

**IN THE
SUPREME COURT OF PENNSYLVANIA**

**IN RE: SENIOR HEALTH :
INSURANCE COMPANY OF :
PENNSYLVANIA (IN :
REHABILITATION) : No. 71 MAP 2021**

**APPEAL OF: THE SUPERINTENDENT
OF INSURANCE OF THE STATE OF MAINE,
THE COMMISSIONER OF INSURANCE OF THE
COMMONWEALTH OF MASSACHUSETTS,
AND THE INSURANCE COMMISSIONER OF
THE STATE OF WASHINGTON**

**STATE INSURANCE REGULATORS'
APPLICATION FOR STAY PENDING APPEAL**

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Pursuant to Pa. R.A.P. 123 and 1732(a), the Appellants/Intervenors Superintendent of Insurance of the State of Maine, Commissioner of Insurance of the Commonwealth of Massachusetts, and Insurance Commissioner of the State of Washington (“State Insurance Regulators”), hereby move for a stay pending appeal of the trial court’s August 24, 2021 Order granting the application of the Insurance Commissioner of the Commonwealth of Pennsylvania as Rehabilitator (“Rehabilitator”) of Senior Health Insurance Company of Pennsylvania (“SHIP”) for approval of the Second Amended Plan of Rehabilitation (“Plan”) for SHIP, as well as the related May 21, 2021 ruling granting the Rehabilitator’s motion in the nature of a directed verdict regarding issue state rate approval and the August 25, 2021 Order denying reconsideration of that ruling (the “Orders”).

The Orders approve the Plan and overrule objections to the Plan. The State Insurance Regulators filed their appeal from the Orders on September 21, 2021.

The Orders and the Memorandum Opinion re Application for Approval of the Plan of Rehabilitation for SHIP issued by the single Judge of the Commonwealth Court (the “Court” or “trial court”)¹ are attached to the State Insurance Regulators’ Jurisdictional Statement filed September 21, 2021.

¹ The Commonwealth Court has original jurisdiction of proceedings for the rehabilitation or liquidation of insurance companies under 42 Pa. C.S. § 761(a)(3).

Background

1. Application to the Trial Court for Stay Pending Appeal

As required by Pa. R.A.P. 1732(a), the State Insurance Regulators applied for a stay pending appeal in the first instance from the trial court. The State Insurance Regulators filed their Application for Stay Pending Appeal with the Court on October 1, 2021. The Rehabilitator filed her opposition on October 15, 2021, as did the Intervenor Health Insurers.

On November 2, 2021, the State Insurance Regulators filed an Application for Expedited Ruling on Application for Stay Pending Appeal in light of the upcoming November 15, 2021 “opt-out” deadline.

On November 4, 2021, the trial court issued a Memorandum Opinion and Order denying the State Insurance Regulator’s Application for Stay (“Stay Op.”). Also on November 4, 2021, the Court issued an Amendment Order amending the August 24, 2021 Memorandum Opinion and an Order designating the amended Memorandum Opinion as an Opinion (“Op.”) for publication.

The Appendix to the State Insurance Regulators’ Application to Stay Pending Appeal (“SIR Appendix” or “SIR App.”) filed herewith includes (1) the State Insurance Regulators’ Application for Stay Pending Appeal (SIR App. 314), (2) the Rehabilitator’s Opposition (SIR App. 351), (3) the Health Insurers’ Response (SIR App. 394), (4) the Application for Expedited Ruling (SIR App.

428), (5) the Memorandum Opinion and Order denying the Application for Stay (SIR App. 433), and (6) the November 4, 2021 Opinion (SIR App. 446).

2. Overview

This appeal involves an unprecedented plan of rehabilitation for an insolvent insurance company. The Plan places the entire \$1.2 billion burden of the insolvency on 30,000 of SHIP's remaining policyholders through benefit cuts and premium increases even though, in a liquidation, based on the Rehabilitator's own comparison analysis, the policyholders would only bear a loss of \$400 million, as insurance guaranty associations would provide over \$800 million of additional support. The Plan also supersedes the authority of insurance regulators in States other than Pennsylvania to review rates for policies issued in their States.

The Court approved the Plan over the objections of the Intervenor State Insurance Regulators. It disagreed with the Intervenor's position that the policyholders' best financial interest must be protected in an insolvency and that state regulators control rates in their states. The Court instead took the view that (a) SHIP's policies were historically "underpriced" so that policyholders should bear the burden of insolvency instead of the guaranty associations, and (b) the state-based rate review system historically resulted in "discriminatory" rates so that rates should be set nationwide by the Rehabilitator and the Court.

In their appeal, the State Insurance Regulators present several fundamental issues. First, they contend that the Rehabilitator was required as a matter of law to protect the financial interest of policyholders in their contracts, rather than pursuing other goals, and that the Rehabilitator and Court must take the policies as they find them. Deeming policyholders unworthy of guaranty association protection and deciding instead to protect those who fund the guaranty associations is contrary to the purpose of the guaranty association statutes. Second, the Plan was constitutionally required, but fails, to provide all policyholders an option with a value at least equal to the value they would receive in liquidation. Third, the Plan exceeds statutory authority and violates the Full Faith & Credit Clause by displacing insurance regulators from their statutory role in reviewing rates applicable to policies issued in their States.²

These novel and important issues should be resolved by the Supreme Court before the Plan is implemented and the rights of policyholders and insurance regulators permanently impaired. The Plan will not correct SHIP's insolvency. However, implementation of the Plan will alter the *status quo* and may permanently reduce the contract rights of policyholders so that they will have less protection from insurance guaranty associations when SHIP is inevitably

² The appeal also involves additional and more specific issues. This relatively brief application does not address all grounds for the appeal. The State Insurance Regulators reserve and do not waive any grounds not discussed herein.

liquidated. It will also require insurance regulators to decide whether to “opt-out” of the Plan to the detriment of policyholders in their States.

