plan, as the statute requires.

It's very important as -- it is familiar for the Commissioner that the plan offer meaningful choices and that we provide policyholders the requisite information to make informed decisions about those choices.

So we are devoting a lot of attention to creating materials that will be easily understood and we are devoting a lot of attention to creating options that we think will be attractive and lure people away from

the very expensive policies.

And then in deference to the objections made to the first version of the plan, we wanted to provide at least some vehicle for states that believed they should set the rates to do so. Albeit, as I said, that even if they do, in reality, they are going to be doing that for a lot of people that don't reside in their states, and a lot of people who do reside in their states will have their rates set by someone else.

But that point aside, it at least gives those states the opportunity to make their own rate increase decisions.

And finally, I think the plan is very flexible and very scaleable. It has a great benefit of adjusting itself consistently and continuously as policyholders make their elections so that Phase Two, if and when it has to be implemented, will be completely responsive to what is left after Phase One.

MR. BROADBENT: Your Honor, that -- that reaches the conclusion of my planned questioning for Mr. Cantilo. I would ask the Court to indulge us a few moments off

the record while I review testimony that we had planned and the exhibits that have been proposed to see if there is anything else additional I need to address with him.

JUDGE LEAVITT: You have it.

(Discussion held off the record.)

MR. BROADBENT: Your Honor, I do not have anything further.

JUDGE LEAVITT: Mr. Cantilo, I just have a question about the communication with the policyholders on their choices available under the plan. You did provide some illustrations of the materials that your plan had developed, and you stated that people will be able to ask questions online.

Are policyholders going to be able to ask questions of a human being by phone?

THE WITNESS: They are. In fact, Your Honor, we don't have an online facility.

JUDGE LEAVITT: Oh. I misunderstood. I thought --

THE WITNESS: We are going to have a phone bank and we will staff it so that

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people who have questions can reach a human. That is a big part of our initiative. What I meant to describe, I may have misspoken, is we are going to provide, either downloadable online or by a CD or flash drive or some other vehicle, a video that will walk policyholders through the process, which we think, based on other industries, is very helpful to inform this group.

JUDGE LEAVITT: Do you know how many agents are still contracting with SHIP?

THE WITNESS: Well, the commissions at issue are the renewal commissions, so even though the agents may not have had anything to do with SHIP or its predecessor --

JUDGE LEAVITT: Right, their predecessor companies.

THE WITNESS: I don't actually know the number. I seem to remember about 6,000, but I could be way off, Your Honor. I would be happy to check it.

JUDGE LEAVITT: It was an excellent walk-through of the rehabilitation

plan. I don't know, the hour is ten after 3:00. Mr. Leslie, would you like to begin your cross-examination today? I think, in any case, we need a break.

MR. LESLIE: Your Honor, starting cross and not finishing it is not terribly desirable, but whatever the Court approves is what we will do.

JUDGE LEAVITT: Does anybody else intend cross-examination, agents, Mr. Horwich?

MR. DONLEY: Joe Donley, Your Honor, on behalf of the agents, I do, but like Mr. Leslie, I would not want to have it interrupted if we are going to have to stop at 4:00.

JUDGE LEAVITT: What about NOLHGA?

MS. GLAWE: We would appreciate the opportunity to review the transcript tonight if there would be an opportunity to ask questions tomorrow. I expect very few, if any, though.

JUDGE LEAVITT: Is the transcript going to be ready tomorrow? We can

go off the record. 03:10

(Discussion held off the record.) 03:10

JUDGE LEAVITT: All right. 03:10

Why don't we recess until tomorrow. We will begin with Mr. Cantilo's cross-examination. 03:10

He's had a long day, as we all have. 03:11

THE WITNESS: Thank you, Your Honor. 03:11

(At 3:11 p.m., the proceedings were adjourned.)

C E R T I F I C A T E

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I hereby certify that the proceedings and evidence are contained fully and accurately in the stenographic notes taken by me on the hearing of the within cause, and that this is a correct transcript of the same.

_____

Karen A. Nickel
Certified Realtime Reporter
Registered Professional Reporter

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IN THE COMMONWEALTH OF PENNSYLVANIA

- - -

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

VOLUME II

- - -

Tuesday, May 18, 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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PROCEEDINGS

JUDGE LEAVITT: Good morning, everyone. Day 2 of the hearing on the Insurance Commissioners plan, second amended plan to rehabilitate the Senior Health Insurance Company of Pennsylvania.

Just a few housekeeping matters for the record. Mr. Cantilo's Curriculum Vitae is marked as R-1.

The Rehabilitator's amended plan will be R-2.

And R-3 will be the slides that were used yesterday in Mr. Cantilo's testimony.

There are both counsel and pro se intervenors participating in the hearing. If you are pro se, please fill out a notice of appearance, entitled Attorney's Notice of Appearance, but please fill one out each day when you arrive and be sure to give it to the Court crier.

And also advise the Court either with the Court crier or with Mr. Fink, maybe you could stand up, Mr. Fink, so everyone knows who you are, whether you expect to participate in any cross-examination. Unless the Court

hears otherwise, we're just going to go through the list of counsel that have entered their appearance one by one to conduct the cross-examination.

And with that, we will turn now to the cross-examination of Mr. Cantilo by the state regulators.

SPEAKER: Reminder that the witness is still under oath.

MR. BROADBENT: Your Honor, Michael Broadbent speaking. With Mr. Leslie's permission, I just wanted to briefly address an issue with the exhibits after the consulting with the parties. Yesterday we informed the Court all the parties had stipulated to the exhibits' admissibility, but we didn't address moving them in. We would like to actually request that we move in all the identified exhibits by the Rehabilitator at once and do so now. And that is with the consent of the parties that everyone has now, in fact, agreed to do it that way.

JUDGE LEAVITT: We can do it that way or you can do it at the completion of your case after the actuary testifies.

MR. BROADBENT: It may be easier, Your Honor, to do it now so Mr. Leslie or others can refer to --

JUDGE LEAVITT: They can in any case refer to the exhibit by number whether or not it's formally admitted, but I'm very flexible. So if you would like to move those R-1, 2 and 3 into the record and there are no objections, if Mr. Broadbent is mistaken in that regard, please make that known now.

Seeing nothing, by way of an objection, they are admitted.

(Exhibits R-1, R-2, and R-3 were admitted into evidence.)

MR. BROADBENT: Your Honor, just to clarify, was that just R-1 through 3? What I am proposing is all of the remaining exhibits, the 50 or so exhibits that we identified.

JUDGE LEAVITT: Have they been presented to the Court? I think they have to be presented and separately marked before they can be moved into evidence.

I'm not sure what you mean by the 50 exhibits; what are they?

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MR. BROADBENT: The exhibits that we identified in our prehearing filings. We spoke with the parties as to the admissibility but also as to whether to request just moving them in all together at once, if Your Honor would accept that. If Your Honor does not, then we would address it in the way you prefer, of course.

JUDGE LEAVITT: Well, it's a little out of order. Normally each exhibit gets marked, shared with all the parties and the court reporter. Right now we have three exhibits that have been marked.

If you want, we can go off the record now and you can have the remaining exhibits marked. Do you have hard copies for the court reporter?

MR. BROADBENT: Yes.

JUDGE LEAVITT: Would you prefer to do that and give a set to the Court and to Mr. Fink?

MR. BROADBENT: That's fine with us, yes.

JUDGE LEAVITT: All right. So should we take -- how long will it take, five

minutes, ten minutes?

MR. BROADBENT: I have them here available in numbered folders, so I don't think it would take too long.

JUDGE LEAVITT: All right. Well, let's just take a five-minute break and make sure that they are each marked and sequenced, the Court has a set, Mr. Fink has a set, and the court reporter.

We will recess for five minutes.

(Short recess taken.)

JUDGE LEAVITT: All right. I apologize -- you may be seated -- for the confusion. What we are going to do is have each one of these exhibits identified for the record. I understand the Rehabilitator would like to have this group of exhibits begin with the numbering RP 3; is that correct?

MR. BROADBENT: Well, what we suggest doing, Your Honor, is RP 1 with the number corresponding to the number of the exhibit as proposed, which also corresponds to the number of the exhibit as it was in Mr. Cantilo's presentation.

JUDGE LEAVITT: All right.

The exhibits that I was just shown begin with 3.

MR. BROADBENT: Yes. That's because a handful of the exhibits were too large to generate printed copies. They resulted in hundreds of thousands of pages of spreadsheet that would be difficult for the Court and difficult to print. So proposed Exhibit 1 and 2, for example, are two Excel spreadsheets of actuarial assumptions which, although part of the analysis of the rehabilitation Special Deputy Rehabilitator and part of the evidence that we believe is important are not physically capable of being printed in a way that would be useful to the Court or the parties.

JUDGE LEAVITT: All right. This is very unusual.

THE WITNESS: Your Honor, I don't know if this helps, but the documents we marked as RP 1 and 2 are also in the stack that you have in front of you. So we could change the number to refer to the one in the stack. So, for example, RP 1, I mean Exhibit 1 is RP 9 and Exhibit 2 is RP 55.

JUDGE LEAVITT: Which refers to the rehabilitation plan?

THE WITNESS: RP 55 is the Second Amended Rehabilitation Plan and yesterday we marked that as Exhibit 2. And RP 1 is my Curriculum Vitae -- I'm sorry, that is RP 9 and yesterday we marked that as Exhibit 1. I am not going to confuse things further, Your Honor, but I thought if we just referred to them as Exhibits RP 9 and RP 55 and be consistent all the way through.

JUDGE LEAVITT: Whatever makes sense, but we are going to have to have done now on the record is have each of those items identified on the record, just a brief statement of what they are.

If there is a stipulation of counsel, you can do that, Mr. Broadbent, or one of your colleagues, just say what RP 1 is, RP 2 and so forth and so on.

MR. BROADBENT: Thank you, Your Honor. So I will identify them as RP 1 in the way that Mr. Cantilo has proposed, and I will end with what we will call RP 56, which will be the slide deck presentation.

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JUDGE LEAVITT: Okay.
MR. BROADBENT: I believe that the stipulation to the admissibility of the exhibits with all counsel is sufficient for me to identify them myself.
JUDGE LEAVITT: That is right.
MR. BROADBENT: Your Honor, RP 1 is an Excel spreadsheet. The exhibit name is Actuarial Assumption Summary 2021-01-11. It is a set of actuarial assumptions summarized as of January 11, 2021.
RP 2 actuarial is -- the exhibit name is Actuarial Assumption Summary 2021-01-22, which is also an Excel spreadsheet providing an inventory of actuarial assumptions as of that date.
RP 3 is entitled Additional Information about SHIP and the Rehabilitation Plan. That document is presented to the Court in a hard copy form.
RP 4 is the amended SHIP Rehabilitation Plan filed as of October 21, 2021. That is the first amended plan which is presented in paper copy.
RP 5 is an exhibit entitled Cash

Flow Projections, which is a set of cash flow projections dated January 1st -- or January 11, 2021, and that document is presented in hard copy.
RP 6 is an exhibit Entitled Comparison of Rehabilitation to Liquidation. It is an Excel spreadsheet presented natively dated November 12, 2020.
RP 7 is an exhibit titled Comparison of Rehabilitation to Liquidation Summary, summarizes RP 6. That document is presented in hard copy.
RP 8 is the set of -- entitled Curriculum Vitae for Oliver Wyman actuaries. That exhibit is presented in hard copy.
RP 1 is the Curriculum Vitae for Special Deputy Rehabilitator Patrick Cantilo. That document was earlier in the record identified as R-1. We are now proceeding with that document being numbered RP 9 as it was identified in our prehearing memoranda. That document is presented in hard copy.
RP 10 is an exhibit entitled Exemplar Agency and Assignment Documents which presents certain agreements with respect to

agent commissions and the assignment of that commission stream. That document is presented in hard copy.
RP 11 is an exhibit entitled Finances-Q3 2020. It is a set of financial information from Q3 2020, presented in hard copy.
RP 12 is an exhibit entitled Financials YTD December 2020. That exhibit represents SHIP's financials year to date as of December 2020.
RP 13 is a general expense analysis for SHIP entitled General Expense Analysis. That document is presented in hard copy.
Exhibit RP 14 is an exhibit entitled Illustrative Policyholder Guidance Page. It is a page drawn from the amended SHIP rehabilitation plan presenting the policyholder guidance, and it is presented in hard copy.
RP 15 is an exhibit entitled Issue State Rate Approval. It summarizes the issue state rate approval option provided by the plan as of March 4, 2021. The document is presented in hard copy.
RP 16 is an exhibit entitled Oliver

Wyman Actuarial Report dated 2021-01-26. That exhibit is an actuarial report prepared by Oliver Wyman as of January 26, 2021. That exhibit is presented in hard copy.
RP 17 is an exhibit entitled Oliver Wyman Assumption Report dated 2021-01-26. That exhibit is an assumption report prepared by Oliver Wyman as of January 26, 2021. That exhibit is presented in hard copy.
RP 18 is an exhibit entitled Phase One Rehabilitation Plan Cumulative Excess Benefits Analysis dated 2021-03-24. That exhibit is presented in hard copy and offers a cumulative excess benefits analysis for the plan as of March 24, 2021.
RP 19 is an exhibit entitled Phase One Rehabilitation Plan Funding Gap Exhibits (as of 6/30/2020) dated 2021-03-02. That document is presented in hard copy and offers certain exhibits related to the funding gap with respect to Phase One.
RP 20 is an exhibit entitled -- if I didn't say it, RP 19 is presented in hard copy.
RP 20 is an exhibit entitled Phase One Rehabilitation Plan Funding Gap Exhibits

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(as of 6/30/2020) dated 2021-04-02. That document is presented in hard copy and also presents certain funding gap exhibits as of April 1 -- April 2, 2021.

RP 21 is an exhibit entitled Phase One Rehabilitation Plan Results as of 6/30/2020. That document is presented in hard copy.

RP 22 is an exhibit entitled Policy Information as of December 31, 2020. It presents certain information related to the policies' premiums and reserves as of that date presented in hard copy.

RP 23 is an exhibit entitled Probability Weighted Scenario Results and Analyses As to Possible Scenarios Under the Plan, and that document is presented natively in Excel.

RP 24 is an exhibit entitled Pro Forma Adjusted for Removal of Reinsurance Assumed Business. That document presents certain financial analyses which have been adjusted for the reinsurance assumed. The document is presented in hard copy.

RP 25 is an exhibit entitled Q2 2020

Liability Cash Flow and Gross Premium Reserve Projections. That document contains an analysis described in its title and it is presented in native form in Excel.

RP 26 is an exhibit entitled Q4 Gross Premium Results and Analytics. It provides the information described in its title and is presented in hard copy.

RP 27 is an exhibit entitled Rate Filing History, provides certain charts and graphs related to the rate filing history of SHIP. That document is presented in hard copy.

RP 28 is an exhibit entitled Rate Increase History, presents certain charts and graphs related to the rate increase of SHIP, and that document is presented in hard copy.

RP 29 is an exhibit entitled Seriatim File With Covered Liabilities and Premium Information. That document presents the information described in its title. It is presented in native form in Excel.

RP 30 is an exhibit entitled Seriatim Phase One Option Results. It contains the information described in its title presented in native form in Excel.

RP 31 is the annual report -- exhibit entitled SHIP Annual Report 2021. It is the annual report filed in the docket with this Court in March of 2021.

Exhibit RP 32 is an exhibit entitled SHIP Data Site Table of Contents. It provides the Table of Contents as of May 17, 2021 for the SHIP data site previously testified to by Mr. Cantilo. That exhibit is offered in hard copy.

RP 33 is an exhibit entitled SHIP Policy and Product Overview, and it is a set of slides providing summary of certain information related to SHIP's policies and products. That exhibit is offered in hard copy.

RP 34 is an exhibit entitled SHIP Rehabilitation Election Response Audit Process, provides a summary of the election audit SHIP proposes to do in the event the plan is approved. That exhibit is offered in hard copy.

RP 35 is an exhibit entitled SHIP Reinsurance as of October 1, 2020. That exhibit summarizes SHIP's reinsurance business as of that date and is presented in hard copy.

Exhibit RP 36 is an exhibit entitled SHIP's Summary of Balance Sheet Changes, provides the information described in its title with respect to assets and liabilities and other information and is presented in hard copy.

RP 37 is an exhibit entitled Standard Claim File. It is presented in native form in .TXT file format.

Exhibit 38 is an exhibit entitled Standard Files Data Layout. It identifies certain information in the standard files -- I'm sorry, certain standard information. That exhibit is presented in hard copy.

RP 39, Standard Policy File, that exhibit is presented natively in .TXT file format.

RP 40 is an exhibit entitled Treasury Bond Historical Rates, provides two charts summarizing historical information related to Treasury bonds presented in hard copy.

There are no exhibits with the numbers RP 41 and RP 42.

RP 43 is an exhibit entitled the

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Policies With Equal/Greater (PV benefits) minus (PV premium) under the rehabilitation plan (Phase One) relevant to liquidation, provides analysis as described in the title. Exhibit is offered in hard copy.

Exhibit RP 44 is entitled policies with equal/greater (PV benefits)/(premium) under the rehabilitation plan (Phase One) relative to liquidation. Exhibit provides the information described in its title and offered in hard copy.

Exhibit RP 45 is an exhibit entitled policies with equal/greater (MPV)/(premium) under the rehabilitation plan (Phase One) relative to liquidation. That document provides the information described in its title and is presented in hard copy.

Exhibit RP 46 is an exhibit entitled policy with equal/greater (MPV)-(PV premium) under the rehabilitation plan (Phase One) relative to liquidation. Exhibit presents the information described in its title and is offered in hard copy.

RP 47 is an exhibit entitled policies with equal/greater MPV under the

rehabilitation plan (Phase One) relative to liquidation. That document presents the information described in its title and is offered in hard copy.

RP 48 is an exhibit entitled Additional Policyholder Guidance and Analysis (basic policy or enhanced RPU) provides certain guidance related to a specific policy under the plan and presented in hard copy.

RP 49 is an exhibit entitled Additional Policyholder Guidance and Analysis (basic policy) and provides certain guidance related to a specific policy under the plan and is offered in hard copy.

Exhibit RP 50 is an exhibit entitled Comparison of Rate Increase to Annual Premium and Annual Premium Including Unapproved Rate Increases, provides the information described in its title with respect to certain states and is presented in hard copy.

Exhibit RP 51 is an exhibit entitled Rate Filing History Table, provides a summary of rate filing history for all states, presented in hard copy.

Exhibit RP 52 is an exhibit entitled

History of Actuarial Assumptions, it is a report prepared by Oliver Wyman offering the information described in its title. It is presented in hard copy.

Exhibit RP 53 is an exhibit entitled Rate Filing Histories Table, spreadsheet. It is presented in native form in Excel and provides information related to the rate filing history of SHIP with respect to all states.

Exhibit RP 54 is an exhibit entitled Actuarial Memorandum December 31, 2011. It is an actuarial memorandum prepared for SHIP on the date identified and it is offered in hard copy.

Exhibit RP 55 is the Second Amended Plan For Rehabilitation proposed by the Rehabilitator. It is presented in hard copy as previously filed with the Court on its docket. It was referenced yesterday as R-2 and will be for the remainder of the proceedings identified as RP 55.

RP 56 is the slide presentation presented by Mr. Cantilo during his testimony on May 17, 2021, in this Court. The document has been presented to the Court in hard copy

and is or upon request will be made available to the parties in digital format, in some cases in hard copy. That document was previously referred to as R-3 and will be going forward referred to as RP 56.

And Your Honor, I have reached the end of the list.

JUDGE LEAVITT: Thank you. With the stipulation of all the intervenors, those exhibits are all admitted.

(Exhibits RP-1 through RP-56, excluding RP-41 and RP-42, were marked for identification and admitted into evidence.)

JUDGE LEAVITT: All right. We will now proceed to Mr. Cantilo's cross-examination.

Mr. Smith and Mr. Leslie, are you both going to be questioning Mr. Cantilo?