3. Schedule for Implementation of the Plan

The Rehabilitator is now moving to implement the Plan, which involves three basic steps. First, state insurance regulators must make so-called “opt out” decisions concerning whether the Rehabilitator should apply for approval of rates in their states (subject to the restrictions, limitations and consequences imposed by the Plan). The Rehabilitator has established a November 15, 2021 deadline for state insurance regulators to make these so-called “opt-out” decisions. *See* the Special Deputy Rehabilitator’s letter of September 30, 2021 (SIR App. 9). Second, the Rehabilitator is to send election packages to SHIP’s policyholders so they may make elections regarding permanent “adjustments” (benefit cuts and premium increases) to their policies under the Plan. The election packages are to be sent out around year-end 2021. Third, the Rehabilitator will make the adjustments effective in April 2022. As the Rehabilitator has advised:

Implementation of the Plan commenced following the entry of the Court’s Memorandum Opinion and Order. We anticipate that most policyholders will be sent Policyholder Election Packages around year-end and be asked to make their elections by around mid March, 2022, becoming effective in April of next year.

Notice of Filing of Approved Plan, Ex. A, p. 19 (Sept. 24, 2021) (SIR App. 7).³

Standard for Stay Pending Appeal

The standard governing this application for stay is well-established.

On an application for stay pending appeal the movant is required to make a substantial case on the merits and to show that without the stay, irreparable injury will be suffered. Additionally, before granting a request for a stay, the court must be satisfied the issuance of the stay will not substantially harm other interested parties in the proceedings and will not adversely affect the public interest.

Maritrans G.P., Inc. v. Pepper, Hamilton & Scheetz, 573 A.2d 1001, 1003 (Pa. 1990) (decision of Nix, C.J.) (citing *Pa. Pub. Util. Comm'n v. Process Gas Consumers Grp.*, 467 A.2d 805, 808-809 (Pa. 1983)).

SUMMARY OF ARGUMENT

The State Insurance Regulators have a compelling case on the merits of their arguments that the Plan should not be approved. As discussed below, the Plan is not feasible as required by law; constitutes an abuse of discretion and error of law because it does not serve the best financial interest of policyholders and ignores guaranty associations; fails to place policyholders in at least as good a position as in a liquidation as required by *Neblett v. Carpenter*, 305 U.S. 297 (1938); and

³ Exhibit A to the Notice is the Approved Plan of Rehabilitation as substituted in accordance with the Court's Order of October 28, 2021 regarding the Praecipe to Substitute Approved Plan of Rehabilitation (September 30, 2021). The Approved Plan is the Second Amended Plan (Ex. RP-55). See SIR App. 28, 531.

exceeds statutory authority and violates the Full Faith and Credit Clause in superseding the regulatory authority of other States over rates. The State Insurance Regulators are properly present here to protect the interests of elderly policyholders, who relied on SHIP insurance policies to protect them in the last stages of their lives, against a plan that seeks to unnecessarily cut their benefits and exclude state insurance regulators.

The policyholders of SHIP and the State Insurance Regulators will suffer irreparable injury if the Plan is implemented during the appeal. The Plan will permanently reduce policyholders' contract rights and displace state insurance regulators from their statutory role in reviewing rates. If the Plan is implemented before the appeal is decided, the Rehabilitator may contend that the appeal is equitably moot. If that were correct, this would leave policyholders with reduced coverage and reduced guaranty association protection in the inevitable liquidation, and regulators with no role in determining rates in their States.

The interests of policyholders should be the central concern, and it would be a potentially disastrous result for policyholders for the Plan to be implemented and evade appellate review. The Plan requires policyholders to absorb \$800 million in losses that should be borne by insurance guaranty associations because the Rehabilitator and trial court concluded in hindsight that the policies were underpriced and then chose not to trigger the guaranty associations. The Plan fails

to satisfy the constitutional requirement that policyholders be treated at least as well in rehabilitation as in liquidation.

Issuance of a stay pending appeal will not harm other interested persons. It will preserve the *status quo*. Policyholders will continue to pay premiums at the lawfully approved rates as before, and those on claim will continue to receive claim payments as they have during the pendency of the Rehabilitator's application for approval of the Plan. The intervenor agents and brokers have settled their issues by the settlement approved by the Court on September 13, 2021. Finally, so long as the appeal is pending, SHIP will not be liquidated and the intervenor health insurers will not need to pay guaranty association assessments.

A stay will not adversely affect the public interest. This appeal protects the financial interests of policyholders that are intended to be protected by the insurer receivership statutes and the guaranty association system and protects the state-based rate regulatory system. The Rehabilitator contends that delaying benefit cuts and premium increases under the Plan will increase SHIP's insolvency and the burden on the guaranty associations, their member insurers and, in many States, on taxpayers. That is not cognizable "harm" because the guaranty associations were created specifically to protect policyholders in the event of an insolvency, and the legislatures have determined how to allocate the burden of that protection.

Facts Relied Upon

This appeal arises from the Rehabilitator's application for approval of a plan of rehabilitation for SHIP. The Second Amended Plan of Rehabilitation (the "Plan", Ex. RP-55) provides an overview. Ex. RP-55 at 81-82, 86-87 (SIR App. 108-109, 113-114). *See also* Op. at 2-5. In brief, SHIP wrote long term care ("LTC") insurance policies. It stopped writing policies in 2003 and has been in run-off paying claims since that time. Its remaining policyholders have an average age of 86, and the policyholders on claim have an average age of 89. SHIP is insolvent. It was placed in rehabilitation proceedings and the Pennsylvania Insurance Commissioner was appointed Rehabilitator on January 29, 2020.

On April 22, 2020, the Rehabilitator applied for approval of a plan of rehabilitation. The Court issued a case management order regarding the application. In accordance with that order, the State Insurance Regulators applied to intervene in the proceedings concerning the proposed plan by application filed July 31, 2020 and joinder filed September 15, 2020 (SIR App. 534, 555). The Court allowed the State Insurance Regulators to intervene by orders entered September 15 and 18, 2020 (SIR App. 568, 569).