MR. LESLIE: Your Honor, this is David Leslie. No; I will be the attorney cross-examining.

JUDGE LEAVITT: You may proceed.

MR. LESLIE: Thank you, Your Honor. Thank you for the courtesy of allowing

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

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

CROSS-EXAMINATION

BY MR. LESLIE:

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

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

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

A. I do not.

Q. Were the premium rates charged on

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

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

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

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

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

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

April.

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

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

A. I do not contend they were unlawful.

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

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

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

A. That would be 9,000.

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

policies, approximately 30,000 are subject to one of the options under the proposed plan?

A. I am not sure what you mean by "subject to."

Q. Meaning eligible to elect one of the five options?

A. Yes.

Q. Okay. Because the non-forfeiture, those who have elected a non-forfeiture option will not be selecting an option under the proposed plan?

A. That is correct.

Q. And that 30,000 correlates to the number of LTC policies in effect for SHIP at a high point of -- do you recall?

A. At the height, SHIP had about three hundred and I think fifty thousand policies in force at one time.

Q. Do you recall what the premium on long-term care policies was in 2020?

A. I'm sorry, Mr. Leslie, I don't understand the question. Are you asking me what is the aggregate premium SHIP was collecting or what was the average premium per policy or something else?

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Q. Do you recall your testimony yesterday about the premium that was charged in 2020 on long-term care insurance?
A. No. I'm still not clear on what your question is, sir.
Q. Okay. Could you pull up Slide 14 from yesterday's testimony.
A. I see the slide and I recall it.
Q. And how much premium was charged last year for long-term -- collected last year for long-term care insurance?
A. Again, are you asking me in the aggregate?
Q. I'm asking you what the annual premium was as of 12/31/2020.
A. Well, the annual premium for all the policies in force at that time was $58 million.
Q. Is that long-term care insurance or all lines?
A. That's long-term care insurance.
Q. So the premium for 2020 long-term care annual premium was $58 million?
A. That is my understanding.
Q. So the $58 million is the premium that we're dealing with here for purposes of

the plan; correct?
A. Again, I don't understand that question.
Q. Well, let me ask it to you a little differently. Yesterday you testified that a certain portion of policies are already paying the If Knew Premium; do you recall that?
A. I do.
Q. So what percentage of those policies are paying the If Knew Premium?
A. I think it's about 38 percent.
Q. So those policies paying If Knew Premium, are they subject to adjustment in Phase One?
A. That depends on the election they make. If they elect Options 1 or 4, there would be no adjustment. If they elected Options 2, 2A or 3, there could be adjustments.
Q. Okay. So If Knew Premium underlies the adjustments in Phase One; is that correct, either premium increases or benefit reductions; is that correct?
A. I'm sorry, I didn't hear the first part of your question.
Q. Is If Knew Premium the basis for

determining the premium increases under options in Phase One or the benefit reductions in Phase One?
A. If your question is are we basing Phase One on If Knew Premium, the answer is yes.
Q. That was my question. So if two thirds of the policies are not paying If Knew Premium, those policies could, depending on the option selected by the policyholder, could be -- could receive additional premium or benefit reductions?
A. That is true.
Q. The remaining one third, where policyholders are currently paying the If Knew Premium, those policyholders do not need to elect an option that will increase their premium or reduce their premium because If Knew Premium is the basis for Option 2; is that correct or incorrect?
A. That is true.
Q. So are we really dealing with two thirds of the $58 million of premium here for purposes of adjustments?
A. No.

Q. What are we dealing with?
A. The full amount, because even those policyholders who are currently paying If Knew Premium will be given the option to elect Options 2, 2A or 3.
Q. And if they elect Options 2, 2A or 3, will their premium go up?
A. I don't know.
Q. You don't know? Do you know if their premium will go down?
A. I do not. I have not requested information or have not reviewed information.
Q. You don't have a sense of the relativity between the If Knew Premium and the benefits available under 2, 2A and 3?
A. You would have to compare the benefits of the current policy to the benefits offered by whichever option you're looking at. If the benefits offered by the selected option were more generous than those in the current policy, I would expect the premium to go up. If the benefits in the selected option were less generous, I would expect the premium to go down.
Q. Thank you. Are you aware of any

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life and health insurance company that has been placed in the rehabilitation which has resolved a $1.2 billion deficit successfully in that rehabilitation?

A. I think that depends on what you mean by resolved that deficit successfully. I think in some respects, the rehabilitation plan for the First Capital Life Company, in which I was involved, and the plan for Executive Life Insurance Company in which I was involved could be viewed as successful rehabilitation plans, and both of those involved deficits essentially larger than $1.2 billion.

Q. Did either of those companies end up going into liquidation?

A. Yes.

Q. Did they both go into liquidation?

A. Well, it's actually three insurers, I do believe that all three went to liquidation. I know at least two of them had fully paid off their policyholder liabilities before they did.

Q. Before they paid off all their policyholder liabilities and then went into rehabilitation?

A. At least one that's the case. In the Fidelity Bankers case, we paid off the policyholder liabilities, created a policyholder dividend and that was at liquidation.

Q. Those three companies all went into liquidation; right or wrong?

A. That is the best of my recollection.

Q. And you were involved in those three insurance companies' receiverships; correct?

A. That is correct.

Q. So the resolution of a funding gap, a deficit, statutory negative surplus, in your opinion, and yesterday you were called as an expert, in your opinion, can an insurance company continue in existence with a billion dollars of negative net worth?

A. Yes.

Q. It can?

A. It can continue in existence, if that's your question.

Q. So an insurance regulator, in compliance with the laws which -- can keep an insolvent insurance company in existence indefinitely, in your opinion?

A. Perhaps, Mr. Leslie, it would be helpful to me if you define what you mean continue in existence.

Q. Well, at some point, one would think an insurance regulator would deal with the insolvency of an insurance company. And I'm trying to understand your view on how long an insolvency can exist. Can an insurance company continue to pay operating expenses, can it continue to pay -- in the case of SHIP, are claims currently being paid?

A. In the case of SHIP, we are paying claims in full, yes.

Q. So could an insurer continue to pay its administrative expenses, continue to pay policyholders, even though it has a billion dollar deficiency, indefinitely under the insurance laws, in your opinion?

A. If you are asking me would an insurance company that has a billion two insolvency be able to pay in full all of the liabilities arising under its insurance policies and all of the expenses necessary to pay those liabilities, based on my experience, I would not expect that to be the case.

Q. Correct. Does the ability of the plan to bridge the $1.2 billion funding gap depend on policyholders agreeing or being required to accept benefits below the guaranty association caps?

A. I'm sorry, you used the term breached? I'm interpreting your question -- I'm sorry.

Q. Let me repeat it again, if I could, please.

Does the ability of the plan to bridge the $1.2 billion funding gap depend on policyholders agreeing to or being required to accept benefits below the guaranty association caps?

A. That is not a requirement of the plan, although I anticipate that some policyholder election would have that effect.

Q. I would like to ask the witness some questions about Exhibit RP 16, if you could pull that up. And Mr. Cantilo, do you have the -- do you have a paper copy of the exhibits?

A. I have a small one, yes. No, I'm sorry, not the full exhibit. You mean the slides or the exhibits?

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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

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the financial statements. This statement does purport to summarize the funding gap.

Q. So just to make clear, this, these financial statements were prepared in accordance with statutory accounting principles, yes or no?

A. I don't know the answer to that.

Q. You don't know. Were they required to be prepared in accordance with statutory accounting principles?

A. No.

Q. Is the $1.2 billion funding gap reflected -- let's go back to the previous exhibit if you would, please, RP 16 -- this gross premium reserve number of 2.684 million, is this predicated on a statutory accounting principles analysis?

A. I am not sure how you use the word "predicated." I believe that that result was determined in accordance with statutory accounting principles.

Q. So the funding gap number flows from that; correct?

A. It does.

Q. So the uncovered reserve of $606

million is the portion of the funding gap not covered by guaranty fund benefits; correct?

A. That is correct, yes.

Q. So in order to reduce the funding gap to zero, would you need to have policyholders agree to accept reductions in their benefits below the guaranty fund limits or otherwise impose through the plan a reduction in their benefits?

A. We would need reductions in liability or increases in revenue which, in the aggregate, would exceed -- match or exceed $1.2 billion. That exercise is not dependent on the portion that's covered by guaranty associations.

Q. So the funding gap could be reduced if the capital markets increased the return on the investments of SHIP?

A. Yes.

Q. Okay. Are you anticipating that?

A. I'm hopeful.

Q. But have your calculations taken that into consideration?

A. I'm afraid I don't have a crystal ball so we do not project future interest rates

beyond what our investment advisors recommend.

Q. Sure. Let's just stay with what you have submitted here as Exhibits, then. So this funding gap analysis is predicated on a comparison of the statutory reserves, compared to the guaranty funds benefits, and it yields $606 million of uncovered reserve. The difference between 606 million and $1.2 billion, would you agree it needs to be addressed if the funding gap is to be eliminated?

A. If the funding gap is to be eliminated, the full funding gap needs to be addressed. I am confused by your continued use of the word "predicated." The plan does not depend on which portion of the funding gap is covered and which portion is not covered by guaranty associations.

Q. My original question was do policyholders have to agree to reduce their benefits below the guaranty fund benefit gap level voluntarily or does it have to be compelled in order to eliminate the funding gap. That was my question.

A. I understood your question. As I

believe I said, the plan does not require policyholders to reduce their benefits below guaranty associations. It is not a term of the plan. The results of elections may be that they do so.

Q. If the current reserve line was the -- I'll put it a little differently.

So if we subtract the 606 million from the $1.2 billion, we have a remaining deficit in the funding gap, and you and I have discussed what that means.

But the $606 million is a claim of policyholders under their policies. It is not covered by the guaranty funds.

As it stands today, that is a claim against SHIP; is that correct?

A. The uncovered portion of the funding gap is an anticipated benefit liability to policyholders. We would expect that over time, requests for benefits or claims would be submitted for those benefits.

Q. All right. The gross premium reserve number which was generated by Oliver Wyman, it is in the Oliver Wyman report, is the methodology they used here the same methodology

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as an actuary would use for a solvent long-term care writer in determining the gross premium reserve?

A. I assume that, but I can't say that I know from firsthand knowledge, as I was not there when it was done and I did not ask whether that was the case.

Q. So using the Oliver Wyman gross premium reserve, which has been used in your financial statements for 12/31/20; is that correct?

A. Yes.

Q. We have a projected, these are Oliver Wyman's numbers, we have a projected unrecovered reserve of $606 million, which is, I believe, the present value of future benefits net the present value of future premium. Is that your understanding as well?

A. If I understand your question, the answer is yes.

Q. So if policyholders had that claim, and if this company was in liquidation, would they have a claim against the assets of SHIP for that $606 million?

A. Yes.

Q. And did the liquidator -- did the Rehabilitator project a liquidation dividend applicable to that?

A. Yes.

Q. Of?

A. About 49 percent.

Q. So if we look at the gross premium reserve, and if we use these numbers that Oliver Wyman has projected, of the gross premium reserve liability, all but 606 million is covered by the guaranty funds; is that correct?

A. I think that's probably true.

Q. And of the 606 million that's left, the liquidation dividend, the 49 percent, would be paid?

A. That depends on the resolution of an issue currently pending before this Court.

Q. It is a legal question, yes. But I am only talking about this illustration in the Oliver Wyman report.

So the Oliver Wyman report is projecting a 49 percent liquidation dividend. So would that -- would that dividend percentage apply to the 606 reduce the loss suffered by

policyholders for their uncovered benefits?

A. If that were realized, that would be the fact. We make that assumption to create the most conservative analysis. We recognize the possibility that the law will turn out that they will not get that liquidation dividend, in which case that would not be the effect.

Q. Is it the position of the Pennsylvania Insurance Department that a liquidation dividend is applicable to benefits in excess of the policy limits, the guaranty fund policy limits?

A. The Pennsylvania Insurance Department is taking that position in a different case than this one.

Q. Yes. Are you aware of any decision anywhere in the United States that has found that benefits in excess of guaranty fund policy limits are not claims for which recovery from the estate is available?

A. Well, you're asking me a legal question so --

Q. You're an expert, Mr. Cantilo.

A. I think some parties interpret the Pennsylvania Supreme Court's decision of the

Warrantech case as making that holding.

Q. Yes, I've read that. I asked about other states. Are you aware of any state, and you have considerable experience with insurance company receiverships and liquidations. Are you aware of any state, any decision where a liquidation dividend of this type was not available to policyholders who had uncovered benefits?

A. None come to mind today, no.

Q. So it's the position of the Pennsylvania department you are unaware of any case anywhere else in the United States to the contrary that policyholders would be entitled to share in the assets of the estate to the extent that their claim exceeds the guaranty fund limit?

A. Correct.

Q. So if one moves these numbers across and applies that 49 percent to the 406 -- to the $606 million, that's the net adverse effect to policyholders in liquidation; isn't it?

A. No.

Q. Why not?

A. Because there are other factors than

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these calculations that affect the impact of liquidation on policyholders.

Q. Tell me what they are.

A. There are many. I can tell you some that come to mind now. In a liquidation, policyholders would be unable, at least in many cases, to continue to retain their full coverage even if they are able and willing to pay the premium for that.

In a liquidation, they would not be able to select the non-forfeiture option that is offered under the plan. So that would be an adverse effect of liquidation.

In a liquidation, they would not have the array of meaningful choices that the plan offers. So in my mind, that would be an adverse effect of liquidation.

Q. So the adverse effect is the absence of choices to accept benefits lower than the guaranty fund benefit level?

A. Well, that is an argument, Mr. Leslie. In my mind, the adverse effect is the absence of meaningful choices.

Q. That's just fine. I think we are saying the same thing. So carrying over the

current reserve number to the right-hand column, the net uncovered reserve after the liquidation dividend is $309 million?

A. Approximately, yes.

Q. These are the Oliver Wyman numbers in this illustration. So in the case of SHIP's liquidation, the policyholders in the aggregate would lose $309 million; do you disagree with that?

A. For all the reasons I explained in response to your prior question, yes, I don't think that that $309 million is the total amount they lose in liquidation.

Q. Well, your answer was that they lose meaningful choice in liquidation.

A. That was part of my answer.

Q. Do you quantify that? Are you able to quantify meaningful choice?

A. Nope.

Q. Okay. So it's an intangible benefit that you perceive that policyholders would have?

A. Yes.

Q. All right. So is it your opinion that guaranty associations may not offer up an

option, a benefit option to policyholders of an insolvent company at a level lower than the guaranty fund benefits?

A. I have not looked at that question. I don't know whether each of the individual guaranty association acts permits guaranty associations to do that, but sitting here today I know of no reason why they could not.

Q. So you have testified that meaningful choice is of significant value to policyholders?

A. I believe so.

Q. Before putting together the plan and its options, did you consult with NOLHGA about the possibility of offering those kind of meaningful choices below the guaranty association limits?

A. No.

Q. Why not?

A. Because there is no practical way to do that.

Q. What do you mean there is no practical way to do that?

A. Based on my experience, had I reached out to NOLHGA and asked exactly the

question you just asked, the most likely response I would have gotten is that NOLHGA itself cannot bind its individual members to make that kind of commitment and that they do not have information as to whether each of their original members would make that commitment.

Q. So is it your opinion that if the Pennsylvania Commissioner of Insurance determined that a liquidation best served the interests of policyholders, so that they only suffered the $309 million of loss, you could not present an array of options to NOLHGA and ask them to consider whether that would be possible in the circumstances of SHIP's liquidation?

A. That's not my testimony.

Q. I'm sorry, I couldn't hear you.

A. That is not my testimony.

Q. Okay. So you don't believe there is a practical option for you to have consulted with NOLHGA about offering benefits less than the guaranty fund limits; is that your testimony?

A. That is right.

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Q. Let me draw your attention to the Exhibit 2.5, the lower half of this page, which is an array of options, again, in the Oliver Wyman report.

Are you familiar with these ten options?

A. Yes.

Q. Okay. Are any of these options predicated on any experience that you've had with a liquidation?

A. There were no other long-term care liquidations before the Penn Treaty case, so the only experience to which we could refer was the Penn Treaty case. The conservative scenario is derived in part from the Penn Treaty experience.

Q. Yes, sir. Is Scenario 1 derived in part from the Penn Treaty experience?

A. Yes.

Q. And that would be Penn Treaty in liquidation, not Penn Treaty in rehabilitation; is that correct?

A. Yes.

Q. So Scenario 1, which is loosely based on Penn Treaty, is that a -- is the use

of the word "loosely" there fair?

A. The words I used were "derived in part."

Q. Okay. I will use those, too, then. So Scenario 1 was derived in part from the experience that the liquidator had with Penn Treaty?

A. Yes.

Q. And under that experience, looking at the options -- let me go back a step.

Were these options calculated based on the liquidator's seriatim file that looks at each individual policyholder and offers an array of ways to test the policyholders -- the effect on policyholders of the options?

A. When you say "these options," are you referring to the options summarized on this exhibit?

Q. Yes.

A. They were derived from an analysis by the Rehabilitator of the seriatim data file.

Q. Okay. How is that different than the -- I will take that -- withdraw that.

So Scenario 1, which is in part based upon the Penn Treaty experience, seven

percent of policyholders would select Option 1; right?

A. That is the assumption we made for that scenario.

Q. The assumption is derived in part from the Penn Treaty actual experience; right?

A. Well, the plan options differ materially from what was offered to policyholders in the Penn Treaty liquidation. So it's not an apples to apples comparison. But we did make hypothetical assumptions in each scenario for what we call the take rate, the number of policyholders selecting each option in each scenario, and in Scenario 1, a hypothetical assumption is that seven percent of the policyholders would have taken that option.

Q. So Option Scenarios 2 through 10, are they predicated in part on actual experience with any insurance company in liquidation, long-term care writer in liquidation or the like?

A. They are based in part on what we infer from the industry's experience as a whole in response to rate increase requests and in

part on the Penn Treaty experience.

Q. Okay.

A. Although no specific insurance company data is embedded in those projections.

Q. Have you submitted any exhibits illustrating that comparative industry experience?

A. No.

Q. So of these ten scenarios --

A. Mr. Leslie, I should add, in fairness to you, all of these are based on judgments. This is all the exercise of judgment by myself and our advisors in calculating the scenarios.

Q. Thank you. That is helpful.

So of the ten, though, isn't Scenario 1 the one that has, you know, some correlation to an actual Pennsylvania long-term care insurance company liquidation?

A. Well, as I said, we took the experience of the Penn Treaty case into account in all of the scenarios. We elected one -- we wanted one to be the most conservative and elected to base it more on the Penn Treaty experience than industry or other experience.

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Q. So under Scenario 1, 81 percent of the policyholders would be expected to select Option 4?
A. Right, as I mentioned yesterday.
Q. And does Option 4, of the five options, does it have the best or the worst effect in reducing the funding gap?
A. In general, Option 4 is the least effective at reducing the funding gap.
Q. So if 81 percent of the policyholders selected Option 4, after Phase One, the funding gap would be the largest as distinct from policyholders selecting Options 2 or 2A or 3?
A. Yes. I believe I addressed that yesterday.
Q. Yes, you did.
A. I think the scenario you described would result in about a $525 million reduction in the funding gap.
Q. Yes. Yesterday you testified, I believe, about the -- that policyholders had an option, had a least one option equal to what would be the case in liquidation; is that correct?