A hearing on the Plan was held on May 17-21, 2021. After post-hearing briefing, the Court issued its Memorandum Opinion and approved the Plan in the Orders on August 24 and 25, 2021.

While the matter is complex, the essential facts are as follows.

1. SHIP's policies are enforceable contracts, and the premiums charged on the policies historically and on the rehabilitation date were lawfully approved rates. Tr. 227-229, 282 (SIR App. 271-273, 275).

2. SHIP is insolvent, with a deficit or "funding gap" of approximately \$1.2 billion. Ex. RP-55 (the Plan) at 87 (SIR App. 114). *See* Op. 13 (referring to "SHIP's insolvency").

3. Under the Plan, the burden of reducing or eliminating the \$1.2 billion funding gap will rest on the 30,000 remaining SHIP policyholders who have not taken non-forfeiture options. Tr. 290-292; Ex. RP-55 at 102-103 (SIR App. 277-279; 129-130). The Plan seeks to reduce the funding gap by reducing policy benefits and increasing premiums. Ex. RP-55 at 10, 102-103 (SIR App. 37, 129-130).

4. The Plan requires policyholders to select among options, only one of which (Option 4) retains the policyholders' full benefits in Phase One. The other options (Options 1, 2, 2a, and 3) all reduce benefits in Phase One. Ex. RP-55 at 23-24; Tr. 113-117 (SIR App. 50-51; 244-245). Policyholders who choose Option 4 in Phase One face the possibility of additional substantial rate increases or benefit reductions in Phase Two. Ex. RP-55 at 15 ("[P]olicyholders selecting

Option Four would face the possibility of additional substantial rate increases or benefit reductions in Phase Two of the Plan.”), 58 (SIR App. 42, 85).

5. In a liquidation, virtually all of SHIP’s policies would be covered by one of the guaranty associations created by statute in each state, subject to the individual state statutory limits on guaranty association coverage. Ex. RP-55 at 93 (SIR App. 120).

6. If SHIP were liquidated now so that guaranty associations are triggered, policyholders will absorb only approximately \$397 million of the funding gap, based on the Rehabilitator’s comparison file. Ex. SIR 5-1, Table 1; Tr. 564 (SIR App. 224; 304). This is because guaranty associations would provide approximately \$837 million in additional support to benefit policyholders, also based on the Rehabilitator’s comparison file. Ex. SIR 5-1, Table 2; Tr. 565-66 (SIR App. 224; 310-311). The Plan does not trigger the guaranty associations, Ex. RP-55 at 92, so these additional funds will not be available to benefit policyholders under the Plan. (SIR App. 119).⁴

7. The policyholder elections under the Plan will be permanent in that guaranty association coverage may be given up. If SHIP is placed in liquidation after the Plan is implemented, the policies to which guaranty association coverage

⁴ The State Insurance Regulators’ exhibits were admitted into evidence at the hearing (Tr. 550-553) (SIR App. 300-303), and the Court summarized the testimony of Frank Edwards on these points (Tr. 560-566) (SIR App. 305-311) in its opinion. Op. 31.

will apply will be the policies as modified as a result of the elections. Ex. RP-55 at 14, 92; Tr. 300-301, 313 (SIR App. 41, 119; 282-283, 286). As stated in the Plan:

Policyholder Elections under the Plan will be permanent. This means that if the Plan does not succeed in rehabilitating SHIP fully and the Company has to be placed in liquidation, the policies to which guaranty association coverage and limits . . . will apply will be those as modified as a result of the Policyholder Elections.

Ex. RP-55 at 14 (SIR App. 41).

8. The Plan is highly unlikely to eliminate the funding gap and restore SHIP to solvency, even considering both Phase One and Phase Two. Tr. 80, 306 (SIR App. 237, 284). In all likelihood, the Plan will not eliminate the deficit, just reduce it materially. Tr. 189-190 (SIR App. 266-267).

9. The Plan will not provide all policyholders with an option with a net present value (present value of future benefits less present value of future premiums – the “Carpenter value”) at least as great as the net present value in liquidation. Only 85% of policyholders will have at least one Phase One option with a net present value equal to or greater than liquidation. Ex. RP-7; Tr. 183, 185, 510, 512 (SIR App. 226; 262, 264, 296, 298). This 85% rests principally on Option 4. Tr. 510, 512-513, 572; Ex. SIR 5-2 (SIR App. 296, 298-299, 313; 225). Option 4 has the least impact on the funding gap, and it is subject to further adjustment in Phase Two. Tr. 259, 513; Ex. RP-55 at 14 (SIR App. 274, 299; 41).

10. Under state statutes, long term care insurance rates are reviewed and approved by the insurance regulatory official of the state in which the policy is issued. Tr. 155, 157 (SIR App. 249, 251). Each state has its own approach to reviewing rates. Tr. 413-414 (SIR App. 290-291). The Plan does not follow this issue state rate approval process. Ex. RP-55 at 33-34, 96; Tr. 158-159 (SIR App. 60-61, 123; 252-253). It removes state insurance regulators from their role in reviewing rates, which is “unprecedented.” Ex. RP-55 at 33-34; Tr. 82 (SIR App. 60-61; 239). The Rehabilitator will not seek approval of rates from state regulators under their statutes but instead from the Commonwealth Court. Ex. RP-55 at 33-34, 96 (SIR App. 60-61, 123).

11. The Plan has an “issue state rate approval” section under which state regulators purportedly may “opt-out” of having the Commonwealth Court approve rates. Ex. RP-55 at 108 (SIR App. 135). The section provides that, unless the “opt-out” state approves the Rehabilitator’s rate application, in full, within 60 days, it is deemed denied. Ex. RP-55 at 111 (SIR App. 138). In that case, the options available to policyholders in that state will be more limited than the options available in other states, and the state’s policyholders will be disadvantaged. Ex. RP-55 at 109, 116; Tr. 169-170 (SIR App. 136, 143; 257-258). *See* Special Deputy Liquidator’s September 30, 2021 Letter at Frequently Asked Questions Response

“Q9” (opting out “is generally expected to be disadvantageous to affected policyholders”) (SIR App. 16).

ARGUMENT

I. THE STATE INSURANCE REGULATORS HAVE A COMPELLING CASE ON APPEAL.

The State Insurance Regulators have substantial arguments that the Court’s approval of the Plan should be reversed because the Plan is based on errors of law. To warrant approval under 40 P.S. § 221.16, the Plan must be free from any abuse of the Rehabilitator’s discretion. *Foster v. Mutual Fire, Marine and Inland Ins. Co.*, 614 A.2d 1086, 1091 (Pa. 1992) (“*Mutual Fire II*”), *cert. denied* 506 U.S. 1080 and 1087 (1993). “It is a paradigmatic abuse of discretion for a court [or the Rehabilitator] to base its judgment upon an erroneous view of the law.” *Commonwealth v. Taylor*, 230 A.3d 1050, 1072 (Pa. 2020).

As an initial matter, the State Insurance Regulator may properly raise policyholder interests. In its ruling, the Court held that the State Insurance Regulators lack standing to “assert claims” on behalf of policyholders, adding that it granted limited intervention based on their interests as regulators, not as representatives for policyholders. Stay Op. at 4-5. This cramped view disregards the essential purpose of our nation’s state-based insurance regulatory system and its regulators – to protect policyholders.

The State Insurance Regulators are public officials seeking to protect policyholders in furtherance of their public responsibilities. They are long-serving chief insurance regulators, one the longest serving in the United States and another being a past president of the National Association of Insurance Commissioners, and do not take this step lightly. They are not asserting “claims” for policyholders but contending in their regulatory capacity that the Plan unlawfully impairs policyholder interests. As stated in the applications to intervene, the State Insurance Regulators are charged with enforcing state insurance laws and regulating insurers,⁵ and they have “a regulatory interest in seeing that contract rights of [the State’s] policyholders are respected and that the standards and protections of the statutory rate-setting process are honored.” Joint Application for Intervention of the Maine Superintendent of Insurance and the Massachusetts Commissioner of Insurance at 11 ((July 31, 2020) (emphasis added); Joinder of the Washington Insurance Commissioner at 6 (Sept. 15, 2020) (SIR App. 544, 560).

The Court’s Orders of September 15 and 18, 2021 granting intervention did not limit the interests the State Insurance Regulators could protect or restrict them to addressing rate review. The State Insurance Regulators sought intervention “for the limited purpose of participating in the proceedings concerning and potentially

⁵ See, e.g., 24-A Me. Rev. Stat. § 211; Mass. G.L. c. 175, § 3A; Wash. Rev. Code §§ 48.01.020, 48.02.060.

opposing” the Rehabilitator’s Application for Approval of the Plan. Joint Application at 14; Washington Joinder at 8 (SIR App. 547, 562).⁶ The Court granted that intervention without qualification (SIR App. 568, 569).

The Court’s erroneous reliance on standing serves to prevent this Court’s scrutiny of the impact of the Plan on policyholders. It avoids discussion of the undisputed facts that (1) in a present liquidation the guaranty associations would provide over \$800 million in support of policy benefits, so that the burden of SHIP’s insolvency on its very elderly policyholders would be about \$400 million, while under the Plan those policyholders will bear the full \$1.2 billion deficit; and (2) the policyholder elections under the Plan are permanent so that policyholder recoveries from guaranty associations in the future liquidation will be limited to the reduced benefits instead of the benefits under the original policies.

These core issues should have been addressed squarely given the Court’s supervisory role. This is not private party litigation but a proceeding pursuant to statute for rehabilitation of an insurer with a Plan that will affect the rights of thousands of policyholders across the country. “[T]o warrant the Commonwealth Court’s imprimatur,” a rehabilitation plan must be found to be free from any abuse of the Rehabilitator’s discretion. *Mutual Fire II*, 614 A.2d at 1091. This means

⁶ The applications sought “limited” intervention because the State Insurance Regulators did not seek to intervene in the rehabilitation proceeding generally but only as to the application for approval of the proposed plan of rehabilitation.

that the Plan must not violate statutory or constitutional requirements. If, as the State Insurance Regulators contend, the Plan is based on an error of law, it constitutes an abuse of that discretion. *See Taylor*, 230 A.3d at 1072; *Bedford Downs Mgt. Corp. v. State Harness Racing Com’n*, 926 A.2d 908, 916 (Pa. 2007). The issues raised by the State Insurance Regulators in their official capacities were properly before the Court, worthy of consideration, and are now ripe for appellate review.

A. The Court Erred In Holding That There Is No Feasibility Requirement And That The Plan Was Feasible In The Absence of Evidence It Is Likely To Restore SHIP To Solvency.

The goal of the Plan as originally presented to the Court was to restore SHIP to solvency – “to restore SHIP to a financially self-sustaining long-term care insurance company.” Rehabilitator’s Application for Approval of the Plan of Rehabilitation ¶ 2 (April 22, 2020) (SIR App. 22-23). At the hearing, however, the Special Deputy Rehabilitator conceded that “it is not likely that we will magically restore SHIP to solvency.” Tr. 80 (SIR App. 237). The Court seemed to acknowledge this (Op. 14, 24-25), but it later said that the Plan “will reduce or eliminate” the funding gap (Op. 78) as if elimination were a reasonable possibility. The Special Deputy Rehabilitator made clear it was not. He testified that: “In all likelihood [the Plan] will not eliminate [the deficit]. In all likelihood, it will just reduce it materially.” Tr. 190 (SIR App. 267). Further:

Q. . . . Yesterday you testified that it was unlikely, I think highly unlikely, that the plan could eliminate the funding gap. Did you mean Phase One or did you mean Phase One and Phase Two?