A. Right.
Q. And of these five options, is Option 4 the option on which you are relying for that assertion?
A. It varies from policyholder to policyholder.
Q. But if 81 percent of the policyholders would be presumed to have accepted selected Option 4, wouldn't --
A. They would retain the maximum policy benefits provided by the policy.
Q. So on a comparison of rehab to liquidation, is the number of policyholders selecting Option 4 important?
A. All of the selections are important.
Q. Well, I understand that. But for purposes of computing the relative benefits of the rehab plan to liquidation, is it important that Option 4 be available to policyholders to select?
A. We believe that it's important to the policyholders that Option 4 be available to them.
Q. Could you achieve the 85 percent better in rehab versus liquidation without

Option 4?
A. I have not looked at that. I think that depends on how you define "better." If you define "better" the way I think it's best defined, the answer is yes.
Q. Right. We will talk about that more in a while. Okay.
Yesterday you testified that it was better to look at, from a policyholder impact perspective, it was better to look at maximum policy values than net present values; is that correct?
A. I don't recall my exact words. I think what I said is that maximum policy value would be a quantity more familiar to policyholders and that more closely resembles terms already defined in many of the policies and that the value you advocate, present value of future benefits less the present value of future premium, is more volatile and dynamic and much less familiar to policyholders.
Q. Yes, sir. Is maximum policy value an element in creating -- estimating an insurance company's liabilities?
A. I'm sure for some purposes. We

don't usually use it in gross premium reserve determinations.
Q. Right. Did Oliver Wyman use it in putting together their actuarial report we talked about a moment ago?
A. I don't know.
Q. You don't know?
A. (Witness shook head negatively.)
Q. Okay. Is maximum policy value a statutory accounting concept?
A. I don't know whether that particular term is. I think the term "policy limits," which is pretty similar, isn't used in some statutory accounting exercises.
Q. The illustration on the screen, did it use maximum policy value at all to determine the gross premium reserve and the funding gap and the uncovered reserve?
A. I don't think so.
Q. Okay. So when you use the term "maximum policy value," does it correlate to the filed financial statements of SHIP?
A. I don't recall whether there is a place in the statement where possibly it is referenced. The statements, as you know, are

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very long.
Q. Yes, but the determination of the liabilities of an insurance company are a critical component of the financial statements; would you agree?
A. Yes.
Q. And are they calculated using maximum policy value?
A. Sitting here today, Mr. Leslie, I don't recall whether they were ever calculated that way.
If you're asking whether under the liabilities page where liabilities are reflected that is the formula, it is not. But it may be elsewhere in the statement.
Q. Okay. Well, let's go to Page 8 of this actuarial report which explains, this is part of the Oliver Wyman report, and it explains how they derive the current gross premium reserve; is that correct?
A. That's what I understand, yes.
Q. Can you take a minute and look at this page and tell me if you see the term "maximum policy value" used.
A. Sure. No.

Q. Okay. Thank you. Yesterday you testified about the impact of Phase Two and how Phase Two will adjust benefits. Does that adjustment utilize present value?
A. Present value calculations will be part of the model for adjustment in Phase Two.
Q. Are assets allocated to policies in Phase Two based on the present value of benefits net of the present value of premium?
A. No.
Q. Okay. We will come back to that.
Could we pull up Exhibit No. R-19.
MR. BROADBENT: Mr. Leslie, do you mean RP 19?
MR. LESLIE: RP 19, yes. Thank you.
BY MR. LESLIE:
Q. Could we move forward a page or two here. Okay. Yesterday, Mr. Cantilo, you testified about this page. Do you recall?
A. Yes.
Q. You see the yellow highlighted at the top?
A. Yes.
Q. Funding gap, and this looks to me to

be a formula; do you agree?
A. Yes.
Q. Who put this together?
A. I'm not sure. Someone at Oliver Wyman.
Q. It was assembled by Oliver Wyman, your actuaries?
A. Yes.
Q. This funding gap analysis, do you know whether it's predicated on present values?
A. Yes.
Q. It is -- is it premised on present values?
A. Yes, I believe so.
Q. So the comparative effect of the options is portrayed here relative to the funding gap calculated on a present value basis?
A. Yes.
Q. And would you look at, I believe Phase One of Option 4 is gold or yellow. You can distinguish that. The chart to the left shows the funding gap.
Could you explain the $227 million number next to the phase, to the Option 4 Phase

One impact, what that means; what does the 227 million mean?
A. Sure. I explained that yesterday. That is what we anticipate would be the result and reduction of the funding gap from every policyholder selecting Option 4.
Q. So if 100 percent of the policyholders selected Option 4, it would reduce the funding gap, or so Oliver Wyman projects, by $227 million?
A. Correct.
Q. To roughly a billion dollars?
A. Yes.
Q. So if 81 percent of the policyholders selected Option 4, we could look at that in a relative way and it would be more than $227 million, because it's not a hundred?
A. It would be 525 million.
Q. Very good. Quick mathematical calculation. I like that. Thank you.
Did you participate in the March 5, 2021 call with Oliver Wyman and the intervening parties to discuss their --
A. I may have introduced people on that call. I think I mostly listened.

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Q. But did you listen to the whole call?
A. Yes.
Q. Do you recall anyone using the term "Carpenter value" during that call?
A. I don't recall, specifically, but I think several people did. It is not unusual to refer to the term "Carpenter value" when you are evaluating rehabilitation plans.
Q. When you are evaluating what?
A. Rehabilitation plans or liquidations, either one.
Q. Or policyholder benefits? What is Carpenter value? What is your understanding of Carpenter value?
A. In simplest form, it's a pro rata distribution of insured and liquidation assets for capping out to policyholders. That's the way the Supreme Court defined it in that case.
Q. Was the term "Carpenter value" introduced to that call by an Oliver Wyman actuary?
A. May have been, I can't recall.
Q. Did the state insurance, intervening state insurance regulators raise the concept of

Carpenter value during that call?
A. Could be. Mr. Leslie, I just don't recall who first used the term.
Q. Yesterday I believe you criticized the use of the term "Carpenter value"; is that correct?
A. No.
Q. No?
A. What I said was the term "Carpenter value" can be many things and what I criticized was interpreting that term to mean only one thing.
Q. So your criticism is over the interpretation of the term "Carpenter value" as distinct from the use of the term "Carpenter value"?
A. Correct. I, myself have used the term "Carpenter value" many times.
Q. Okay. Are you familiar with the comparison file that was loaded onto the Rehabilitator's data site, it's Exhibit 6, but thankfully it was not presented. It's a huge seriatim file. But are you familiar with that file and why it was created?
A. I am generally familiar with that

file.
Q. Was the purpose of this file to compare each of the rehabilitation plan options for each SHIP policyholder to the guaranty association benefit?
A. Without looking at the file, I couldn't answer that question.
Q. Do you recall it being referred to as the comparison file?
A. Yes.
Q. What was it comparing?
A. That's the part I don't remember.
Q. You don't think it was comparing it to liquidation, then, huh?
A. Well, I'm under oath here, I'm not going to speculate. If I can look at the file, I would be happy to answer your questions.
Q. Okay. Who prepared the comparison file?
A. I assume it was done by either Oliver Wyman's staff or SHIP staff. I'm not sure who prepared it.
Q. Were the benefits reflected in the comparison file for the plan options and the guaranty funds prepared on a net present value

basis?
A. Without looking at the file, Mr. Leslie, I can't tell you.
Q. You don't know?
A. Sitting here today, I do not.
Q. Yesterday you testified on some of this. That's why I'm asking.
A. I don't recall testifying about the comparison cost.
Q. Were the guaranty association values used in this comparison file based on If Knew Premium, net premium?
A. May I see the file?
Q. I'm sorry?
A. May I see the file so I can answer your question?
Q. The file is Exhibit 16. Excuse me, Exhibit 6. I mean, you don't -- you're not going to be able to look at Exhibit 6?
MR. BROADBENT: We have it.
MR. LESLIE: I'm sorry. Yes.
MR. BROADBENT: Would you like it?
MR. LESLIE: Yeah, give it to him.

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BY MR. LESLIE:
Q. So let's look at the purpose here.
A. May I have a minute to look at this document?
Q. Sure. Look at the purpose, if you would, please.
A. All right.
Q. Does this refresh your recollection about the purpose of the comparison file?
A. Yes.
Q. And its purpose was?
A. It was one way of evaluating policyholder options under the plan in comparison to what we anticipate, what I believe would be the measure of liquidation that you would use in this case.
Q. Did the Rehabilitator place this file in the data site so that my clients and others who were interested in this plan could see this comparison to liquidation?
A. And all the states as well, yes.
Q. And other regulators, as I said?
A. Oh, yes.
Q. Okay. So the comparison is the options to liquidation; right?

A. Correct.
Q. Okay. And it uses the present value of a liquidation benefits, is that what PV means here?
A. I believe it's present value of benefits plus expenses less present value of premium under each scenario.
Q. The critical point, though, is it's using present values in liquidation?
A. Oh, yes.
Q. Okay. And it's comparing that to present values of benefits under the options, too; right?
A. Correct.
Q. It's not using maximum policy value; is it?
A. That is correct.
Q. Okay. So the Rehabilitator prepared -- had this exhibit prepared for the benefit of interested persons like other insurance regulators, and used a net present value calculation to do so?
A. Yes. For the purpose of demonstrating how the options would affect the insurance company, not how they would affect an

individual policyholder.
Q. Isn't -- I thought this was a seriatim file that was able to model every policyholder.
A. It is.
Q. So doesn't it model every policyholder against their liquidation benefit, too?
A. It does.
Q. And it models each of those policyholder benefits attributable and uses the five options as well; is that correct?
A. I believe so, yes.
Q. So one is able to use the comparison file to look at the net present value benefit of Option 1, Option 2, Option 2A and so forth?
A. For purposes of understanding the effect on the company's financial condition, yes.
Q. It isn't used -- it's not reasonable to use it for purposes of understanding the impact on the policyholder?
A. On the policyholders as a group, yes. In terms of relative value of the options for individual policyholder, at least in my

view, that would not be the best way to do that.
Q. I'm asking you about this file. Doesn't this file compute the present value benefit of each option for each policyholder?
A. I assume that it does, yes.
Q. Doesn't it also compute the present value of the guaranty fund benefit for that same policyholder?
A. I believe that it does, yes.
Q. And this is all done in a comparison file; right?
A. Yes, sir.
Q. So one would presume it's for the purpose of comparing those options, one to the other, as to a policyholder, as to a specific policyholder, as to that specific policyholder's liquidation benefit; is that correct?
A. As that affects the funding gap, yes.
Q. The -- I apologize for focusing on this, but I think it's an important point, the comparison file calculates, does it not, the present value of the estimated benefit that the

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Rehabilitator has estimated for each option for that particular policyholder; correct or incorrect?

A. I think that is correct. Obviously, those are actuarial calculations. So I suspect they are done in the aggregate and then allocated to the policyholders. But the end result is a policyholder by policyholder presumed present value calculation for each option.

Q. Do you believe it's inappropriate to compare the present value of each of these individual options to the present value of liquidation for that same policyholder; is that inappropriate?

A. No.

Q. Okay. That's the purpose of the exhibit; isn't it?

A. Well, that is a purpose of the exhibit, but I don't think it is inappropriate.

Q. Excuse me? I couldn't hear you. I'm sorry.

A. That is a purpose of the exhibit and I don't think it is inappropriate.

Q. So isn't that what the state

insurance regulators did in their illustration, take the present values in this comparison file and compute which benefit, you know, what the present value of those options were compared to liquidation? Didn't you do that? You testified to it yesterday.

A. That's part of what they did, yes.

Q. Okay. So it's not unreasonable, in your opinion, to compare the present value as projected by Oliver Wyman, for each policyholder, for each option, to the liquidation value that Oliver Wyman also calculated on a present value for that same policyholder?

A. No.

Q. Do you recall whether Oliver Wyman used, for purposes of the guaranty fund benefit, present value, used If Knew Premium?

A. I believe they did, yes.

Q. You believe they did use the If Knew Premium?

A. I believe so.

Q. So the If Knew Premium is used in the rehabilitation option calculations; right?

A. Yes.

Q. And if the If Knew Premium is used in the comparison to liquidation options as well?

A. In part, yes.

Q. In part? What does that mean?

A. I believe the If Knew Premium for the liquidation option was truncated to the aggregable guaranty association limit.

Q. Sure. In order to come up with the present value of the premium versus the present value of the guaranty fund benefit, absolutely. Understand.

Yesterday you testified that one of the reasons why rehabilitation was preferable to liquidation was that it could correct historical rate inequities; is that correct?

A. Prospectively.

Q. Oh, prospectively. But I believe your testimony was this was one of the principal reasons for selecting liquidation -- rehabilitation over liquidation; is that correct?

A. Correct.

Q. Okay. So is it your opinion that all SHIP's rate increase filings from 2009 on

should have been approved?

A. I have not looked at those files individually, so I can't express an opinion as to that.

Q. Did you have anybody look at them, did you have counsel, did you have some other consultant look at each of those rate filings from 2009 through 2020?

A. I don't think so.

Q. So are you able to assess whether those rate filings were appropriate or inappropriate based on the facts as presented to the regulator and the law as it stood in that state at that point in time?

A. I have no reason to believe that the actuarial justification analysis underlying those filings was inappropriate.

Q. I asked you the question that you didn't review the individual filings, and you had no one else do that; correct?

A. Correct.

Q. And so it's your opinion that those rate filings were properly supported by actuarial backup, SHIP actuarial backup; is that what you're saying?

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A. I made that assumption, yes.
Q. That's an assumption; right?
A. Correct.
Q. You don't know it to be the case?
A. I have not tested it, that's correct.
Q. In your opinion as someone expert in insurance company receiverships, and insurance companies in general, are rate submissions commonly approved 100 percent by the states when they are filed?
A. Some are and some aren't.
Q. So it is your experience that a hundred percent is -- happens, and some lesser amount sometimes happens?
A. And some greater amount sometimes happens.
Q. I'm sorry, I apologize. We are in a hall of mirrors here, it seems. I can't hear you.
A. And some greater amount. There have been rate filings, rate increase request filings that have resulted in approval in excess of the request.
Q. Right. Yesterday, you testified to,

I believe you presented a slide on rate submissions and rates not approved from 2009 through 2020. Do you recall that?
A. I think it may have been 2009 to 2019, but you may be right. It may have been to 2020.
Q. And was your estimate about $300 million?
A. The nominal value of the amount of those requests that was rejected was about $311 million.
Q. Were those SHIP filings between 2009 and 2020 based on If Knew Premium methodologies?
A. I don't believe so.
Q. Okay. You testified that between 2013 and 2015, SHIP didn't make any rate filings, rate increase filings?
A. I believe that's right or they made a very small number.
Q. I think you also testified that they felt they were doing fine at that point; is that right?
A. That's what I was informed, yes.
Q. So if they thought they were doing

fine, could that have affected the rate decision regulators made on their submissions prior to 2013?
A. I suppose that is possible. I would be speculating.
Q. Why did you include 2013 to 2016 If Knew Premium increases when no rate filings were filed for those years?
A. Because if the company had priced the policies appropriately and If Knew at inception, those rates would have applied continuously throughout the period.
Q. I believe you used the words "discriminatory" and "cross subsidy" and the like to refer to the rates as they stood prior to the order of rehabilitation entering; is that correct?
A. I think so, yes.
Q. So are state regulators to blame for SHIP not making rate increase filings from 2013 through 2016?
A. I don't know the answer to that, Mr. Leslie.
Q. You don't know whether, if rate filings weren't made, whether regulators made a

mistake in not approving them?
A. That was not the question you asked me.
Q. Okay. So no rate filings were filed for those years, but your If Knew Premium illustration includes the If Knew Premium for those years, notwithstanding the fact the rate filings weren't submitted?
A. That's true.
Q. You think that's a fair portrayal of the situation?
A. Yes.
Q. All right. Were the rates, as they stood on the day the rehabilitation order entered, were they lawful rates; had they been lawfully approved?
A. I assume they were, yes.
Q. So does the rehabilitation plan seek to modify rates that were lawfully approved or disapproved?
A. The plan will modify the rates as described in the plan, and I am assuming that some or all of the rates that will be modified were roughly approved.
Q. You, yesterday you showed us a chart

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by state showing the experience on rate approvals; do you recall that?
A. I do.
Q. And I believe you also criticized regulators for not approving those rate increases, and that to the extent that a rate increase wasn't approved, that the difference had to be paid by somebody else; is that --
A. That's right.
Q. That's fair?
A. (Witness nodded head affirmatively.)
Q. So is there an element of criticism in your testimony as to the state regulators not approving the rate increases?
A. I don't know whether I intended to criticize regulators yesterday in that regard. I do think that regulators who routinely fail to approve actuarially justified rate increases in many cases contribute to the problem.
Q. That's your opinion, correct, as an expert?
A. That's my opinion in response to the question you asked me today, yes, sir.
Q. That is your opinion as an expert. So but you didn't --

MR. BROADBENT: Your Honor, I have to object to Mr. Leslie's characterization because the witness clearly stated something different than Mr. Leslie just stated in a non-question.
MR. LESLIE: That's fine. I withdraw the question, Your Honor.
MR. BROADBENT: Thank you.
BY MR. LESLIE:
Q. Yesterday you testified that the collapse in the capital markets impacted the underpricing of SHIP's coverages; is that correct?
A. It affected -- it contributed to the funding gap. I'm not sure it contributed to the underpricing.
Q. You testified to the rates that weren't approved, the 300 and some million. What portion of the funding gap is attributable to the collapse of the capital markets?
A. I have not calculated that number.
Q. Okay. So one of the purposes of the plan is to address these rate inequities and failure to approve rate increases; that is correct, isn't it?

A. One of the purposes of the plan is to affect the current rate structure.
Q. So 300 and some million of the funding gap is attributable to that, by your testimony?
A. To what?
Q. You testified that approximately 300 and I believe 20 million dollars of premium wasn't approved, and so taking that premium that was not approved, the chart you showed yesterday, and comparing that to the $1.2 million gap, presumably it contributed to the funding gap; right?
A. If I understand your question to mean did the 311 million in unapproved rates from 2009 to 2020 contribute to the funding gap, the answer is yes.
Q. Yes, by 300 some million?
A. As I said, 311.
Q. 311 plus the failure to -- the company couldn't earn investment income on that premium as well, you computed that to about I believe 370 or 80 million dollars; right?
A. Correct.
Q. Okay. But you're not able to -- you

haven't projected what the effect of the actuarial pricing assumptions on investment returns compared to actual was as it contributed to that funding gap, you haven't computed that, had anyone do that?
A. No. There is nothing I could do about that.
Q. But it could be computed; couldn't it? You showed yesterday, you showed the period of time in which rates were submitted and what investment returns were during those years.
A. Yeah. I suppose one could create a table that would show what the difference in investment income year by year would have been under scenarios different than the ones that actually occurred in each of those years based on the assets invested by the company during each of those years. We have not done that.
Q. Mr. Cantilo, is a comparison of the assumption of investment return to actual, is that difference material to the amount of the funding gap?
A. I'm sorry, can you tell me what the two things are that I'm comparing?

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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?

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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.

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

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

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

A. You could call it that.

Q. Are the guaranty funds created by statute?

A. Yes.

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

A. Not anymore, no.

Q. But the Pennsylvania Commissioner --

well, are certain of SHIP's policyholders not worthy of guaranty fund coverage because their benefits are too rich and they didn't pay enough premium?

A. That's not my opinion, no.

Q. I'm sorry?

A. That is not my opinion, no.

Q. So policyholders aren't at fault here; are they?

A. Correct.

Q. Correct, policyholders aren't at fault?

A. Correct.

Q. But the exclusive -- the burden of the plan is exclusively on those policyholders who are not at fault; right?

A. You can be underpaying for something without being at fault and still not have a reasonable expectation that you should continue to be allowed to underpay at taxpayer expense.

Q. But the guaranty funds were created by law.

A. Yes.

Q. They exist as statutes right now.

A. Yes.

Q. They exist, as you testified, and they have the effect of spreading loss beyond the policyholders?

A. Yes.

Q. Is the $1.2 billion funding gap today attributable to the 30,000 long-term care policyholders of SHIP that have in force policies now?

A. In part.

Q. In part? Is it mostly the 30,000 policyholders' fault?

A. Probably not.

Q. Probably not. So the 600,000 or 800,000 policyholders that SHIP insured received the benefit of underpricing?

A. Yes.

Q. And the 30,000 policyholders that are left are going to exclusively bear the consequences of the funding gap; is that correct?