A. I meant Phase One and Phase Two. . . .

Tr. 306 (SIR App. 284). As the Court implicitly acknowledged, the most that can be said is that the Plan will “materially reduce” the funding gap. *See* Op. 66-67.⁷ That the Plan may be intended or designed to eliminate the funding gap is irrelevant. Where the Plan is expected only to materially reduce the funding gap, it is not feasible, as SHIP will still need to be liquidated.

The Court held that feasibility is not required, and that it is sufficient if the Plan reduces the funding gap because it also pursues other goals. This was error.

1. A Rehabilitation Plan Must Be Feasible.

To be approved, a rehabilitation plan for an insolvent insurer must be reasonably likely to restore the insurer to solvency. This commonsense requirement reflects the fact that if the insurer continues to be insolvent after the plan, it will still need to be liquidated. It is not enough that the “ultimate goal” of a plan is to restore the company to solvency if the plan is not actually likely to do so.

⁷ The Court asserted that the State Insurance Regulators did not offer evidence on this point (Stay Op. at 5), suggesting they were obligated to present a witness. That is incorrect. The Special Deputy Rehabilitator testified on direct examination and the State Insurance Regulators elicited clarifying testimony on cross as described above. The record is clear that the Plan is not expected to restore SHIP to solvency.

Feasibility is a well-recognized requirement. *See 1 Couch on Ins. 3d* § 5:24 (2021) (“Above all, the rehabilitation plan must be feasible . . .”). Contrary to the Opinion (Op. 65), feasibility has been recognized as a requirement in Pennsylvania. *See Sheppard v. Old Heritage Mut. Ins. Co.*, 425 A.2d 304, 310 (Pa. 1980) (“It is clear that [the company] has the burden of showing that rehabilitation is feasible.”) (citing *Comm. Ins. Dep’t v. Safeguard Ins. Co.*, 336 A.2d 674, 680 (Pa. Commw. 1975)). In *Mutual Fire II*, the Supreme Court detailed the history of the rehabilitator’s and trial court’s consideration of feasibility. 614 A.2d at 1090. While feasibility was not an issue on appeal, the discussion shows that a rehabilitation plan that is not feasible should not be approved. *See also Grode v. Mutual Fire, Marine & Inland Ins. Co.*, 688 A.2d 233, 234 (Pa. Commw. 1996) (noting that court had required the rehabilitator to report on feasibility and that the initial plan did not proceed because it was not feasible). The feasibility requirement also rests on the statutory standard for conversion to a liquidation. Tr. 90 (SIR App. 241). Where rehabilitation is “futile,” it should not proceed. *See* 40 P.S. § 221.18.

Feasibility is particularly important here because the Plan is expressly intended to permanently reduce policyholders’ benefits and increase their premiums. Ex. RP-55 at 14, 92 (SIR App. 41, 119). If SHIP is liquidated after the

Plan is implemented, the guaranty associations and liquidation estate will only cover contractual obligations as reduced under the Plan.

2. The Court’s Redefinition of Feasibility is Unlikely to be Upheld.

The Court refashioned feasibility, holding that it means “properly conserving and equitably administering the assets of the involved insurer.” Op. 66. This deprives feasibility of any meaning. The quoted language from *Mutual Fire II* did not describe the purpose of rehabilitation but only that a plan need not restore the insurer “to its exact original condition.” 614 A.2d at 1094.

“The goal of rehabilitation is to manage the affairs of an insolvent insurer with the intended result of restoring the entity to sound fiscal status.” *Mutual Fire II* at 1096 (emphasis added). See *Kueckelhan v. Fed. Old Line Ins. Co.*, 444 P.2d 667, 674 (Wash. 1968) (*en banc*) (rehabilitation aims to “restore the company to a viable status for the benefit of the policyholders”). The Plan’s feasibility must be measured against the goal of restoring SHIP to solvency.⁸

Where the insurer is insolvent, measuring feasibility against goals other than financial viability is improper. Whatever the merits of the other goals, liquidation will follow if the insurer remains insolvent. Rehabilitation must be reasonably

⁸ The State Insurance Regulators have not contended that feasibility requires SHIP to resume operation as an insurer writing insurance in the market, only that the Plan (assuming it were otherwise proper) must be reasonably likely to restore SHIP to solvency so that it can run off its obligations paying them in accordance with the options selected pursuant to the Plan.

likely to avoid liquidation, and not just serve as a means to reduce policyholders' contract rights on the way to liquidation.

B. The Plan Is Contrary To Law By Disregarding The Financial Interest Of Policyholders And The Guaranty Association System.

The Court's approval of the Plan is an unprecedented departure from the fundamental goal of insurer rehabilitations – to protect to the maximum extent possible the contractual rights of policyholders. Instead of seeking to protect those contract rights, the Court approved reductions in those rights on the theory that the policies were historically “underpriced.” Op. 43, 51, 63-64. The Court explicitly rejected triggering the insurance guaranty associations established to protect policyholders' contract rights because that would impose a burden on the association's insurer members and, ultimately, taxpayers. Op. 45, 63, 81. The Court also relied on its view that the state-based rate approval system resulted in “discriminatory” rates contrary to the public good. Op. 45, 68-69, 80-81.

The Court's approval of the Plan on these policy grounds is contrary to the purpose of the rehabilitation statute to protect policyholders to the maximum extent possible and frustrates the legislative judgment that the policyholders of insolvent insurers warrant guaranty association coverage. “[T]he power of courts to formulate pronouncements of public policy is sharply restricted. . . . Generally speaking, the Legislature is the body to declare the public policy of a state and to

ordain changes therein.” *Conway v. Cutler Grp., Inc.*, 99 A.3d 67, 72 (Pa. 2014) (quoting *Mamlin v. Genoe (City of Phila. Police Beneficiary Ass’n)*, 17 A.2d 407, 409 (Pa. 1941)). Contrary to the Court’s assertion that this is a question of discretion (Stay Op. 6), it is a matter of law. The Court improperly disregarded the statutory mandates to advance its policy views at the expense of policyholders.