A. No.

Q. Why not?

A. Because the plan only adjusts the rates prospectively so the effect will be that they will be paying a fair rate going forward,

but they will not be asked to pay a penny to make up for the underfunding retrospectively.

Q. But is it true that rates have two effects in the plan; one is higher premium, but don't they have a bigger effect on reducing benefits?

A. If by that you mean that in exchange for not paying the higher rate, a policyholder might choose an option that reduces benefits, the answer is yes.

Q. Didn't you testify yesterday that there aren't enough policyholders to pay enough premium to bridge the funding gap?

A. I don't recall whether I testified to that, but the answer is that that would be the case, yes.

Q. And didn't you testify that benefit reductions are what is needed to fill the funding gap, even voluntary or otherwise?

A. I don't recall testifying to that, but benefit reductions are needed to reduce the funding gap.

Q. But aren't premium increases and benefit reductions two sides of the same coin? Aren't the benefit reductions the result of

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application of the If Knew Premium to the coverage that would be available?
A. Not exclusively, no.
Q. Well, what are the other factors?
A. Well, policyholders may choose an option which has fewer benefits and does not consist simply of reducing the current premium based on If Knew rates to those benefits.
Q. So policyholders could choose to accept a lower benefit than available today at a lower premium because they choose to do that today, and that would have the benefit -- have a benefit to the estate or to deficiency by reducing the obligation the company has to that policyholder?
A. Yes.
Q. Okay. So can that occur in the case of a benefit within the guaranty fund limit as well?
A. Can you repeat the question?
Q. Could the hypothetical policyholder you just described, could that adjustment of benefits be an adjustment of benefits that falls below the guaranty association benefit?
A. Yes.

Q. That would be an example of a policyholder voluntarily choosing to give up some coverage in exchange for the benefit of lower premium and a lower benefit because of their financial circumstances at that time?
A. That is possible, yes.
Q. Now, these adjustments in Phase One are permanent; isn't that correct?
A. The adjustment resulting from selecting Options 2, 2A or 3 under the plan are intended to be permanent under the plan.
Q. Yeah.
A. Obviously, if the plan is unsuccessful in keeping the company out of liquidation, then other changes might result in liquidation.
Q. So a policyholder, your hypothetical policyholder that makes the decision you just described, could their circumstances change in Phase Two?
A. Yes.
Q. Okay. So that policyholder is making a choice in Phase One which has a permanent effect on that policyholder?
A. In the sense I just described, yes.

Q. Well, in the sense that guaranty association coverage may be given up?
A. Yes.
Q. And so in Phase Two, I believe the plan says premium could be materially increased for those selecting Option 4; is that correct?
A. That is correct.
Q. And benefits could be materially reduced for those selecting Option 1; is that correct?
A. That is correct.
Q. So our hypothetical policyholder who gives up a certain level of guaranty fund protection in Phase One may find a result in Phase Two that looks very different than what that policyholder thought the circumstances were in Phase One?
A. That is possible, yes.
Q. So why do policyholders have to give up guaranty association benefits in Phase One permanently; why do they have to do that?
A. I'm not sure what you mean by "have to."
Q. Well, the plan requires them to give those benefits up permanently, it specifies

that they give up the benefits permanently at Phase One; doesn't it?
A. The plan says they can elect to do that.
Q. Sure.
A. Your question is why does the plan allow policyholders to elect to do that?
Q. No.
A. Because it's part of the meaningful choices we are offering --
Q. I apologize if my question wasn't clear.
JUDGE LEAVITT: Mr. Leslie, we are after noon, do you have a sense of how much longer your cross-examination is going to take?
MR. LESLIE: I'm not sure, Your Honor. It depends in part on the witness.
JUDGE LEAVITT: Well, let me -- there is some repetition, and the Court is -- understands, sometimes there is a need for repetition, but I think that could go a little bit faster on your part.
There is no need to argue with the witness. You're going to have plenty of opportunity to make your points and you have

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good points and you're making them well, but I'm just wondering if they might not, some of them, be better made in a brief.

MR. LESLIE: I don't know what time it is, Your Honor.

JUDGE LEAVITT: It's after noon. Is this a good time to break? The court reporter has been here for two hours.

MR. LESLIE: I would respectfully suggest we break and resume. And I will -- I am properly admonished by the Court and will focus on trying to do this as quickly as possible.

JUDGE LEAVITT: All right. We will recess for 45 minutes.

(At 12:07 p.m. a lunch recess was taken until 12:52 p.m.)

JUDGE LEAVITT: You may be seated. All right, Mr. Leslie, you have the conn, as they say.

MR. LESLIE: I will try to keep the conn as briefly as possible, Your Honor.

Could we have Slide 67, please.

Should I start, Your Honor?

JUDGE LEAVITT: Yes, please.

BY MR. LESLIE:

Q. Good afternoon, Mr. Cantilo.

A. Good afternoon, Mr. Leslie.

Q. You see Page 67 from your presentation yesterday?

A. I do.

Q. This morning I asked you some questions about Phase Two and how Phase Two works vis-a-vis present value.

A. Yes, sir.

Q. And so this slide describes how Phase Two will work insofar as dealing with the shortfall amount. Could you describe what the shortfall amount is?

A. Yes, sir. For each policy there is an internal calculation of the present value of future benefits and expenses, and the future value of -- the present value of future premiums, and then an allocation of assets. And if the present value of future benefits and expenses exceeds the sum of the present value of future premiums plus allocated assets, that excess is the shortfall amount.

Q. And so this chart deals with how

that shortfall is then addressed in Phase Two. It looks like --

A. Yes, sir.

Q. It looks like that causes the allocation of assets to policyholders proportional to the shortfall?

A. No, sir.

Q. Could you help me and explain how that works, if you would.

A. Certainly. The assets allocated as the portion of the formula I just described are allocated among the policyholders in proportion to the accumulated premiums they have paid over the life of the policy.

Q. So do you agree that this calculation, again, is a present value calculation?

A. It's present value as to future benefits, future expenses and future premiums.

Q. All right. So would you agree that Phase Two is an integral part of the plan?

A. I don't know how you mean the word "integral." It is an important part of the plan. But as I think I said yesterday, in my opinion, the plan can be successful in Phase

One.

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

A. Yes.

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

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

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

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

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

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

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premiums or benefits could be adjusted is too small to absorb the funding gap if it was quite large?

A. That would be a factor, yes.

Q. Now, I would like to draw your attention to the second amended plan. And I used to know what that exhibit number was.

A. It is Exhibit 55.

Q. If you would be so kind to put that up and, particularly, Page 11. Okay. I draw your attention to the first paragraph on this page, once you're ready. Take your time.

A. I have Page 11 in front of me.

Q. The first paragraph provides that the results of Phase One will be evaluated and it talks about self-sustaining premiums, which you have testified to, but it also refers, and I believe this was not in the amended plan, so this is new in the second amended plan, additional policy modifications may be necessary.

What do you think that means? Is that something beyond self-sustaining premium adjustments?

JUDGE LEAVITT: Mr. Leslie,

what line are you on?

MR. LESLIE: Page 11, the first sentence --

JUDGE LEAVITT: Okay.

THE WITNESS: Your question is what again, sir?

BY MR. LESLIE:

Q. What does the additional policy modifications mean?

A. As intended by that sentence, it would be the policyholder selecting from Options 1 through 4, comparable to Phase One but based on self-sustaining premium in Phase Two.

Q. Go on to the next sentence, if you would. It is expected that modifications in Phase Two will largely be based on self-sustaining premium.

What else might the adjustments be based on?

A. Well, policyholder elections, for one.

Q. Wouldn't they have already occurred in Phase One?

A. No. Policyholders will be given the

opportunity to make new elections in Phase Two.

Q. So it's your testimony that self-sustaining premiums will be the exclusive method used for -- in Phase Two; there aren't additional modifications that haven't been described that could also occur?

A. You've asked me two questions. The plan does not envision additional policy modifications other than those resulting from the five options.

Q. Okay. Let's go to Page 59. And this, I'm going to ask you a question about Roman Numeral IV A6, which begins when policy modifications in Phase Two, while policy modifications in Phase Two. Would you take a minute and read that.

A. Yes. I am familiar with that paragraph.

Q. Do you see the language in the third line that talks about an alternative premium structure will be used in Phase Two?

A. Yes.

Q. So it says it is possible an alternative premium structure will be used in Phase Two. Is that an alternative to

self-sustaining premiums?

A. Yes.

Q. What would that be or do you not know?

A. I don't know today. That's a placeholder for the possibility that the results of Phase One would make some other rate structure in Phase Two better in many respects and more equitable or easier to implement or something else.

Q. Is the plan -- does the plan, as submitted, provide for judicial review with regard to Phase Two? Does the Court need to approve Phase Two?

A. As I said yesterday, I anticipate now that between Phase One and Phase Two we would report to the Court and advise the Court whether our recommendation is to go on with Phase Two as described in the plan now or as modified in some way.

Q. So I don't mean to be argumentative, but there is a difference between report and the Court approving. What does the plan envision?

A. The plan does not address that.

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Q. The proposed order, I believe it's at Paragraph 6, provides for the Court to approve the plan and it stops at that.
A. Correct.
Q. It doesn't provide for any further judicial review. The Court, if that order were to be entered as submitted by the Rehabilitator, then the Court would approve the plan as it stands and there would be no further judicial review, at least that order wouldn't call for any.
I'm asking what -- you know, the Rehabilitator submitted that, so presumably that's what the Rehabilitator intended.
A. Well, in my experience, Mr. Leslie, there will be many times when we will come to the Court for review of specific steps along the way, for example, the policy restructuring upon which I spoke yesterday. So the plan does not enumerate the times at which we will come to the Court for guidance on specific items.
One of those could be elements of the second phase of the plan. As you probably know, Mr. Leslie, the rehabilitation of insurers is typically a collaborative effort

between the Rehabilitator and the Court.
Q. So you are envisioning that order will be modified on this point?
A. No, no. That's something different.
Q. So will the Court review this and approve this, if you need to have it, alternative methodology?
A. Yes.
Q. But that's -- how does that arise? It's not in the order. The order gives the Rehabilitator the power to implement the plan.
A. Well, I haven't seen the order. You obviously have a crystal ball that I don't have, but I would envision that whatever order the Court enters with respect to the plan would be subject to the further orders of the Court, as is typically the case.
Q. So you would be comfortable with the Court approving the plan subject to approving any Phase Two self-sustaining premium or alternative adjustments?
A. Of course I would be comfortable with that, yes.
Q. You would. Okay. That is great.
So would you -- then why, if the

Court would be asked to do that, why did the modifications in Phase One have to be permanent? Why couldn't they be voluntary elections, after which everyone looks at the situation and decides how it looks like it will work? Why does Phase One have to be mandatory?
A. They are described that way in the plan in fairness to the policyholders so that they recognize the possibility that whatever elections they make in Phase One will be permanent to them. There is no guarantee about anything about this plan going forward, and it is certainly possible that the Court will want to review aspects of the plan after Phase One.
Q. Okay. I mean, we are here to deal with the plan as it is, to deal with it as the order stands, and that order doesn't provide for any judicial review.
It also doesn't provide for any judicial review of disclosure to the policyholders. Yesterday you testified about trend-setting disclosure, I believe. Do you envision the Court approving that disclosure?
A. We had not contemplated coming back to the Court separately for that, no.

MR. LESLIE: Okay. Your Honor, I am finished. I hope that was prompt enough.
JUDGE LEAVITT: That was very prompt. Thank you very much.
Mr. Broadbent, do you have any redirect?
MR. BROADBENT: Your Honor, my preference would be to just conduct a single redirect at the conclusion of all testimony. I think that's most efficient and the other testimony may eliminate the need for some of my questions.
JUDGE LEAVITT: That's fine. We will hear next from Ms. Glawe.
MS. WILSON: Your Honor, Jane Dall Wilson on behalf of NOLHGA. We don't have any cross-examination for Mr. Cantilo, but just want to very briefly address a housekeeping matter.
With respect to the admission this morning of Exhibit 56, which was the slide deck that was used in Mr. Cantilo's testimony, our agreement with Rehabilitator's counsel was that we understood that that was being offered and

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would be admitted in the context in which it was used as a demonstrative exhibit.

So we just wanted to clarify that position for the record.

JUDGE LEAVITT: That's fine.

MS. WILSON: Thank you.

JUDGE LEAVITT: All right. Mr. Galla, are you or Mr. Donley --

MR. DONLEY: Your Honor, I will be asking the questions.

JUDGE LEAVITT: All right. That's fine.

MR. DONLEY: If Your Honor is ready?

JUDGE LEAVITT: We're ready.

MR. DONLEY: Thank you very much, Your Honor.

CROSS-EXAMINATION

BY MR. DONLEY:

Q. Good afternoon, Mr. Cantilo.

A. Good afternoon, Mr. Galla.

Q. If I fail to make my questions heard to you or if I do not make them clear, please let me know. I will try to rephrase them.

A. Certainly. Did I misidentify you?

I'm sorry, I don't know you gentlemen so --

Q. I'm Joe Donley. So you got it right. And with me is my colleague Scott Galla.

A. Glad to meet you gentlemen, and I will call you Mr. Donley.

Q. We represent the agents and the brokers in this matter.

A. I am aware of that. Thank you.

Q. I have just a few questions for you. How many rehabilitations have you been involved in in Pennsylvania?

A. Two, if you include the stage of the Penn Treaty matter during its rehabilitation.

Q. So with regard to Penn Treaty --

A. I'm sorry. I misspeak. I also served as a witness in connection with -- I'm not sure whether it's a rehabilitation or a liquidation, so let's just say those two.

Q. And with respect to those two, did you ever -- let me back up. For Penn Treaty, there were two entities involved; isn't that correct?

A. Yes, sir.

Q. And the other entity besides Penn

Treaty was American Network Insurance Group; right?

A. American Network Insurance Company.

Q. Insurance Company. Thank you.

And with respect to those two entities, were you involved in the original plan for rehabilitation that was a joint plan?

A. Which do you mean by the original plan?

Q. The April 2013.

A. Yes.

Q. And what was your capacity in that -- with respect to your involvement?

A. I was the Special Deputy Rehabilitator.

Q. Same as in this case?

A. Yes, sir.

Q. And when were you appointed with respect to the Penn Treaty matter?

A. I believe in December of 2012.

Q. And I believe you said, with respect to the questions that were put to you previously, that you drew a lot from the Penn Treaty experience for purposes of creating the plan in this case; is that true?

A. Yes, sir.

Q. Now, the joint plan that was presented in April of 2013 in Penn Treaty, did you have a hand in drafting that?

A. Yes, sir.

Q. And is it -- am I correct that that plan provided for the suspension of payments of commissions similar to the suspension of payment of commissions to agents in this plan?

A. To the best of my recollection, yes, sir.

Q. And because it was a joint plan, it applied to both entities as well?

A. Yes, sir.

Q. Now, you received a lot of opposition, shall we say, to that proposal in Penn Treaty; is that correct?

A. Yes, sir.

Q. And the matter was taken up in court, briefs were filed, but isn't it true that you never had a decision approving the use of the plan to suspend commissions?

A. Yes, sir.

Q. And to your knowledge, has there ever been a rehabilitation in Pennsylvania

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where such a provision was approved by a Court?
A. I don't know of any, no, sir.
Q. Now, that plan in Penn Treaty, the April 2013 plan, that was never implemented; is that correct?
A. Yes, sir.
Q. And because it's not necessary from my perspective to get in deeply to the Penn Treaty, I would like to shortcut this a little bit by saying that ultimately what you ended up doing was preparing a plan where Penn Treaty went into liquidation and ANIC went into rehabilitation; correct?
A. There was a later plan under which that would have been the case, yes, sir.
Q. And, sir, I'm going to put up for you a copy of the Second Amended Plan of Rehabilitation with respect to Penn Treaty and America Insurance Company -- and American Network Insurance Company and ask you if you can take a quick look at it and just see if you are familiar with the document.
A. It looks familiar, yes, sir.
Q. And is it fair to say that you also had a hand in the drafting of this?

A. Yes, sir.
Q. And isn't it correct that, at the time this was drafted which, I believe, was October of 2014, you -- the decision was made to put Penn Treaty into liquidation and to take ANIC and put it through rehabilitation?
A. Well, that is not exactly right, Mr. Donley. The plan was complex. It would have moved policies back and forth between the two companies. So the resulting ANIC, or ANIC as we called it, would have gone -- would have come out of rehabilitation in due course and the resulting Penn Treaty which would include policies previously held at ANIC would have gone to liquidation.
Q. In that plan, is it not correct, sir, that the proposal made way for Penn Treaty not to pay any commissions on preexisting contracts before the effective date for commissions for agents?
A. I don't have a very good recollection of all that, but that sounds right.
Q. With respect to ANIC, ANIC agents would be paid those commissions?

A. I'm sorry, Mr. Donley, I just don't remember.
Q. Well, if you would, sir, go to Page 11. Could we put up Page 11, and just to shortcut this, sir, if you will, Page 11, the last sentence on that page states, in addition, ANIC will pay agents' commissions arising from premium it collects after the effective date. PTNA will not do so.
A. I see that, yes, sir.
Q. And that is correct to the best of your recollection?
A. That refreshes my memory that we had that provision in that plan, yes, sir.
Q. Now, the reason that was done, was it not, that you -- it was recognized that, unlike liquidation, the statutes in Pennsylvania didn't provide for the suspension of agent's commissions?
A. No.
Q. For rehabilitation?
A. That is not the reason, no.
Q. What was the reason?
A. That if the plan had been implemented as proposed, ANIC, which is what in

a good bank/bad bank scenario what we call good bank, would have been a solvent company back in the marketplace.
Q. So this plan was based upon what you described the other day in court, or yesterday in court, as your good bank/bad bank setup?
A. Yes, sir.
Q. And am I correct in remembering your testimony from yesterday that you said, and I believe this is a quote from it, we don't think the plan should put the agents in a better position than they would have been in a liquidation at the expense of the policyholders, so if SHIP were placed in liquidation or happened -- as happened in Penn Treaty, we would suspend the accrual of the commissions and suspend the payment; is that correct?
A. That sounds right.
Q. So you were trying to put the agents in the same position in the rehabilitation that is before the Court as it would have been in the liquidation; correct?
A. In no better position.
Q. But that was not provided by

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statute?
A. I don't think there is a statute specifically addressing that, no, sir.
Q. But you believed it would be fair?
A. Yes, sir.
Q. And as you testified just earlier, most of what appears in your proposed plan for rehabilitation is subject to judgment?
A. I'm not sure I understand your question. There is, certainly, judgment involved in the SHIP rehabilitation plan, if that's what you're asking me.
Q. And your objective was to establish a plan to the best of your ability that would decrease the debt of the company and protect the policyholders' benefits?
A. Those were the goals of the plan, yes, sir.
Q. Your plan doesn't concern itself with the agents and the brokers that benefit; does it?
A. I'm not sure what you mean by "concern itself."
Q. You don't address the equities of the agents' right to the commissions that they

had vested?
A. I think the plan does address that, yes, sir.
Q. By suspending the payments?
A. Yes, sir.
Q. So your focus is on the policyholders; is that correct?
A. The focus is on the policyholders, yes, sir.
Q. And do you consider the agents to be just general creditors?
A. Yes, sir.
Q. If they are just general creditors, why was it necessary for you to construct a separate section of the plan to address them as opposed to dealing with them as you would any other general creditor?
A. Because my Penn Treaty experience informed me that agents would likely appear in the case and wonder how they would be treated, and so we spelled that out rather than leave it unspecified.
Q. And that is because there is no provision protecting the action to suspend the agents' commission in the statutes in

Pennsylvania; correct?
A. I don't believe the statutes specifically address that.
Q. Thank you. I would like you to take a look at what was marked by the Rehabilitator's counsel as Exhibit 10. I believe that's RP 10, which was described when it was introduced as an exemplar of the agent contract, agency contracts with SHIP in this case.
Are you familiar with that document?
A. Somewhat. And this looks like that document. Obviously you don't have the whole document up on the screen. So from what I can see, that's what it looks like.
Q. Does that look familiar to you, sir?
A. Yes, sir.
Q. Okay. Would you go to Paragraph 7 of that contract, sir. And do you see where it provides that the commissions have --
A. May I read that paragraph to myself, sir?
Q. Absolutely. Absolutely. Please do.
A. Okay. I read it.
Q. Do you agree that that provision

provides or recognizes that the commissions of the agents have vested?
A. That is what it says.
Q. And you don't have any evidence to the contrary; do you?
A. No.
MR. DONLEY: If you will indulge me one moment, Your Honor.
I have nothing further, Your Honor. Thank you very much, sir. Appreciate it.
JUDGE LEAVITT: Mr. Donley, is the amended Penn Treaty rehabilitation plan an exhibit?
MR. LESLIE: Yes, Your Honor. Oh, I'm sorry, do you mean a previously marked exhibit?
JUDGE LEAVITT: Right.
MR. LESLIE: Then no, Your Honor.
JUDGE LEAVITT: Could you provide one.
MR. LESLIE: Yes, we will provide it.
JUDGE LEAVITT: And that will

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be marked as Agent's No. 1.
MR. LESLIE: That's fine, Your Honor.
(Agent's Exhibit No. 1 was marked for identification.)
JUDGE LEAVITT: Mr. Horwich?
CROSS-EXAMINATION
BY MR. HORWICH:
Q. Good afternoon, Your Honor. Good afternoon, Mr. Cantilo.
For the record, I am Harold Horwich and this is Benjamin Cordiano from Morgan Lewis & Bockius representing the health insurers.
Mr. Cantilo, yesterday you referred to actuarial assumptions that were incorrect at the time the insurance policies that SHIP has assumed, that those were inaccurate when the policies were issued; is that correct?
A. Yes, sir.
Q. Was the effect of those incorrect actuarial assumptions that the policies were underpriced when they were issued?
A. I believe so, yes, sir.
Q. And there were several assumptions that were inaccurate; right?

A. In my opinion, yes, sir.
Q. So those assumptions would have included, among others, assumptions about morbidity and mortality?
A. Certainly morbidity. I don't know, sir, to what extent the mortality assumptions were wrong.
Q. Would they also have included incorrect assumptions about interest rates?
A. Yes, sir.
Q. And the If Knew Premium develops a premium based on a correction of all of these assumptions; correct?
A. Yes, sir.
Q. So it develops a premium based on a hindsight look at what actually happened?
A. Correct.
Q. So the decision by the Rehabilitator to use the If Knew Premium in the plan, does that depend on the cause of the errors in the assumptions?
A. No.
Q. So it's just designed to rectify the inaccuracies in the assumption, whatever their cause was?

A. The effect of them, yes, sir.
Q. Mr. Cantilo, are you familiar with the six insurance policies that were posted on the share site?
A. I have seen those, yes, sir.
MR. HORWICH: Your Honor, we are going to distribute those and ask that they be moved into evidence. These will be, I think, H 1.
(Deposition Exhibit No. H 1 was marked for identification.)
BY MR. HORWICH:
Q. Mr. Cantilo, just looking at these policies briefly, and take your time, do these appear to be accurate copies of the policies that were on the share site?
A. Just glancing at them, that seems to be exactly right.
Q. And were you involved in the selection of these policies to post on the share site?
A. Yes, in the sense that I asked SHIP staff to select one sample policy for each of the intervening agents.
Q. Thank you.

A. I did not select the actual policy.
Q. And these are policies that were issued by companies that were predecessors of SHIP; correct?
A. Yes, sir.
Q. And then these policies were -- the obligations under these policies were then assumed by SHIP?
A. Yes, sir.
MR. HORWICH: Your Honor, I would request that these policies be admitted into evidence as Intervenor Health Insurers Exhibit H 1.
JUDGE LEAVITT: Is there any opposition?
MR. BROADBENT: None from us.
COUNSEL: No, Your Honor.
JUDGE LEAVITT: They are admitted.
(Exhibit H 1 was admitted into evidence.)
BY MR. HORWICH:
Q. Have you, Mr. Cantilo, reviewed the provisions of these policies that deal with the company's right to modify premiums?

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A. Yes, sir.
Q. And as an expert in long-term care insurance rehabilitation, would you say that these provisions are typical of long-term care insurance policies issued in the LTC insurance industry?
A. Yes, sir.
Q. And, in general, Mr. Cantilo, what do these provisions that deal with premium rates provide as far as the right of the insurance company to increase those premium rates?
A. In general, the policies provide that the company may change the premium rate going forward. Some policies go further and provide that those rate increases in the future will require the approval of state regulators, and some policies go even further and specify that such rate increases will be sought only as to the group of similar policies, not as to one policy individually.
So I guess you could say they fall into three different buckets.
Q. Right. And do any of the policies provide for a specific methodology applied to

rate increases?
A. I have never seen one. But that --
Q. They don't specify If Knew Premium?
A. I have never seen one that does.
Q. And likewise, they don't prohibit a premium rating methodology that would seek to recover for past underpricing; do they?
A. I have never seen a policy that does that.
Q. And is the rate increase methodology used in the plan in Phase One, is that consistent with the provisions of these policies?
A. Yes.
Q. Now, the policies at issue in this case were all not originally issued by SHIP, is that correct; they were issued by other carriers?
A. Yes, sir.
Q. And then, subsequently, they were assumed by SHIP?
A. Eventually, yes, sir.
Q. And did policyholders receive written notice of that assumption?
A. I am not sure whether they all

received written notice. I believe most or all of them had an endorsement sent to them that at least changed the name of the company. Some of the endorsements may have gone further. I have not looked at all of them.
Q. Right. But would it be reasonable to assume that those endorsements notified policyholders that their policies had been assumed by SHIP?
A. Yes, sir.
Q. And would it be reasonable to assume that all of the policies have some form of notice or endorsement informing the policyholder that their policy had been assumed by SHIP?
A. Yes. I make that assumption.
Q. And would policyholders who have been informed that their policies have been assumed by SHIP, would it have been reasonably straightforward for them to find out that SHIP was a Pennsylvania-domiciled insurance company?
A. I think that the endorsements typically stated that.
Q. But in any event, it wasn't a secret that it was a Pennsylvania-domiciled company?

A. That is correct.
Q. Now, the intervening regulators state in their papers that the regulators, that the Maine Insurance Department reviews rates to ensure that "the rates are not excessive, inadequate or unfairly discriminatory."
And in Massachusetts and Washington, the regulators ensure that "the benefits provided therein are not unreasonable in relation to the premium charged."
Do the rates contemplated by the If Knew methodology meet these requirements?
A. In my opinion, they do.
Q. Now, earlier, there was some cross-examination on the question of whether the modifications in Phase One are permanent. They are permanent; is that correct?
A. That's the intent of the plan, yes, sir.
Q. But the policies, as modified by the plan, are still entitled to guaranty association protection; correct?
A. Yes, sir.
Q. They don't lose that protection for the modified policies as a result of the plan?

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A. That is correct, sir.
Q. Now, the guaranty association statutes, other than the New Jersey statute, have a limit on covered benefits; is that correct?
A. Yes, sir. I think there is some question as to whether the Utah statute has a limit as well, but, certainly, with the exception of Utah and New Jersey, the rest all have limits, yes, sir.
Q. Now, the limit of benefits that would be covered under guaranty association statute, that would be the maximum policy value as we have been discussing it this morning?
A. That would be a comparable measure, yes, sir.
Q. And the present value of net future benefits, which we have also been discussing this morning, that would not be a factor in the limits of guaranty association coverage; would it?
A. That is correct, sir.
Q. Mr. Cantilo, you were involved in the Penn Treaty receivership. Are you familiar with the options that were offered to

policyholders by the guaranty associations in Penn Treaty?
A. Generally.
Q. And did the liquidator in that case participate in the formulation of those options?
A. No.
Q. And can you tell us how the non-forfeiture option under the Second Amended Rehabilitation Plan compares with the non-forfeiture option offered by the guaranty associations to policyholders in the Penn Treaty case?
A. The non-forfeiture option offered under the Second Amended Rehabilitation Plan, in my opinion, is substantially more generous for most policyholders than the non-forfeiture option that I understand was offered by the various guaranty associations in the Penn Treaty liquidation.
Q. Under the Second Amended Rehabilitation Plan, I believe you testified that Option 2 under the plan is intended to provide a scaled back and, therefore, more affordable level of coverage to policyholders;

is that correct?
A. That's true for many policyholders, yes, sir.
Q. And are you aware of whether such an option was provided by the guaranty association's policyholders in Penn Treaty?
A. In my understanding, it was not.
Q. Now, you are familiar with the non-forfeiture option that is offered by SHIP to its policyholders prior to the rehabilitation?
A. Yes, sir.
Q. And, in general, if one compared the present value of the benefits under that non-forfeiture option with the present value of benefits under the policy that that non-forfeiture option replaced, is it your view that, in general, the present value of the policy would exceed the present value of the non-forfeiture option?
A. Generally, yes, sir.
Q. Earlier I believe you testified that over 9,000 policyholders selected the non-forfeiture option prior to the rehabilitation on policies that were still --

that are still in force?
A. I think it's just a bit under 9,000 as of today.
Q. And what percentage of SHIP's total in force long-term care policies have elected the non-forfeiture option?
A. I believe it's 23 percent.
Q. Okay. And so the regulators say in their papers that "the most plausible scenario is one assuming that each policyholder would choose the rehabilitation option that would provide them with the greatest value."
Assuming that that value was determined on the basis of net present value of the benefits, do you agree with that assumption?
A. No.
Q. And is it your testimony that policyholders choose not only on the basis of value in the abstract, but also on the basis of what's valuable to them as individuals?
A. That is part of the reason, yes, sir.
Q. Now, if the Court approves the Second Amended Rehabilitation Plan, from the

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date of that approval, approximately how many months do you think it will take to implement the plan?
A. Six, approximately.
Q. And when we talk about implementing the plan, at least my reference is to putting together, offering regulators the opt out option and sending packages to the policyholders, are we agreed on that as a definition of implementing the plan?
A. Yeah. And I would add to that sequence, receiving policyholder elections.
Q. Okay. So the period that you identify would get us from, basically, ground zero to having options selected?
A. Yes, sir.
Q. And how many months after that do you think it will be until the Rehabilitator knows how much of the funding gap was resolved?
A. I think we probably will have some good guidance on that within the next two to three months.
Q. So within eight months of approval of the plan, less -- well, less than a year, the Rehabilitator will know how much of the

funding gap has been closed?
A. We expect that, yes, sir.
Q. I would like now to direct some questions to the agency relationships that SHIP has.
When SHIP assumed the long-term care policies from the various insurance companies, did it also assume agreements with the agents that produced those policies?
A. That is my understanding, yes, sir.
Q. And do those agreements govern the relationship between SHIP and the agents?
A. Yes, sir.
Q. And, to your knowledge, are there any other agreements to which SHIP is a party that govern SHIP's obligations to those agents?
A. I'm not sure whether you would characterize these as agreements, but there were assignments made by which SHIP or SHIP's predecessors assumed the responsibility of fulfilling the company's part of those agency agreements.
Q. Fine. Okay. So those, I think, those are a certain part of the agency agreements but the assumption agreements as

well. Are there any agreements besides the assumption agreements or the agency agreements themselves?
A. None of which I am aware.
Q. Is there anything, to your knowledge, is there anything in the insurance policies that impose an obligation on SHIP to pay agent commissions?
A. No, sir. At least none that I have seen. And I have looked at a number of policies looking for exactly that provision.
Q. You testified under the plan that payment of the agents is deferred to Phase Three of the plan?
A. Correct.
Q. And what other types of creditors are having their payments deferred to Phase Three?
A. If there is an unfunded benefit liability that remains, they would be in that category. There will be a number of fees and taxes owed to state authorities around the country that have been deferred.
If there are amounts still owed to American Health & Life and to Primamerica on

account of claims that they have paid and which they assert SHIP should have paid, then those would be in that category.
And there may be some creditors that are entitled to payment for services or goods rendered to SHIP that have not yet been paid.
Q. Thank you.
A. And I should add, there may be amounts owed to former employees as well in that category.
Q. So during the implementation of the plan, are any expenses being paid other than current expenses necessary for the implementation of the plan?
A. Yes, sir. All claims are being paid in full.
Q. Besides claims and current operating expenses?
A. No, sir.
Q. And are the ongoing services of the agents needed for the success of the plan?
A. I'm not sure what the ongoing services of the agents are, sir.
Q. So you're not aware of any services that they're rendering at this point?

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A. I am not, no, sir.
Q. And if they were, do you believe that they would be essential to the success of the plan?
A. No, sir.
Q. Just one point on the ANIC plan that was referred to a few minutes ago. Now, under that plan, the policies that had been assigned to ANIC, were those policies going to be paid in full?
A. The way that plan worked, some of those policies might have been modified before they were assigned to ANIC. But once they became ANIC policies, they would be paid in full.
Q. Now, under the existing arrangements with the agents, do the agents collect any premium for the company?
A. Today?
Q. Yeah.
A. I don't believe so, no, sir.
Q. And to your knowledge, has -- does SHIP now, or has it ever, segregated a premium for the payment of agent commissions?
A. No, sir.

Q. So there are no trust funds or other segregated funds out of which premiums are paid?
A. With the exception of the trust fund to which I referred yesterday from -- for the business assumed by reinsurance from Transamerica, the answer is no.
The claims and commissions attributable to the Transamerica business would be paid out of that trust fund.
Q. But payments on policies for which SHIP is the primary responsible party, that would not be the case?
A. That is correct.
MR. HORWICH: Give me one minute, please, Your Honor.
That is all the questions we have, Your Honor. Thank you very much.
JUDGE LEAVITT: Thank you. Is Mr. Lapinski in the courtroom, a policyholder, or Mr. Tobin? Well, that completes the cross-examination.
Would you like a few minutes before you begin your redirect?
MR. BROADBENT: Yes, that

would be much appreciated, Your Honor.
JUDGE LEAVITT: All right. We will recess for ten minutes.
MR. BROADBENT: That will be sufficient. Thank you.
(Short recess taken.)
JUDGE LEAVITT: Mr. Broadbent.
MR. BROADBENT: Thank you, Your Honor.

REDIRECT EXAMINATION
BY MR. BROADBENT:

Q. Mr. Cantilo, this morning, you spent some significant time with Mr. Leslie discussing present value benefit, present value premium analysis.
Do you recall that?
A. Yes, sir.
Q. Is it your view that that analysis is meaningless in assessing the plan?
A. Not at all, sir. If I left that impression, I did not intend to.
Q. I will just ask you, what is the value of that analysis?
A. So as other techniques of projecting the insurance company's commission, the present

value of benefits net expenses less the present value of premiums is a very useful tool for assessing both the current financial condition of the company, that is does it have enough money to pay its anticipated liabilities, and also for measuring the impact in the aggregate of each plan and option on that financial condition.
So we do use that measure for those purposes. I only meant to suggest that it was not an appropriate measure for determining whether a particular option was the best option for a particular policyholder.
So I would not use it for either greatest value or best interest, as the regulators have done.
Q. The regulators I think used the term "rational policyholder." So I will ask that directly. Do you think the present value analysis they described informs you what a rational policyholder would do?
A. No. I think a rational policyholder would take subjective considerations into account as well, and those play no role in the formula used by the regulators.

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Q. Did you testify earlier that the Rehabilitator and her team, by that I mean you and Oliver Wyman, have taken into account policyholder preferences?
A. Did we take that into account, yes, absolutely.
Q. Have you spoken to any policyholders during the time in which you have been Special Deputy Rehabilitator?
A. Yes, I have, a few.
Q. Have any of those conversations involved the options available under the plan?
A. Yes, a few.
Q. Any of those conversations that might address the issue of what might provide the best value or rational value for a policyholder?
A. As I was able to do so with some policyholders, I walked them through the same analysis as the policyholder guidance page that we had here yesterday. And for many of them, for the ones I spoke to, I should say, it was enlightening, because at least one or two told me, well, we were inclined, from reading the materials, to do the option X, and now that you

point out these results, which of course we don't have for our individual policy, it seems to me that option Y is better for me, which I found encouraging.
It removed -- I mean, it corroborated my suspicion that giving that kind of detail would be very helpful guidance to the policyholders.
Q. Did any of those policyholders mention the present value of benefits or the present value of premiums?
A. No, we didn't talk about that.
Q. Mr. Cantilo, there was also some discussion this morning from Mr. Leslie regarding the elections under the plan must be permanent.
Do you recall that?
A. Yes, sir.
Q. Further discussion as to whether we might come back to the Court and confer with the Court on what the options were, et cetera; do you recall that as well?
A. Yes, sir.
Q. In your view, is there any harm if the plan is approved does not make the

elections permanent?
A. I think it would make the plan ineffective. It would amount to just polling the policyholders about what they like. But for the plan to help both with respect to the deficit that the company faces and with respect to the correction of what I view as the premium rate inequities, the modifications would have to be permanent.
In other words, you couldn't give with one hand and then take back with the other. It doesn't help any.
Q. Finally, a few questions, Mr. Cantilo, on the subject of guaranty associations and the benefits available. Do you recall discussing that topic with Mr. Leslie this morning and this afternoon?
A. I do.
Q. In your view, do policyholders have an absolute right to the benefits that may be available from the guaranty association?
A. No, sir. I think that depends on the circumstances and the law applicable under the circumstances.
Q. So then in your view, sir, are the

policyholders giving up any absolute right that they have in making an election under the plan?
A. No, I don't believe so.
Q. Do you have a view as to whether the guaranty associations across the states can offer the options that the plan proposes to give the policyholders?
A. I do have a view about that because we looked at that fairly carefully in evaluating whether we should go into rehabilitation or liquidation early on. And we concluded that at least two of the options that we're able to offer under the plan could not be available in liquidation. That is the enhanced reduced benefit option. And -- I'm sorry, the enhanced non-forfeiture option, and Option 4, keeping your full coverage and paying whatever premium that would take.
I get that guaranty associations can also structure reduced benefit options, but I think some benefit options would be beyond their capability.
Q. Mr. Cantilo, do you recall Mr. Leslie referring frequently to the burden that may be placed on policyholders if the plan

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is approved?
A. Yes, sir.
Q. In your view, sir, would policyholders bear some burden if SHIP were immediately liquidated as well?
A. Yes, sir.
Q. What would that burden be?
A. For one thing, their benefits would be limited to the applicable statutory limit at least until the issue was resolved under Pennsylvania law.
For another, they would lose the ability to select some of the options I just identified that would not be available under liquidation.
MR. BROADBENT: No further questions, Your Honor. That is all I have for Mr. Cantilo.
JUDGE LEAVITT: Does any intervenor wish to do some very brief recross?
COUNSEL: Not us.
JUDGE LEAVITT: All right. That's good news.
Mr. Cantilo, I just have a couple of questions.