1. The Plan Is Adverse to the Best Financial Interest of Policyholders.

SHIP is massively insolvent, with a deficit of \$1.2 billion. Accordingly, it could be placed in liquidation on grounds of insolvency, *see* 40 P.S. § 221.19, § 221.14(1), which would trigger guaranty association coverage. The undisputed evidence, based on the Rehabilitator’s own Comparison File, is that in a liquidation the guaranty associations would provide over \$800 million in additional support, so that in liquidation the policyholders would bear a loss of only \$397 million from SHIP’s insolvency. Ex. SIR-5-1; Tr. 564-566 (SIR App. 224; 309-310). While the Court acknowledged this (Op. 31-32), its decision disregards this undisputed adverse financial impact on policyholders.

Under the Plan, the entire \$1.2 billion burden of SHIP’s insolvency rests on SHIP’s 30,000 remaining non-NFO policyholders through benefit cuts and premium increases. The benefits foregone under the Plan will be given up permanently, and they cannot form the basis for a claim to guaranty association benefits or a liquidation dividend in any subsequent liquidation. In a present

liquidation, by contrast, the policyholders stand to receive the benefit of guaranty association coverage based on their original policies plus potentially a liquidation dividend on the excess.

The Rehabilitator and Court thus chose to place the entire burden of the insolvency on the remaining policyholders and to forgo over \$800 million in guaranty association support that in a liquidation would fill much of the funding gap, spread the loss, and reduce the burden of insolvency on policyholders.

**2. Intentionally Placing the Burden of Insolvency
Solely on Policyholders is Contrary to the
Purpose of the Rehabilitation Statute.**

This disregards the fundamental purpose of the rehabilitation statute – to protect policyholders by preserving their contract rights to the maximum extent possible. A rehabilitator’s “first duty [is] to the ‘grave and important public interest’ in not depriving the . . . policyholders of the protection of their policies.” *In re Exec. Life Ins. Co.*, 38 Cal. Rptr. 2d 453, 465 (Cal. Ct. App. 1995) (emphasis added) (quoting *Carpenter v. Pacific Mut. Life Ins. Co. of Cal.*, 74 P.2d 761, 775 (Cal. 1937) (“*Carpenter*”), *aff’d sub nom. Neblett v. Carpenter*, 305 U.S. 297 (1938) (brackets omitted)). The goal of rehabilitation is not just to restore the company to solvency, but to do so in a way that benefits policyholders. *See Kueckelhan*, 444 P.2d at 674 (rehabilitation aims to “restore the company to a viable status for the benefit of the policyholders”) (emphasis added). A

rehabilitation plan must minimize harm to policyholders, as the statutes aim to protect them. *See* 40 P.S. § 221.16.

To support its efforts to “correct” historical underpricing and rates and avoid burdening those who fund the guaranty associations, the Court relied on general statements in *Mutual Fire II* that rehabilitation is intended to protect “the public good.” *See* Op. 42-44 (quoting *Mutual Fire II*, 614 A.2d at 1094 & n. 4). *See* 40 P.S. § 221.1. Those generalized statements, however, do not address the question here: whether a plan can advantage other persons to the detriment of policyholders. That issue was not presented in *Mutual Fire II*. Indeed, the Supreme Court recognized the primacy of policyholder interests elsewhere in that decision. *See Mutual Fire II*, 614 A.2d at 1100 (“If, after all, insurance is to perform its function of risk assumption and distribution of loss, then those statutes which govern it must first protect the insuring public.”) (quoting *Grode v. Mutual Fire, Marine and Inland Ins. Co.*, 572 A.2d 798, 807 (Pa. Commw. 1990) (“*Mutual Fire I*”) (emphasis added); *id.* at 1102 (referring to “the ultimate goal of this process, the overall good of the general public and the insurer’s policyholders”) (emphasis added); *id.* at 1104 (referring to “the statutorily charged duty of the Rehabilitator to protect the interests of Mutual Fire insureds”) (emphasis added). The Supreme Court’s initial, general statements do not provide the Rehabilitator with a roving

commission to adjust contract rights and refuse guaranty association support as she chooses.

The rehabilitation statute is limited. It provides for a rehabilitator to “correct” the conditions that constituted the ground for the rehabilitation order (here, insolvency), not to require the policyholders to exclusively bear the consequences. 40 P.S. § 221.16(b), (d). A rehabilitator is to honor policies to the extent possible and treat policyholders equally. *See* 40 P.S. § 221.15(d) (rehabilitation order “shall not constitute an anticipatory breach of any contracts of the insurer”); 40 P.S. § 221.44 (preferring policy obligations by giving them priority and prohibiting subclasses within a priority class). The statutes do not contemplate that a rehabilitator will decide that policyholders have been “underpaying” for “Cadillac” policies and should have their benefits cut. Tr. 78, 102 (SIR App. 235, 242). This may leave SHIP as an entity in “better shape” (Op. 25), but its policyholders are worse off. A plan that only attempts to materially reduce the size of the insolvency at the sole expense of policyholders, but still leaves the company insolvent, is not a proper rehabilitation plan.

3. The Court Improperly Rejected Guaranty Association Protection for Policyholders.

The Court approved the Plan because, in its view, SHIP’s policyholders should have paid more for their coverage so that it is “unjustified” to seek to trigger the guaranty associations because that would burden others through the

assessment mechanism. Op. 43, 45, 63, 81. This rationale is legally erroneous. The Court's view that it "serves the public good" (Op. 43) to avoid triggering guaranty associations is contrary to the very purpose of having such associations. The legislatures in Pennsylvania and other states have chosen to protect policyholders of insolvent insurers by establishing guaranty associations to provide coverage (subject to certain limits), and they have chosen how to spread the burden of those protections through the assessment mechanism. It is not within the Rehabilitator's or Court's discretion to reject these statutory protections because they deem the policyholders unworthy of guaranty association support. *See Weaver v. Harpster*, 975 A.2d 555, 563 (Pa. 2009) ("[I]t is for the legislature to formulate the public policies of the Commonwealth.")