Do you know if policyholders who are on premium waiver, whether their agents are paid a commission?
THE WITNESS: The company generally does not pay commissions on premium not collected because of the waiver of right or termination or lapses.
JUDGE LEAVITT: Okay. I believe, and this came up during your examination by Mr. Leslie, the 2020 premium revenues were approximately $58 billion. I could be incorrect, but that is my memory.
THE WITNESS: That is correct, Your Honor.
JUDGE LEAVITT: And about ten percent of that is paid to the agents?
THE WITNESS: I don't recall. The rates vary a fair amount among the agents.
JUDGE LEAVITT: I'm sure it does.
THE WITNESS: But I think some of them get six percent and some of them may get as much as ten percent.
JUDGE LEAVITT: Okay. All right. That would probably be in the most

recent statutory statement?
THE WITNESS: Definitely. The commission liability is specified in our financials, and I apologize, Your Honor, for not having that number memorized.
JUDGE LEAVITT: All right. Unless you have more questions, you are excused, Mr. Cantilo.
THE WITNESS: Thank you, Your Honor.
(The witness was excused.)
JUDGE LEAVITT: Mr. Broadbent, would you like to present -- is your first witness Mr. Lambright?
MR. BROADBENT: Yes, Your Honor. Our next witness is Mr. Lambright. We expect him to be on the stand for a short period of time. I'm happy to offer him now.
JUDGE LEAVITT: Okay. Why don't we keep going.
MR. BROADBENT: The Rehabilitator calls Marc Lambright.
MARC LAMBRIGHT, a witness herein, having been first duly sworn, was examined and testified as follows:

DIRECT EXAMINATION
BY MR. BROADBENT:
Q. Good morning, sir. Can you please state your name for the record?
A. Sure. My name is Marc Lambright.
Q. Mr. Lambright, are you currently employed?
A. I am employed.
Q. Who is your employer?
A. Oliver Wyman actuary consulting.
JUDGE LEAVITT: Mr. Lambright, could you move closer to the microphone.
BY MR. BROADBENT:
Q. Mr. Lambright, what is your chosen profession?
A. I'm an actuary.
Q. Well, I think all of us understand what that means. Just briefly can you explain what an actuary is and what an actuary does?
A. Sure. I specialize in financial reporting, valuation issues. I am a health actuary, so I would be involved in types of business that are generally considered accident and health, things like medical long-term care, long-term disability, other ancillary products.

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Q. Mr. Lambright, I am going to ask Mr. Martin to pull up RP 8. Specifically, Mr. Lambright, the page on the screen, can you tell me what that document is?
A. That is my CV.
Q. Is the CV true and correct as of the date it was prepared?
A. It is.
Q. Does it remain materially correct as of today?
A. It does.
Q. Mr. Lambright, the exhibit was previously admitted before the Court so I am just going to ask you a few questions which you may need to refer to the CV if you need to do so, but just generally can you summarize your professional experience for the Court?
A. Sure. I have been doing actuary work for about 27 years, the last 13 years or so with Oliver Wyman. Ten years prior to that, I worked with KPMG largely in auditing health insurers. Prior to that, I spent about four years with the CIGNA corporation.
I'm currently the chairperson of the Financial Reporting and Solvency Committee with

the American Academy of Actuaries Health Practice Council and currently do, as I mentioned, a fair amount of valuation work, also do some pricing, some mergers and acquisitions and other regulatory work.
Q. I think in that last answer, other regulatory work, do you provide services to financial regulators or insurance regulators?
A. I do. I provide services for multiple states.
Q. Within the experience which you had testified, did your work include long-term care insurance?
A. It has.
Q. Can you just generally describe your experience with long-term care insurance matters?
A. I spent a couple of years in my career pricing long-term care insurance. Following that, I did a fair amount of audit work, quoted several long-term care insurance insurers. I have done examinations of multiple insurers for the State of Pennsylvania. I have worked as an outsourced actuary for some accounting firm and long-term care insurance.

Q. Mr. Lambright, in the course of your work for Oliver Wyman, have you provided any services to the Pennsylvania Insurance Department with respect to SHIP?
A. I did.
Q. Can you describe generally what that engagement was?
A. Sure. In early 2017, we were engaged by the Pennsylvania Insurance Department to, basically, participate in a target examination of certain, you know, facets of SHIP's operation, focusing on traditional actuarial items. Most of the work was related to reserves and, you know, reserving assumptions.
We also did some work, a little bit of work related to investments and a little bit of work with reinsurance, but the focus was on the, you know, actuarial items and actuarial assumptions.
Q. Mr. Lambright, what is a targeted examination in the sense that you used it?
A. Typically, insurers will be examined on a cycle. This, the examinations are pretty straightforward. There is no ANIC manuals on

how to conduct those widespread financial examinations. This targeted examination was really only related to specific items that the insurance department in this instance was really interested in knowing more about.
Q. Was the examination on the cycle to which you just referred?
A. No. It was off cycle. So it wasn't any full breadth examination.
Q. Sir, did you say that the engagement began early 2017?
A. Early 2017 related to year-end 2016 financials.
Q. Do you have any understanding as to what led the Department to conduct an off cycle examination?
A. Sure. I mean, they obviously had been monitoring SHIP. There were a few concerns noted in the 2013 regular on cycle examination. 2016, they, you know, reported financials that had a new reinsurance arrangement in the net reported financial results which they had some questions about and they had some ongoing questions related to certain investments. So there were some

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specific items that they were interested in exploring further.

Q. Just so the record is clear, sir, how did you come to the understanding of what led the Department to conduct the examination?

A. Just primarily from discussing the reasons for the examination with the individuals that the Department engaged.

Q. Did Oliver Wyman's work as part of that target examination include any analysis of the reserves of the company?

A. It did. It was a large focus of the examination, as you might imagine, with the, you know, disabled life reserves and active life reserves being the largest liabilities of the company.

Q. Sir, can you just briefly again for the record define the disabled life reserves and the active life reserves as well as the concept of life reserves generally?

A. Sure. With regard to insurance, obviously, you know, the insurance company is going to receive premiums and, you know, associated with its premiums they have certain benefit obligations.

The benefit obligations for long-term care insurers are -- could be probably categorized as providing benefits to people that are currently on claims so those are oftentimes referred to as disabled life reserves.

There is a reported and a non-reported component of that so you may have heard the term IBNR, and that could be a substantial liability of the company, or incurred but not reported claims. And then the other large piece is what is often referred to as active life reserve. And, due to the nature of many insurance products, you basically have somewhat level funding of premiums, but then the benefits tend to be back weighted so you need to accumulate assets in order to pay those claims on the back end.

So really the active life reserve is set up to, basically, ensure that the balance sheet has, you know, sufficient assets to -- to ensure that the liability is properly stated to cover those pre-funded benefits.

Q. And I will return to the reserves in a moment, but just to make sure we are on the

same page as to what Oliver Wyman was doing, did the work include any close analysis of the investments or the assets of SHIP?

A. We did some limited review, but they had some other consultants engaged at the time so we didn't do a full depth review of the assets or the investments.

Q. Did Oliver Wyman's work include any close analysis of the reinsurance transactions?

A. We did review the reinsurance transactions. There were some real questions that were raised fairly early on. It wasn't clear if the transactions would be permanent or not. So we decided to pivot during the examination and really, you know, look at the company more on a gross basis, not taking into consideration specifically the Roebling Re arrangement.

We did look at obviously some other more traditional and likely more durable reinsurance arrangements that the SHIP was also engaged or agreed to.

Q. Mr. Lambright, I have referred a few times to you or to Oliver Wyman. Are you the only person at Oliver Wyman doing this work?

A. I had several people on my staff that were supporting the work.

Q. Who was the lead role?

A. I was in the lead role.

Q. So with respect to the reserves analysis conducted by Oliver Wyman, what is the actuarial component of that?

A. I mean, the reserves are generally thought of as mostly actuarial. As far as the actuary's job in setting reserves is to come up with specific assumptions that make sense for the -- related to the obligations created by the insurance contracts.

And largely, the assumptions are related to the likely occurrence of a claim so we have claim instances in claim one termination which is essentially how long a claim will, you know, somebody will be on a claim, how long the benefit will last.

Obviously benefit amounts, how much we pay during that point in time, the point in time that those claims will take place.

We talk about discounting a number of times today the discount component or interest component has a significant impact on

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developing the reserves.
Again, whether or not somebody will be around at a certain point in time and would have a claim would depend upon mortality assumptions, death rates, as well as, you know, voluntary lapse assumptions. So basically if somebody needs to be covered, they're going to have claims, they are going to, you know, incur costs from the insurance company at a certain point in time and those costs would be offset by premiums in the intermittent period.
But those are the most significant components of reserving.
Q. At the time of the targeted examination, had SHIP engaged an actuarial firm to conduct the analyses you were describing?
A. SHIP had engaged Milliman at that point. It's my understanding that they were serving as the actuary to SHIP for a significant period of time, if not since its inception.
Q. As part of the targeted examination, what role did Oliver Wyman play specifically as to the assumptions?
A. So our job was to really review

various actuarial work products, and then the underlying assumptions created by the, you know, that were driving those work products.
So a big part of the actuarial work that would be done at any year end is to prepare an actuarial opinion, which basically states that the liabilities are adequate -- in simplest terms and that based on cash flow testing, that the assets were sufficient to support those liabilities.
And, again, that is very general terms. It's a little more sophisticated than that. And as part of that, you need to make a series of fairly complicated assumptions, and our job was largely to, you know, validate or invalidate, I guess, certain assumptions or, you know, make recommendations related to certain assumptions.
So they really wanted us to dig into the same information that Milliman was using or the same reports that they were using in setting reserve assumptions underlying the actuarial opinions in the actuarial memorandum that basically, you know, summarized or provided documentation for those assumptions.

So really it was kind of a deep dive into, you know, really things that impacted the reserves and impact the, you know, reported financial position of the company.
Q. Was it Oliver Wyman's role to decide as part of that analysis whether the assumptions were, for lack of a better way of saying it, right or wrong?
A. No. I mean, ultimately that's the responsibility of management and the opining actuary. We made several recommendations related to the assumptions, and we also made several suggestions for -- related to ongoing monitoring that we thought were --
Q. Mr. Lambright, were you in one of the courtrooms or ancillary rooms yesterday?
A. Was I in the courtroom? Yeah, I was in both, actually. Yes.
Q. I would like to show you -- are you familiar with the fact that Mr. Cantilo presented certain slides during his testimony?
A. I am familiar with that fact.
Q. I would like to show you one of those slides. Slide 53, please.
Mr. Lambright, just take a moment to

review this and make sure you are familiar with what the document is and what it says.
Mr. Cantilo yesterday testified, as it says on the slide here, that these are certain observations or actions taken by the Department in 2017 for year-end 2016.
Do you see that description on the slide?
A. I do.
Q. For those bullet points, the four bullet points under the initial header there PID observations and actions, was Oliver Wyman involved with any of the work PID was doing on those items?
A. Those items were all certain things that we reviewed during the course of the examination.
Q. The fourth bullet point there, PID assumption recommendations, did Oliver Wyman play a role in developing those recommendations?
A. We did. I mean, the first two items were really recommendations that we made with regard to the assumptions. Part of the design of the examination was that we would ask

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Milliman to basically rerun their models under different assumptions and that's what the third bullet is related to, one of the scenarios we asked them to run.

Q. Generally, did Oliver Wyman assess the way in which assumptions might affect the future outcomes for the company?

A. I'm sorry, can you repeat the question?

Q. Yeah. So that the -- what you identified here is that the alternative assumptions indicate a potential surplus overstatement of a certain number. Was that the only scenario run by Oliver Wyman or were there multiple scenarios?

A. There were multiple scenarios. The base scenario was basically indicating reserve adequacy. The number that was stated there was the high end, and there were multiple scenarios in between, I guess, those two points. So there were multiple scenarios and results.

Q. Did the work Oliver Wyman did for the department at this time result in any final written presentation or report?

A. Yeah. We did provide a written

report to SHIP. We gave SHIP and their actuaries plenty of time to respond to it and then had a meeting in, I believe it was October 11th of 2017 where we discussed our report, we discussed the response and we discussed some of the items that, you know, the insurance department was still concerned about at that point in time.

Q. Did members of the Department attend that meeting?

A. They did.

Q. Did representatives of SHIP attend the meeting?

A. They did.

Q. And representatives of Milliman?

A. They did.

Q. You mentioned a response from SHIP and Milliman. What were those -- how were those responses provided to you?

A. In a formal written response. I think we made about 15 recommendations directly related to, I guess, findings of the examination and then we made several other recommendations related to ongoing monitoring, and I think they -- some of the recommendations

were clearly around areas of judgment, which is one of the reasons why we ran multiple scenarios, got multiple answers, and I think they were somewhat receptive to, you know, maybe a small number of the assumptions, but largely, you know, indicated that they were fine with their view of the data and, you know, some of the contention was around using more data that would go back further, so kind of a longer period and it gives you more data points, and our view is that if you look at what has happened more recently, you could get different answers than we asked them to run in the scenarios.

So I think they basically said they were fine with what they were doing and largely didn't take many recommendations at that point.

Q. Just for the sake of the record, you used the term "they" and "their." Can you clarify who you meant?

A. So those would be the actuaries at Milliman that were -- basically, provided responses to our recommendations.

Q. Following the meeting which I believe you stated was October 11, 2017, was

there any further work by Oliver Wyman with respect to this off cycle targeted examination?

A. We did a little bit of work that I think we completed the next month related to work that was in process on the claim reserve. So they were in the process of strengthening the claim reserves and hadn't completed the analysis.

So we did review that analysis and the revised claim reserves in the month of November, or we finished in the month of November. So it would have been shortly after the meeting.

Q. Did the company change its position with respect to your recommendations after that November 2017 memorandum?

A. I mean, the November memorandum was fairly limited, but they didn't really change anything related to that memorandum or the report of findings. I wouldn't say anything substantial. I don't want to say they didn't change anything because I think they did review our findings and took them seriously, but I think the net effect was pretty limited.

Q. Was that the end of your work for

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the Department with respect to SHIP?
A. It was the end of it with respect to the targeted examination. I was asked to do some additional work early the following year after the company was put into supervision or under supervision, rather.
Q. Just to break that out, who asked you to do that additional work?
A. Largely, the new consultant or representative of the Department, Mr. Cantilo, had asked me to do that work.
Q. And I believe you testified it was sometime early in the next year. If you could put a finer point on when that occurred?
A. Yeah. It would have been sometime the first quarter of 2018. I can't recall exactly what the date was.
Q. Do you have any understanding as to what Mr. Cantilo's role was with respect to SHIP at that time?
A. Well, I think there were obviously concerns by the department. They were, you know, under supervision. Mr. Cantilo had been hired at that point to, you know, to look into things and I think really understand what was

going on.
There were, you know, several items that, you know, that were part of our examination that he was concerned about, obviously the actuarial assumptions, the reserves, some of the investments which we spoke about in a little more detail, you know, during his testimony. The Roebling Re insurance agreement that was only in place really at year-end '16 and some questions around that.
So I think he was largely fact finding and trying to understand things, you know, early on in 2018 to understand what, I guess, advised the Department of what the next steps might be.
Q. Mr. Lambright, this is Slide 54 from Mr. Cantilo's presentation describing, again, observations and actions taken by the Pennsylvania Insurance Department and SHIP up at the top there and then below for year-end 2017 and 2018.
Did your work with Oliver Wyman include any part of these tasks which Mr. Cantilo described yesterday?

A. Yeah, so we -- I would have supported Mr. Cantilo on, you know, with this. You know, some of the findings were, or some of these items are related to things where I probably would have provided more advice. We obviously continued to have a lot of back and forth with the actuaries at that point in time to really, you know, get them to further substantiate their reserves.
I think the one item that was important, you know, up top is or two of the items, the first item was, one of the first things that we looked at, which is the INR permitted practice which allowed the company's reported surplus position to improve by 72 million.
I, you know, worked with Mr. Cantilo to, you know, kind of talk through maybe some things that the company might do and, you know, was involved in various meetings where he requested of the company to, you know, come up with a corrective action plan based on, you know, some of the things that we were seeing and some of the other items.
Down at the bottom, I think they

were obviously pretty significant. By the end of 2018, I think, obviously, the Beechwood asset, you know, the recognition of those losses had a significant impact on the financial position, you know, as did the premium deficiency reserve that was booked at the end of 2018.
Q. So did Oliver Wyman provide any advice to Mr. Cantilo with respect to the corrective action plan?
A. Oliver Wyman has been providing, you know, ongoing advice. I think the first ask was for the company to come up with their own, and then I think early in the process I did provide, you know, assistance to Mr. Cantilo and then the rest of the team coming up with the corrective action plan.
So I did assist and then was -- subsequently, one of my colleagues more or less took over involvement in the actual, you know, building of the, you know, the corrective action plans that ultimately became the rehabilitation filing.
Q. So who was that colleague?
A. Vince Bodnar.

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Q. And do you recall when Mr. Bodnar joined the team?
A. Yeah. Mr. Bodnar joined our firm in, I believe it was March of 2019, so, you know, we spent a fair amount of 2018 kind of continuing to push the company to substantiate some of their assumptions, and then I think Vince and I were kind of, you know, working kind of in tandem really from the outset when he joined the firm because he had some obvious skills in this area supporting Mr. Cantilo and the rest of the team with the corrective action plan really throughout 2019 and kind of jointly attending meetings probably through, you know, I would say roughly third quarter of 2019, and then following that point in time he largely took over, you know, responsibilities for our support of Mr. Cantilo and the team.
I did stay on kind of in a more or less advisory role because I had some, obviously, experience understanding the history of the company, understanding, you know, some of the challenges, some of the particulars with different types of policies and provide some, just kind of another set of eyes and ears

really with certain items.
Q. Final slides to show you, Mr. Lambright, entitled Observations and Actions taken by the Pennsylvania Insurance Department and SHIP. This is Slide 55 from Mr. Cantilo's presentation.
That fifth bullet point under 2019 and 2020, independent actuarial assumptions developed by Oliver Wyman, between you and Mr. Bodnar, who had a primary role in that task?
A. That would have been Mr. Bodnar and the team working for Mr. Bodnar. I think some of the work that I had done, I think, would have helped inform the ultimate development of assumptions, but it would have been his team that dug into the data and independently developed the assumptions.
MR. BROADBENT: That is all that I have.
THE WITNESS: Thank you.
JUDGE LEAVITT: All right, Mr. Leslie, would you like to -- are you ready?
MR. LESLIE: Your Honor, the intervening state regulators have no questions

of this witness.
JUDGE LEAVITT: Okay.
Ms. Glawe?
MS. GLAWE: Your Honor, NOLHGA has no questions for this witness.
JUDGE LEAVITT: Okay.
Mr. Donley?
MR. DONLEY: Agents and brokers have no questions.
JUDGE LEAVITT: All right. Mr. Horwich?
MR. HORWICH: Likewise, we have no questions of this witness.
JUDGE LEAVITT: Any redirect?
MR. BROADBENT: I have a few hours, Your Honor.
JUDGE LEAVITT: You may step down, Mr. Lambright.
Would you like a break before you ask your next witness to take the stand?
MR. BROADBENT: I think a brief break before Mr. Bodnar coming on the stand would be appreciated, Your Honor.
JUDGE LEAVITT: We will take a 15-minute break.

(Short recess taken.)
JUDGE LEAVITT: All right. Mr. Broadbent.
MR. BROADBENT: Thank you, Your Honor. The Rehabilitator calls Vince Bodnar.
VINCENT BODNAR, a witness herein, having been first duly sworn, was examined and testified as follows:
DIRECT EXAMINATION
BY MR. BROADBENT:
Q. Sir, can you please state your name for the record?
A. Vincent Bodnar.
Q. Mr. Bodnar, just to shortcut this, based on Mr. Lambright's testimony, you're an actuary at Oliver Wyman; right?
A. Yes, I am.
Q. Can you briefly provide for the Court some background on your experience as an actuary generally?
A. Sure. I have been an actuary or practicing in that field for 37 years, 31 of those years has been in the specialty of long-term care insurance.

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I have worked in most aspects of actuarial practice within the long-term care specialty; that would be product development, reserving, reinsurance, financial projections, operations as well as mergers and acquisitions, premium rate increase filings and advisory services to regulators, and also quite a lot of time in volunteering in the professional organizations of the Society of Actuaries and the American Academy of Actuaries.

Q. Mr. Bodnar, I'm going to ask Mr. Cantilo to pull up on the screen, if it is not already, what has been marked as RP 8.

Mr. Bodnar, just take a look at this document briefly and can you tell me what it is?

A. This is my CV.

Q. And to your knowledge, does this CV remain materially accurate at this time?

A. Yes, it is.

Q. Mr. Bodnar, I would like to ask a few questions on some of the specific items of professional experience that you have here.

The -- thank you, Mr. Cantilo.