Guaranty associations have been established around the country to protect policyholders by fulfilling the insolvent insurer's contractual obligations (subject to statutory limits). For instance, the Pennsylvania guaranty association statute provides:

The purpose of this article is to protect, subject to certain limitations, [policyholders] against failure in the performance of contractual obligations, under life, health and annuity policies, plans or contracts . . . because of the impairment or insolvency of the member insurer that issued the policies, plans or contracts.

40 P.S. § 991.1701. *See Pennsylvania Life and Health Ins. Guar. Assn. v.*

Pennsylvania Ins. Dept., 218 A.3d 9, 14 (Pa. Commw. Ct. 2019); *cf. Illinois Ins.*

Guar. Fund v. Reliance Ins. Co. in Liquidation, 88 A.3d 313, 317 (Pa. Commw. Ct. 2014) (referring to “the primary policy objective of the [property/casualty guaranty association] Act to protect innocent policyholders whose insurance carriers have become insolvent”). The statutes do not limit guaranty association coverage based upon the insufficiency of premiums that the policyholders paid in the past. They seek to honor the insurer’s contractual obligations, subject to specific limits. *E.g.*, 40 P.S. § 991.1703, § 991.1706(b).

The legislatures also chose how to allocate the burden of honoring the insurer’s contractual obligations. The guaranty association statutes generally fund the associations through assessments on member insurers. *See, e.g.*, 40 P.S. § 991.1707. They typically permit the member insurers to offset the assessments against their premium tax obligations or to recoup assessments by a surcharge on premiums. *See, e.g.*, 40 P.S. § 991.1711. The legislatures chose to spread the burden of an insurer’s insolvency broadly, including on taxpayers, not to focus it exclusively on the insurer’s policyholders.

The Court improperly overrode these legislative judgments.

C. The Court Misapplied *Neblett v. Carpenter*.

The State Insurance Regulators also have substantial arguments that the Plan fails to satisfy the requirement of *Neblett v. Carpenter*, 305 U.S. 297 (1938), that the Plan must place policyholders in no worse off a position than they would

face in a liquidation of SHIP. Contrary to the Court’s opinion (Op. 62-64), this fundamental standard was recognized by the Supreme Court in *Mutual Fire II*, 614 A.2d at 1093-94 (“Under *Neblett*, creditors must fare at least as well under a rehabilitation plan as they would under a liquidation . . .”), at 1096 (plan provision “ensures that the creditors herein, at a minimum, will fare at least as well under the rehabilitation as they would in a liquidation proceeding as mandated by the holding of *Neblett*”), and at 1096 n. 6 (noting “the fundamental right of the creditors to be treated, at a minimum, as well under the rehabilitation as they would in a liquidation”).⁹

Under this standard, the Plan must provide policyholders with an option that provides at least the value of the policyholder’s policy in liquidation. *See Neblett*, 305 U.S. at 305 (policyholders were not forced to accept policy modifications “but are given the option of a liquidation which on this record appears as favorable to them as that which would result from the sale of the assets and pro rata distribution in solution of all resulting claims for breach of outstanding policies.”). The

⁹ The Commonwealth Court previously shared this understanding of *Neblett*. In the decision leading to *Mutual Fire II*, the Commonwealth Court said “[T]he Rehabilitator agrees that *Neblett* requires claimants be treated the same or better than in liquidation. We shall not belabor this point except to agree with the parties that the Plan must also be viewed in the light of this principle.” *Mutual Fire I*, 572 A.2d at 804. *See also Koken v. Fidelity Mut. Life Ins. Co.*, 907 A.2d 1149, 1155 (Pa. Commw. Ct. 2006) (“Under the Plan, [creditors] have received or will receive at least as much as they would receive in a forced liquidation, as is required if a rehabilitation plan is to be deemed fair and equitable,” citing *Mutual Fire II*).

Supreme Court in *Mutual Fire II* did not replace the *Neblett* standard with the three-part test of *Energy Reserves Grp., Inc. v. Kansas Power and Light*, 459 U.S. 400 (1983). It treated them as two separate issues.

Neblett established a floor of liquidation value that each policyholder should be able to obtain if desired. It is undisputed that the Plan fails to provide every policyholder with such an option based on the “Carpenter value” of net present value (present value of benefits less present value of premiums). Based on the Rehabilitator’s own Comparison File, only 85% of policyholders have such an option in Phase One. Op. 65. Moreover, this percentage falls sharply if Phase Two is considered. The Court cited evidence showing that the 85% figure principally reflects the availability of Option 4 in Phase One, that Option 4 is subject to benefit reductions and premium increases in Phase Two, and that premium increases alone can bring the percentage of policyholders with net present value in excess of liquidation value below 50%. Op. 31-32. However, the Court did not address the significance of these points.

The Court instead rejected the net present value “Carpenter value” relied on by the State Insurance Regulators (and, initially, by the Rehabilitator) in favor of the Rehabilitator’s new “maximum policy value” approach. Op. 65. This does not comport with *Neblett*. The United States Supreme Court there set the constitutional floor as the value that would result “from the sale of the assets and

pro rata distribution in solution of all resulting claims for breach of outstanding policies.” *Neblett*, 305 U.S. at 305. That is the expected value of a policyholder’s claim at the time of the breach, which is the policy’s net present value, not its policy limit. As stated in a leading treatise:

The measure of damages adopted must be that which will, as nearly as possible, put the policyholders in as good a financial position as they would have been in if there had been no breach, which has been calculated as the present value of the benefits that would have been payable if there had been no insolvency, less the present value of the gross premiums which would have become payable upon the policies.