The first item, key leadership to

the guaranty system in the Penn Treaty matter, to the extent you can, what did that work involve?

A. I was advisor to the guaranty system through NOLHGA, and, in general, this was providing the services to them related to their strategy in the post-liquidation -- contingency planning for liquidation of Penn Treaty and then the liquidation as well.

Q. Are you familiar, sir, with the policy options available to policyholders through the various guaranty associations following the liquidation of Penn Treaty?

A. I am, yes.

Q. How did you come to that knowledge?

A. Just through my involvement in advising the guaranty system at that time.

JUDGE LEAVITT: Mr. Bodnar, I think you need to sit a little bit closer to the microphone, if you can.

BY MR. BROADBENT:

Q. Mr. Bodnar, second item here, regulator, education efforts related to LTC premium rate increases and new product innovation.

Can you put any more color on what that means?

A. Yes. That was various activities both on behalf of the industry and at the request of regulators themselves and other clients I had to meet with commissioners and their staff in various states to describe what, you know, what led to long-term care insurance experience evolving in a way other than what was priced for and why rate premium increases were needed, different approaches to premium rate increases and, you know, this was done not only at meetings, but testifying at public hearings and forums at various regulatory meetings.

And also advising the ANIC and some of the commissioners in some of the key committees on new product innovation.

Q. The third item, experience analysis of existing box of LTC business, can you elaborate on that, please?

A. Yes. This is the review of premium and claims and other experiences of -- or of various long-term care blocks in the industry, usually for the purpose of developing actuarial

assumptions for the purpose of either developing premium rate increase filings, preparing new products, pricing new products and also reserve valuations.

Q. The fourth item there, reserve reviews and LTC financial projections, just the first part of that statement, what does it mean to reserve reviews -- to do reserve reviews and LTC financial projections?

A. These were generally independent reviews of company's reserve balances, all done leveraging what I described in the prior bullet there, usually doing an independent analysis of the company's experience developing actuarial assumptions independently from that experience analysis, and then comparing -- from that developing actuarial projection models and comparing those to what the companies may have provided to gauge the adequacy of reserves held by companies, insurance companies.

Q. The second part of that bullet point, proven to be accurate over a ten year plus period of time. To what is that referring?

A. The work that I have done either

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myself or my staff has supported me over the last 20 years, we have developed projections of long-term care insurance blocks and have been able to look at them ten years later or sometimes longer from there, and they have proven to be fairly accurate over that period of time.

Q. Mr. Bodnar, the fifth bullet point, nationwide LTC premium rate increase filings, what work have you done with respect to that item?

A. Various clients, insurance company clients in the industry that have long-term care insurance blocks, preparation of actual memorandum in support of premium rate increase filings.

Q. Mr. Bodnar, turning to your professional history, the second item, Genworth, do you have any experience related to long-term care as a result of your work with Genworth?

A. Yes. I was at Genworth twice, in the late 1990s and most recently, years 2017 to 2019, the more recent experience at Genworth was Senior Vice President of Product

Management. My primary responsibility was the development of new products and also helping the company develop to think through its options that it would present to policyholders at the time of premium rate increases.

Q. And the third item there, Long-Term Care Group, can you explain what that is and what work you did there?

A. Long-Term Care Group is also known as LTCG. They are the largest third-party administrator of long-term care insurance policies in the industry.

I led its actuarial practice there from 2015 to 2017 and I was their chief actuary and we did most of the things that I have described in my professional experience in one aspect or another.

So, you know, regulatory education efforts, experience analysis, reserve reviews, rate increase filings.

Q. Just to summarize, Mr. Bodnar, I would like to ask about a few specific areas. You have experience, I believe, based on what you testified to, with respect to LTC product development; is that right?

A. Yes, I do.

Q. Is the same true as to the rate setting process?

A. Yes.

Q. That would include the approval process for the various states?

A. Yes. Yes.

Q. I apologize if I didn't hear any testimony on this subject, but do you have experience with respect to the sales or renewal process for policyholders?

A. You mean the initial sales?

Q. Yes, yes. Focus there, please.

A. I'm sorry, what was your question, any experience?

Q. Do you have any experience in the sales process for policyholders?

A. Yes. Related to my job and also not related to my job, I have, or my various jobs, I have sat in on focus groups in which products and features are presented to potential policyholders. I have also sat in on actual sales and the same can be said of, you know, not only the initial sale, but also consultations and advice being given at the

time of premium rate increases when various options are presented.

Q. In the course of your career, Mr. Bodnar, have you acquired any experience with financially troubled long-term care insurers?

A. Yes, I have.

Q. Can you describe that experience for me, please?

A. I have worked with, in addition to my work here with SHIP, I became involved with the Penn Treaty matter.

I also have experience with, I would say, several other carriers that I'm not -- it depends on your definition of "financially troubled," but I worked with several other carriers that are -- that are, I would say, probably their capital levels are a little less than optimal.

I'm trying to be as politically correct here as possible.

Q. Thank you, Mr. Bodnar. I won't make you say more than that.

MR. BROADBENT: Your Honor, I will pause here briefly. I think Mr. Bodnar's

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testimony will involve areas that would be generally considered expert testimony, and so based on the experience and knowledge of Mr. Bodnar, we would offer him as an expert to the extent he offers such testimony and we would like to do so now subject to any questions from the parties or objections that Your Honor will address.

JUDGE LEAVITT: Mr. Leslie, would you like to do a Voir Dire? Mr. Horwich? No.

Ms. Glawe?

MS. GLAWE: No, Your Honor.

JUDGE LEAVITT: Mr. Donley?

MR. DONLEY: No, Your Honor.

JUDGE LEAVITT: So you are having him qualified as an expert to --

MR. BROADBENT: Well, with respect to matters related to long-term care insurance, and I think more specifically the areas of his experience and knowledge to which he testified which will include the product itself and long-term care generally, financially troubled within the definition given by Mr. Bodnar, long-term care insurers,

product development, sales to policyholders and the rate setting and approval process as well as, to some degree, outcomes in liquidation.

JUDGE LEAVITT: Okay. You shall qualify.

BY MR. BROADBENT:

Q. Thank you, Mr. Bodnar. Were you present here or in one of the overflow rooms when Mr. Lambright was testifying?

A. Yes, I was.

Q. Do you recall he gave some testimony as to you, Mr. Bodnar, joining the Oliver Wyman team with respect to SHIP.

A. Yes.

Q. Do you recall when that was?

A. Yes. Mr. Lambright remembered correctly. I joined Oliver Wyman in March of 2019, and I almost immediately became involved with the -- with this SHIP project at the time. It was not in rehabilitation, but the SHIP project.

Q. What was the scope of the work that you were doing in that March 2019 time period?

A. At that time, I was really getting up to speed with the work that Marc and his

team had done over the prior year or so, it was like two years, understanding, you know, what their findings were, the approaches they used to develop their findings, and I began to look at some of the work they had done for reasonableness and then, you know, from there began to, you know, see if there were some other ways that we could get some comfort around the range of results, possible reserve deficiency that SHIP was holding at the time.

Q. Did you do any analysis of the existing assumptions of the company's actuaries?

A. Yes, yes. It was -- it was -- we were really looking at the assumptions that Milliman had developed, how they were developed, the granularity with which they were developed, whether they fit historical experience to a level that I would find to be satisfactory and indicative that they had developed the assumptions properly.

We reviewed the output from Milliman's models to see if they were projecting in a way that made sense given the assumptions that were being deploy ed and also

made sense given historical experience of the company.

Q. Did Oliver Wyman at any time in 2019 prepare its own set of assumptions for SHIP?

A. Yes, we did. Yes, we did. It was not until later in 2019.

Q. You will have to forgive me, Mr. Bodnar, but not being an actuary, I don't know how complex that is. Was it you doing this? Was there a team of folks? How big was that project?

A. It was not me by myself, for sure. It was a team of people, just sitting here probably I would guess about a half a dozen people on our team, other actuaries, more junior actuaries collecting data from SHIP. We got very granular seriatim data from the company. We spent a lot of time looking at it, scrubbing it, making sure it made sense, from there developing experienced studies from the raw data, asking questions of people at SHIP and Fuzion about some anomalies we might have seen in some of the data.

Again, I think that explains very common for such -- for data to require a lot of

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explanation in long-term care.
And in developing assumptions, making sure that they fit historical experience properly, then building a granular model and looking at the output from that model, again, making sure the output made sense compared to historical experience and getting comfortable with that as well.
So that's a pretty involved process. I want to say it took us several months to do that and build that model.
Q. Mr. Bodnar, a few times in the testimony over the last day or so we heard the phrase "seriatim" used. Do you have an understanding what that means?
A. Seriatim means a policy, a record by record, in this case a policy by policy, you know, set of records. So seriatim data means you are getting data on every individual policy. A seriatim model means you are creating a model that can be loaded with the data points of every single policy and use that in the projection.
Q. Did Oliver Wyman prepare any seriatim model in the way you have described?

A. Yes, yes. So our model is seriatim. It has been refined a few times since we first developed it, but, yes, it has always been a seriatim model.
Q. When, approximately, would you say that it was first developed?
A. We had a first, I would say preliminary version of our model, I want to say it was around November or December, maybe it was November-ish of 2019.
Q. Did the company's existing actuaries have a similar model?
A. Yes. That had become the industry standard to develop models on a seriatim, we call it a first principals basis, and I would say within the last five years that has become the industry standard.
Not every company does that, but in general, that is the approach that is used today.
Q. So why did Oliver Wyman prepare its own seriatim model if the company had one from its existing actuaries?
A. We did it so that we could be more confident in the model itself. So when you

develop the assumptions as a team yourself and build the model yourself, and these are very complex models, very complex studies, you can gain confidence that the model is being -- it was prepared in a way that, you know, is satisfactory to your own standards and approach.
Q. In the course of your work with Oliver Wyman in that 2019 time period, did you have any involvement with the corrective action plans that had been prepared by SHIP?
A. Can you repeat that first part?
Q. Sure. I will ask it more directly. Did you have any role in assessing the corrective action plans offered by SHIP?
A. I recall reviewing them, but I wasn't involved. I don't recall being involved in developing them.
Q. Mr. Bodnar, are you familiar with the Second Amended Plan of Rehabilitation that the Rehabilitator has offered for the Court's approval?
A. Yes, I am.
Q. Are you familiar with the prior versions of that plan as well?

A. Yes, I am. Yes.
Q. How did you become familiar with those documents?
A. I was on a team of people that was involved with developing and drafting the plan from, I guess, the time it was decided to begin to develop the plan. So I was involved with, I guess, early part of, you know, sketching out its, you know, high level, you know, high level features all the way to, you know, the final draft.
Q. And is that true from the first filed plan in April 2020, the amended plan, first amended plan filed in October 2021 and the most recent second amended plan filed in May 2021?
A. Yes, that is true.
Q. And I stated October 2021, but that's because it was October 21, 2020. I just wanted to clarify that for my question. I apologize.
So, again, Mr. Bodnar, you described being part of -- working on developing the plan and -- from inception. Do you recall when that was when you first began working on a plan, a

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plan that resembles the current plan?
A. Sitting here now, I can't remember when it switched -- we switched from a company developing a corrective action plan to the team working on a rehabilitation plan. Just sitting here right now, I cannot recall the exact time that happened.
Q. Was it in 2019?
A. If it was, it would have been in -- it would have been in the later part of 2019.
Q. And, again, Mr. Bodnar, when you were working on plan, was it you alone or were you joined by other team members at Oliver Wyman?
A. No, it was never me alone. It was always with a team of people from Oliver Wyman.
Q. And with whom were you working in developing the plan on behalf of the Pennsylvania Insurance Department?
A. The Pennsylvania -- so the whole team was providing input into the plan, it was Mr. Cantilo, myself, Bob Robertson, there was several staff from the Department, Lars Leemaker (phonetic), I would have to go back and look at my notes, but there was a pretty --

it was a team that comprised probably another four or five people beyond that.
Q. Before I move on to the plan, Mr. Bodnar, can you describe in a little more detail what the seriatim model looks like? If I were to put one up and look at it, what would that be?
A. What does a seriatim model look like?
Q. I guess let's back up and ask what is an actuarial model?
A. So an actuarial model has as its components first an input file, which is all of the policyholder records themselves, and it has every policy, the characteristics of that policyholder that you need in order to project the assumptions for that policyholder, so age, gender, you know, issue age, and then characteristics of the policy itself.
So the various benefit features, the premium rates that are being charged. So they would be the input. And then that gets -- then applied to that input is an array of assumptions about the future. One would be -- one set would be around morbidity, so the rate

that claims, people go onto claim, and then when they do, the amount of time that they stay on claim, and what their utilization of their benefits are, so all that will help you determine the size of an expected claim.
The other assumptions that are key would be morbidity rate -- I'm sorry, mortality rates, so the rates that people die, and then lapse rates, the rates that people will voluntarily lapse their policy. We also inherently would be modelling exhaustion rates, and to that we would apply all of that to develop future claims. We would also project feature premiums based on the persistency assumptions, lapse in mortality.
We would also in these models apply expense assumptions to predict future expenses. So all those assumptions would be applied to the file. The modeling software will then prepare a projection generally on a month by month basis for every individual policy, and then the model, after it's done performing all these calculations, stores them and summarizes them for us to be able to access them at the various points in time.

Q. So does all of that information make its way into the seriatim model you described earlier?
A. Yes. Yes, it does.
Q. With respect to the plan, Mr. Bodnar, do you have a view as to the philosophy behind the plan?
A. I have an understanding of it, and a view. I mean, the understanding of the plan is, or of the goal of the plan is threefold. It's to reduce the funding gap, it is to provide policyholders with meaningful choices and options, and it is also to deploy an equitable premium rate standard to the policyholders.
Q. Is it your view that, if approved, the plan would meet those goals?
A. Yes.
Q. Do you have an understanding, sir, of the phased structure of the plan?
A. Yes, I do.
Q. Are you familiar with what we have all been referring to as Phase One?
A. Yes, I am.
Q. In a high level, what is Phase One?

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A. Phase One, you know, the objective is to present all the policyholders with options for modifying their policies, using the If Knew Premium rate basis. So the objective is to deploy the If Knew Premium rate basis and present policyholders with four options, really five. You know, the first is Option 1 is to keep your premium rates the same, but modify your benefits so that it's what can be purchased with the If Knew Premium rate.

And then on the other end of the spectrum is Option 4, which is retain your benefits and pay the new premium for those benefits.

And then there is the basic plan which has two variants and those enhanced reduced benefits.

Q. There has been, I think, a lot of testimony about the term If Knew, but I would like to ask you still to provide a little more explanation on that from an actuarial perspective. What is If Knew Premium?

A. So If Knew means if you knew today, if you could go back in time, knowing what you know today, so if you knew all this back at the

time the policy was originally priced, what assumptions would you develop and what premium rates would you charge such that you would expect a lifetime loss ratio of 60 percent.

Q. I think I heard you say if you knew then what you know today, what are the things that you didn't know then that you do know today that go into calculating If Knew Premium?

A. Well, the whole experience we observed in generally the last 30 years in the long-term care insurance industry, but specifically on any given block this tends to hold true, one is that interest rates, you know, did not hold out at six to eight percent, which is what most actuaries were assuming in the early to mid 1990s. Instead, they have been much lower than that.

The other is that people are living longer than we had assumed back in the early 1990s. So back then, we were assuming, you know, mortality rates that were not quite as low as they are today, as they proved out to be. And also lapse rates are much lower than we thought they would be. We did think they would be in the five percent range back in the

-- 30 years ago and, instead, they have been in the one to two percent range, in some cases even lower.

And, you know, claim incident rates, it has been a mixed experience across the industry, sometimes claim incident rates have been higher than what was expected, sometimes they have been lower from block to block.

But, certainly, claims are lasting longer than we thought they would back 30 years ago, and that's due to people just living longer than we thought they would, but also just really a change in how care has been delivered in the last 30 years.

30 years ago, the predominant setting for receiving care was in a nursing home where people's life expectancy was quite short, and what we have learned is that that has now become not the most popular place for people to receive care. It is now given in assisted living facilities, and also delivered at home. In both of those settings, people just tend to live longer than they did in a nursing home.

So all of those things added up have

meant the premium rates had to have -- would have been much different 30 years ago if we had set them with all that knowledge.

Q. Sir, are you familiar with the term "claim terminations"?

A. Yes.

Q. And can you explain what that is?

A. Claim termination -- a claim termination is when somebody comes through on benefit receiving long-term care benefits under their policy, comes off claim, and that can happen because they recover or because they die in the care setting, or because they -- also because they exhaust their benefits.

Q. Has the experience on claim terminations changed over time?

A. They have in the sense that people are receiving care in different settings, and so that's really -- that has been driving the difference in claim termination rates more than anything else, although it does seem that, even given that, there are certain blocks for claim termination rates are getting lower over time, even within the same setting.

Q. Sir, in explaining the If Knew

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Premium concept, you used the term "lifetime loss ratio." Can you just explain what that is for the record?

A. Yes, the lifetime loss ratio is, it's measured from the inception of a policy and it is the present value of expected future benefits divided by the present value of expected future premiums.

And so, you know, in general, I think it's 60 percent lifetime loss ratio was generally held as the measure of benefits being reasonable in relation to premiums at this time.

Q. Why does it matter whether the benefits are reasonable to the premiums?

A. That is a key requirement in setting premium rates, and in a lot of regulations, that's actually spelled out in regulations as a requirement.

Q. Mr. Bodnar, do you have an understanding as to whether a -- the question whether a rate is actuarially justified, do you understand what that would mean?

A. Yes. It is commonly used in regulatory premium rate filings to mean that

the premium rates have been -- they are demonstrated to be actuarially justified or appropriate. And usually it means meeting the standard of benefits are reasonable in relation to premiums.

Q. Is an If Knew Premium, in your opinion, actuarially justified?

A. Yes. In today's, in the current regulatory view, I would say that that is universally held as a -- I would even call it a menial task, it's a -- and I say that because there is no effort to recoup past losses, and so if you can -- if you can demonstrate that an If Knew Premium rate at least meets the lifetime loss ratio requirement, then you are at least demonstrating that you are not recouping past losses, and that seems to be a minimum threshold, although many regulators are open to and will approve rates that exceed that requirement.

So you can -- they do allow you to recoup some past losses, and some of the more modern proposals, current proposals by regulators will allow some recoupment of pass losses.

Q. What does it mean to recoup past losses?

A. So it means to, since the rate is the one you would theoretically charge from issue, but you haven't until the rate is implemented, it means that you haven't been collecting that premium for all the past years.

And so there is no attempt to go back and claw back some of those premiums over the last ten, 20, or 30 years on the policyholders.

Q. When examining the premium rate to be set for a specific policy and determining whether it's actuarially justified, do you consider what part of that premium would be used to pay benefits?

A. Yes, yes.

Q. How do you do that?

A. So we do that by, through an actuarial projection of future premiums and future claims. And so, I mean, that's the measure of the loss ratio is the future claims divided by the future premiums.

You can also look backwards in an actuarial projection. It's like a historical

summary of experience through the date of the premium rate increase request, and that's present value. So it's accumulated with interest, both the premiums and the claims, and it's also projected looking forward.

So that's in the context of a traditional premium rate increase filing.

Q. I guess if we can pause there, I believe you testified that you have some experience with rate increase filings; is that correct?

A. Yes.

Q. Can you just describe in the ordinary course of a company doing business what the rate increase filing would require from an actuarial perspective?

A. Yes. It requires assembling all of the general historical premium and claims data of a, you know, whatever block of business you are requesting a premium rate increase for. And it requires a, you know, all the things that need to go into developing an actuarial model, so looking at the company's experience, developing assumptions around morbidity and persistency, everything I described that goes

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into an actuarial model and then projecting that forward and predicting that on, the premiums and the claims, on a calendar year basis and putting those all together in an actuarial memorandum demonstrating that the result of the premium rate increase produces lifetime loss ratios that don't exceed or don't go below minimum requirements.

It also, you know, requires some description of, in general, you know, what led to the -- what, sometimes, you know, what led to the premium rate increase, and description of the actuarial assumptions and, you know, again, what was the methodology used to develop the premium rates, if there was any.

Q. Does the application process make reference to or involve industry data outside of the company's specific data to which you testified?

A. It could. I have certainly seen a fair number of them just rely on intercompany studies, claim cost studies, but more and more they are not. As companies have developed their own very credible sets of data themselves, I am seeing less and less of it

being based on industry data and more being based on their own data.

Q. Did you testify, sir, that If Knew Premium was -- I think you said something like widely accepted? Can you clarify what you meant by whatever phrase you used --

A. Often regulators will ask, they will ask questions, although these won't necessarily be presented in an actuarial memorandum. The regulators often ask, you know, what would the loss ratio look like if the premium rates that you are proposing be charged had been charged from the beginning.

So that really is, in a way, getting back If Knew Premium rate test. It's not necessarily what they would approve; it's often a benchmark or a data point that regulators will use.

Q. In your experience, have regulators denied rate increases that otherwise satisfy the 60 percent loss ratio requirement?

A. So if you mean the If Knew requirement?

Q. Yes.

A. Yes. I have seen that, for sure.

But, in general, if it meets that standard, again, just I think, in today's environment, a lot of regulators will view that as actuarially justified.

Q. If you're seeking a rate increase in, let's say, ten states, how many applications do you need to prepare?

A. Ten, at least. Usually ten.

Q. And would each one of those applications involve the processes you were describing earlier with respect to the historical and the claim data, et cetera?

A. Yes, they would. In general, you would do all that work and based on the regulatory requirements of the ten different states, each filing document might look a little different because every state has, you know, not all the states require all the same things, and you can anticipate some questions that they might ask, given experience in any of the states, so you could have ten documents that are worded differently and present slightly different information to satisfy the requirements of the ten different regulators.

But in general they will look about

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

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

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

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

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

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

Do you recall that?

A. Yes.

Q. How does that compare to what

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ordinarily happens in the rate application process?

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

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

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

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

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

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

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

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

rate than younger people with more rich benefits.

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

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

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

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

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

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

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

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

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

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

A. State A, the issuing state.

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Q. Which guaranty association rules would apply to that policyholder in the event of a liquidation?

A. It's generally the resident state.

MR. BROADBENT: Your Honor, I note the time is 3:57 and I am about to ask Mr. Bodnar to turn to the options under the plan, which I am happy to do and continue on for some time, but I wanted to know whether you would rather us pause here or get started and see how long we can discuss the options for.

JUDGE LEAVITT: I think this is a good time to break.

MR. BROADBENT: That's fine with me, Your Honor, and I suspect perhaps some others as well.

JUDGE LEAVITT: We can go off the record.

(Discussion held off the record.)

JUDGE LEAVITT: We will resume tomorrow morning at 10:00 a.m.

(At 3:58 p.m., the proceedings were adjourned.)

C E R T I F I C A T E

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I hereby certify that the proceedings and evidence are contained fully and accurately in the stenographic notes taken by me on the hearing of the within cause, and that this is a correct transcript of the same.

_____

_____

Karen A. Nickel
Certified Realtime Reporter

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Exhibit 16

Date: 11/22/21

Virtual Meeting
(in lieu of meeting at the 2021 Fall National Meeting)

RECEIVERSHIP AND INSOLVENCY (E) TASK FORCE
Tuesday, Nov. 30, 2021
12:00 p.m. – 1:00 p.m. ET / 11:00 a.m. – 12:00 p.m. CT / 10:00 – 11:00 a.m. MT / 9:00 – 10:00 a.m. PT

ROLL CALL

Cassie Brown, Chair	Texas	Anita G. Fox	Michigan
James J. Donelon, Vice Chair	Louisiana	Chlora Lindley-Myers	Missouri
Peni Itula Sapini Teo	American Samoa	Troy Downing	Montana
Evan G. Daniels	Arizona	Eric Dunning	Nebraska
Michael Conway	Colorado	Marlene Caride	New Jersey
Andrew N. Mais	Connecticut	Russell Toal	New Mexico
David Altmaier	Florida	Mike Causey	North Carolina
Colin M. Hayashida	Hawaii	Edward M. Deleon Guerrero	Northern Mariana Islands
Dana Popish Severinghaus	Illinois	Glen Mulready	Oklahoma
Doug Ommen	Iowa	Jessica K. Altman	Pennsylvania
Vicki Schmidt	Kansas	Elizabeth Kelleher Dwyer	Rhode Island
Sharon P. Clark	Kentucky	Raymond G. Farmer	South Carolina
Eric A. Cioppa	Maine	Johnathan T. Pike	Utah
Gary D. Anderson	Massachusetts		

NAIC Support Staff: Jane Koenigsman

AGENDA

1. Consider Adoption of its Oct. 21 Minutes—*Brian Riewe (TX)* — Attachment One

2. Consider Adoption of a Referral to the Financial Regulation Standards and Accreditation (F) Committee—*Brian Riewe (TX)* — Attachment Two

3. Consider Adoption of a Memorandum to States on Receivership and Guaranty Fund Laws—*Brian Riewe (TX)* — Attachment Three

4. Consider Adoption of the Reports of its Working Group and Subgroup
   A. Receivership Financial Analysis (E) Working Group—*Toma Wilkerson (FL)*
   B. Receiver's Handbook (E) Subgroup—*Kevin Baldwin (IL)* — Attachment Four

5. Hear Update on Federal Activities—*Patrick Celestine (NAIC)*

6. Discuss Any Other Matters Brought Before the Task Force—*Brian Riewe (TX)*

7. Adjournment

Draft: 10/26/21

Receivership and Insolvency (E) Task Force
Virtual Meeting
October 21, 2021

The Receivership and Insolvency (E) Task Force met Oct. 21, 2021. The following Task Force members participated: Cassie Brown, Chair, represented by Brian Riewe (TX); James J. Donelon, Vice Chair (LA); Peni Itula Sapini Teo represented by Elizabeth Perri (AS); Michael Conway and Rolf Kaumann (CO); Andrew N. Mais represented by Jared Kosky (CT); David Altmaier represented by Toma Wilkerson (FL); Colin M. Hayashida represented by Patrick P. Lo (HI); Doug Ommen represented by Kim Cross (IA); Dana Popish Severinghaus represented by Kevin Baldwin (IL); Vicki Schmidt represented by Tish Becker (KS); Sharon P. Clark represented by Bill Clark (KY); Gary D. Anderson represented by Christopher Joyce (MA); Eric A. Cioppa represented by Robert Wake (ME); Anita G. Fox represented by Randall Gregg (MI); Chlora Lindley-Myers and Shelley Forrest (MO); Mike Causey represented by Jackie Obusek (NC); Eric Dunning and Justin Schrader (NE); Russell Toal represented by Victoria Baca (NM); Glen Mulready represented by Donna Wilson (OK); Jessica K. Altman represented by Laura Lyon Slaymaker (PA); Elizabeth Kelleher Dwyer represented by Matt Gendron (RI); Raymond G. Farmer represented by Michael Shull (SC); and Johnathan T. Pike (UT).

1. Adopted its Summer National Meeting Minutes

Mr. Riewe said the Task Force met July 27 in lieu of the Summer National Meeting. Ms. Wilkerson made a motion, seconded by Mr. Baldwin, to adopt the Task Force's July 27 minutes (see *NAIC Proceedings – Summer 2021, Receivership and Insolvency (E) Task Force*). The motion passed unanimously.

2. Exposed a Draft Referral to the Financial Regulation Standards and Accreditation (F) Committee

Mr. Riewe said the Executive (EX) Committee and Plenary adopted the receivership revisions to the *Insurance Holding Company System Regulatory Act* (#440) and the *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450) at the Summer National Meeting. As the Task Force and its working group were responsible for drafting these model revisions, the Task Force will need to send a referral recommending the Part A Standard that should be considered by the Financial Regulation Standards and Accreditation (F) Committee. Part A standards are those laws and regulations that are required to ensure a state has authority to regulate financial solvency of insurers.

Mr. Riewe said the Task Force sought the input of members to draft an initial recommendation. With one exception, the feedback received was in favor of recommending that the revisions be acceptable, but not required to be adopted by states, rather than identifying substantially similar provisions that would be required. Since there were other revisions to these models for group capital and liquidity stress testing, states are hopefully considering all the model revisions together on their merits and the benefits to receiverships regardless of accreditation requirements. Mr. Wake said while he would like to see more substantive accreditation standards for receivership and insolvency, it is an excellent referral.

Hearing no objections, the draft referral was released for a 30-day public comment period ending Nov. 22.

3. Exposed a Draft Memorandum to State Insurance Departments

Mr. Riewe said when the Task Force adopted the final recommendations from the Macroprudential Initiative (MPI), it had identified several provisions of receivership law that were considered important to a multi-jurisdictional receivership. These are provisions for which all states should consider reviewing their laws and potentially making updates. This included conflicts of law, continuation of coverage, priority of distribution, full faith, and credit on stays and injunctions. In addition to those, the NAIC has adopted the receivership revisions to Model #440 and Model #450 and adopted the new *Guideline for Administration of Large Deductible Policies in Receivership* (#1980) and *Guideline for Definition of Reciprocal State in Receivership* (#1985). Lastly, while 34 states have adopted those 2017 revisions to the *Life and Health Insurance Guaranty Association Model Act* (#520), the memorandum reminds state insurance departments to consider adoption. The draft memorandum is intended to encourage states to consider a review of their laws and adopt updates. The memorandum is concise and may be used as a starting point for discussion with each state insurance department's legal or legislative liaison staff. Any volunteers willing to speak at zone meetings could use this memorandum as talking points for those discussions.

Hearing no objections, the draft memorandum was released for a 30-day public comment period ending Nov. 22.

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4. Heard an Update on International Resolution Activities

Mr. Wake said the International Association of Insurance Supervisors (IAIS) Resolution Working Group adopted the *Application Paper on Resolution Powers and Planning*. The Working Group began work on an application paper on policyholder protection schemes. Mr. Wake said the U.S. is undergoing a targeted jurisdictional assessment regarding the holistic framework, which includes an assessment of resolution and crisis management.

Having no further business, the Receivership and Insolvency (E) Task Force adjourned.

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Attachment Two
Receivership and Insolvency (E) Task Force
11/30/21

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Date: November 30, 2021

To: Superintendent Elizabeth Kelleher Dwyer (RI), Chair of Financial Regulation Standards and Accreditation (F) Committee

From: Commissioner Cassie Brown (TX), Chair of Receivership and Insolvency (E) Task Force

Re: 2021 Amendments to the *Insurance Holding Company System Regulatory Act* (#440) and *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450)

On August 17, 2021, the NAIC Executive (EX) Committee and Plenary unanimously adopted revisions to the NAIC *Insurance Holding Company System Regulatory Act* (#440) and *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450). The revisions help ensure efficient coordination with affiliates and to enforce the continuation of essential services by an affiliate to an insurer in the event of insolvency.

These revisions were drafted by the Receivership Law (E) Working Group under charges assigned by the Receivership and Insolvency (E) Task Force. These revisions, referred to as the "receivership revisions" do not include recent revisions to Models #440 and #450 for group capital calculation or liquidity stress test. The receivership revisions address the continuation of essential services through affiliated intercompany agreements with an insurer that is placed into receivership by: 1) bringing affiliate service providers deemed "integral" or "essential" to an insurer's operations under the jurisdiction of a rehabilitator, conservator, or liquidator for purposes of interpreting, enforcing, and overseeing the affiliate's obligations under the service agreement and give the commissioner authority to require that "integral" or "essential" affiliate service providers consent to such jurisdiction; 2) further clarifying the ownership of data and records of the insurer that are held by the affiliate; and 3) clarifying that premiums of the insurer held by the affiliate are the property of the insurer and rights of offset are determined by receivership law. See attachment A for a copy of the amendments.

The recommendation for Part A Accreditation Standards is that these receivership revisions be considered acceptable, but not required to be adopted by states. However, the revisions are considered important and all states are encouraged to adopt them. States may consider adoption of the changes in conjunction with opening their holding company laws to consider adoption of the Group Capital Calculation and Liquidity Stress Test revisions.

The Task Force will continue to encourage states to adopt these revisions based on the benefits these revisions add to state regulation, and to the goal of improving efficiencies in receivership and reducing costs to a receivership estate.

DRAFT

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Date: November 30, 2021

To: State Insurance Departments

From: Receivership and Insolvency (E) Task Force

Re: Recently Adopted Model Amendments and Guidelines; and Provisions of Receivership Laws Critical to a Multi-Jurisdiction Receivership

In 2020, the Task Force concluded its Macroprudential Initiative (MPI) to evaluate receivership and guaranty fund laws. Through this process the Task Force highlighted several topics that it identified as being critical for states laws with respect to a multi-jurisdictional receivership and which may require a state's attention.

The Task Force encourages state insurance departments to review their receivership and guaranty fund laws to ensure it addresses the following topics.

Insurer Receivership Model Act (#555, "IRMA")

- Conflicts of Law (IRMA §102) was added as a new section in IRMA and it states that receivership and guaranty fund laws govern together; however, receivership law prevails when there is a conflict between the guaranty fund law or the provisions of any other law. The benefit of having this provision is that it prevents potential legal delays in the administration of a receivership.

- Continuation of Coverage (IRMA §502) provides that all insurance policies, excluding life, disability, long term care, health, or annuities, are cancelled at a specified time unless the Liquidator, with the consent of the receivership court, extends the period. This provision was re-written and improved in IRMA.

  The Task Force conducted a survey in 2019 that showed that states' laws differ with respect to IRMA §502 from having provisions substantially similar to IRMA §502B, or to a prior version of Model #555, or a state has no continuation of coverage provision, or no exclusions for life and health lines of business. This provision has been the subject of litigation in receivership. For these reasons, states are encouraged to review their law against IRMA and consider amendments.

- Priority of Distribution (IRMA §801) of estate assets is a provision that was rewritten in IRMA. It outlines the priority scheme for payment of claims, which places policyholder claims above that of unsecured creditors or shareholders. The benefit of having this provision is that it furthers state insurance department goals to protect policyholders in the administration of a receivership.

Reciprocal State; Full Faith and Credit on Stays and Injunctions

An effective stay provision promotes judicial economy and predictability, which benefits all participants in the receivership process. However, the significant improvements in IRMA regarding stays have not been widely

adopted. Further background on the topic is available in the 2017 Financial Condition (E) Committee memorandum posted to the NAIC website.[1] States are encouraged to review their receivership laws, and consider the following:

1) States with no stay provisions, or provisions based on older NAIC models, should compare their laws to the more recent NAIC Models, and evaluate the benefits of a more comprehensive stay. (IRMA §108)
2) States with no reciprocity provisions, or provisions based on older NAIC models, should consider adopting a provision similar to IRLMA § 5 (C) (2) or IRMA § 1002 (A). In the alternative, a state could update its definition of a "reciprocal state." In 2021, the NAIC adopted the *Guideline for Definition of Reciprocal State in Receivership Laws* (GDL#1985) that defines reciprocal state as any state that has enacted a law setting forth a scheme for receivership.[2]

Ancillary Conservation of Foreign Insurers (IRMA §1001) provides for ancillary conservation of an insurer writing in the state but domiciled in another state, in limited circumstances. Ancillary conservation is relevant to insurers conducting business in multiple jurisdictions, should be coordinated with the domiciliary state, and may require consideration of whether the involved states are reciprocal.

2021 Revisions to the Insurance Holding Company System Model Act and Regulation (#440 & #450)

In 2021, the NAIC adopted receivership revisions to the NAIC *Insurance Holding Company System Regulatory Act* (#440) and *Insurance Holding Company System Model Regulation with Reporting Forms and Instructions* (#450). The revisions address the continuation of essential services through affiliated agreements with an insurer that is placed into receivership by bringing affiliate service providers deemed "integral" or "essential" to an insurer's operations under the jurisdiction of the receiver; clarify the ownership of data and records and premiums of the insurer that are held by the affiliate; and, outline provisions that should be included in affiliated management services and cost sharing agreements in the event the insurer is placed into receivership.

The Task Force encourages state insurance departments to consider these Model amendments based on the benefits these revisions add to state regulation, and to the goal of improving efficiencies in receivership and reducing costs to a receivership estate.

Treatment of Workers Compensation Large Deductible Policies

In 2021, the NAIC adopted the *Guideline for Administration of Large Deductible Policies in Receivership* (GDL#1980) to address the treatment of large deductible policies in receivership. The Guideline makes significant improvements over IRMA §712 Administration of Loss Reimbursement Policies, and the National Conference of Insurance Guaranty Funds (NCIGF) Model Large Deductible Legislation, Administration of Large Deductible Policies and Insured Large Deductible Collateral. The Guideline provides that the guaranty associations, on behalf of the claimants, are entitled to any deductible reimbursements from the policyholder and the right to draw on the collateral. While some states already have existing laws on this topic, states that do not or that wish to update their existing laws, are encouraged to consider Guideline #1980.[3]

2017 Revisions to the Life and Health Insurance Guaranty Association Model Act (#520)

The 2017 amendments to Model #520 aimed to address issues arising in connection with guaranty fund coverage in insolvencies of insurers writing long-term care insurance. While states have made good progress adopting these amendments with 34 states adopting to date, remaining states are encouraged to consider adoption. Further guidance is available in the Task Force's 2018 memorandum, which is posted to the NAIC website.[4]

[1] https://content.naic.org/sites/default/files/inline-files/cmte_e_receivership_related_170717_committee_recommendation.pdf
[2] https://content.naic.org/sites/default/files/GL1985.pdf
[3] https://content.naic.org/sites/default/files/GL1980.pdf
[4] https://content.naic.org/sites/default/files/inline-files/committees_e_receivership_related_rev_memo_520.pdf

For further resources or information about these Model Laws and Guidelines, states may contact NAIC staff, jkoenigsman@naic.org.

Draft: 11/22/21

Receiver's Handbook (E) Subgroup
Virtual Meeting
November 18, 2021

The Receiver's Handbook (E) Subgroup of the Receivership and Insolvency (E) Task Force met Nov. 18, 2021. The following Subgroup members participated: Kevin Baldwin, Chair (IL); Toma Wilkerson, Vice Chair (FL); Joe Holloway (CA); Jared Kosky (CT); James Gerber (MI); Leatrice Geckler (NM); Donna Wilson and Jamin Dawes (OK); Laura Lyon Slaymaker and Crystal McDonald (PA); and Brian Riewe (TX).

1. Adopted its June 14 Minutes.

The Subgroup met June 14 and took the following action: 1) adopted its May 26 minutes; 2) discussed the drafting group process; and 3) demonstrated the SharePoint Collaboration website to the drafting groups. Mr. Baldwin noted that the minutes from the June meeting were in the meeting materials.

Mr. Geckler made a motion, seconded by Ms. Wilson, to adopt the Subgroup's June 14 minutes (Attachment Four-A). The motion passed unanimously.

2. Exposed Revised Chapter 1 and Chapter 2 of the Receiver's Handbook

Mr. Baldwin thanked the volunteers who had participated in the drafting groups for Chapters 1 and Chapter 2 of the *Receiver's Handbook for Insurance Company* Insolvencies (Receiver's Handbook). Chapter 1 had extensive revisions and was presented in the meeting materials as a clean copy. To view the original Receiver's Handbook, the current Receiver's Handbook version is posted on the Subgroup's website under the documents tab. Chapter 2 was presented in the materials as a markup version of the original Receiver's Handbook chapter. The Subgroup considered public exposure of revised Chapter 1 and Chapter 2 for a 30-day period with all comments to be sent to Sherry Flippo (NAIC).

Mr. Holloway made a motion, seconded by Ms. Wilkerson, to expose Chapters 1 and Chapter 2 of the Receiver's Handbook for a 30-day public comment period ending Dec. 20. The motion passed unanimously.

Having no further business, the Receiver's Handbook (E) Subgroup adjourned.

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