1 *Couch on Ins.* 3d § 6:1 (2021) (footnotes omitted) (citing *Commissioner of Ins. v. Massachusetts Acc. Co.*, 50 N.E.2d 801, 808-809 (Mass. 1943)).

The “maximum policy value” of a policy is not the value of a claim for breach of the policy. It is just the maximum amount that a policy could pay. *See* Ex. RP-55 at 126 (defining “Maximum Policy Value” as the Maximum Daily Benefit times the Maximum Benefit Period) (SIR App. 153). It is an “outer boundary” (Tr. 468) (SIR App. 293) that does not consider the likely amount (projected value) of a claim or the cost (projected premiums) of the policy. RP-55 at 126 (SIR App. 153). Maximum policy value is not an economic value, and it is not a proper measure for the constitutional standard under *Neblett*.

**D. The Court Erred In Overriding The States’
Regulatory Authority Over Rates.**

The State Insurance Regulators also have strong grounds to contend that the Court’s approval of the Plan should be overturned because the Plan’s rate provisions exceed the Rehabilitator’s authority under the Pennsylvania statutes and violate the Full Faith & Credit Clause. Rate regulation has long been committed to the individual States. *See 1 Couch on Ins. 3d* § 2:31 (2021); *German All. Ins. Co. v. Lewis*, 233 U.S. 389 (1914); *Ins. Dep’t v. City of Phila.*, 173 A.2d 811, 813 (Pa. Super. Ct. 1961). The states regulate rates for long-term care insurance by providing for review by the insurance regulator of the State in which the policyholder resided when the policy was issued and judicial review in the courts of that State. *See, e.g.*, 24-A Me. Rev. Stat. § 2736; Mass. Gen. Laws ch. 175, § 108; Wash. Rev. Code § 48.19.010(2), §§ 48.83, 48.84, § 48.18.110. The Court improperly overrode these statutes.¹⁰

This presents an important question of first impression. The Rehabilitator acknowledges that this aspect of the Plan is “unprecedented,” Tr. 82 (SIR App. 239), and the State Insurance Regulators are not aware of any plan of rehabilitation that has purported to supersede state regulation and set rates payable by

¹⁰ Contrary to the Court’s assertion (Stay Op. at 7), the statutory basis for state rate regulation was cited in the State Insurance Regulators’ Application at 23 (SIR App. 336).

policyholders in other states without review and approval by the insurance regulators of those states.

1. The Rehabilitation Statute Does Not Authorize Displacement of State Regulatory Authority.

The Court's expansive view of the Rehabilitator's powers (Op. 49-50) is not consistent with the statutory language. "A creature of statute, such as the Insurance Commissioner acting as rehabilitator, can only exercise those powers which have been conferred by the Legislature in clear and unmistakable language." *Koken v. Legion Ins. Co.*, 831 A.2d 1196, 1227 (Pa. Commw. Ct. 2003). The statutes do not authorize the Rehabilitator and Court to impose rates in disregard of the long-standing state-based system for review and approval of insurance rates. The rehabilitation statutes provide the Rehabilitator with control over assets and the business of the insurer. They do not oust state regulation of the insurer.

An order to rehabilitate an insurer "shall appoint the commissioner . . . rehabilitator and shall direct the rehabilitator forthwith to take possession of the assets of the insurer . . . and to administer them under the orders of the court." 40 P.S. § 221.15(c). Subject to court approval, a rehabilitator "may take such action as he deems necessary or expedient to correct the condition or conditions which constituted the grounds for the order of the court to rehabilitate the insurer." 40 P.S. § 221.16(b). Nothing in this language provides the rehabilitator with authority beyond the insurer itself. Its limited scope is confirmed by the sentences that

follow, which specify that the rehabilitator “shall have all the powers of the directors, officers and managers” and “full power to direct and manage, to hire and discharge employees subject to any contract rights they may have, and to deal with the property and business of the insurer.” *Id.* (emphasis added). The statutes authorize the Rehabilitator to manage SHIP. *See Koken*, 831 A.2d at 1227-1228. They do not authorize her to disregard State regulation.¹¹

Nor does the provision for rehabilitation plans exempt insurers in rehabilitation from State regulation. A rehabilitator may “prepare a plan for the reorganization, consolidation, conversion, reinsurance, merger or other transformation of the insurer.” 40 P.S. § 221.16(d). This does not authorize a rehabilitator to change contracts and rates without required regulatory approvals. Nothing in the text allows the Rehabilitator or Court to supplant otherwise applicable regulatory authority over the business of the insurer in other States.

A domiciliary state has an interest in rehabilitation, but it is not “overriding” (Op. 52). The rehabilitation statutes recognize that a rehabilitator must seek relief from courts in other jurisdictions as to litigation in other states. 40 P.S. § 221.5(b) (“The receiver may apply to any court outside of the Commonwealth for the relief

¹¹ The language describing Article V’s purpose further demonstrates the intent to authorize displacement of private, not public actors: “The purpose of this article is the protection of the interests of insureds, creditors, and the public generally, with minimum interference with the normal prerogatives of the owners and managers of insurers” 40 P.S. § 221.1(c) (emphasis added). *See also* 40 P.S. § 221.6 (requiring cooperation by officers and employees).

described in subsection (a) or suspension of any insurance licenses issued by the commissioner.”); 40 P.S. § 221.17(a). Article V also specifies that it “shall not be interpreted to limit the powers granted the commissioner by other provisions of the law.” 40 P.S. § 221.1(a). Where the Article expressly does not limit the Pennsylvania Commissioner’s regulatory authority, it cannot reasonably be interpreted to limit the regulatory authority of other States.

The purpose of rehabilitation is “to rehabilitate the business of an insurer,” 40 P.S. § 221.15(b), not to supersede regulation of the insurer. *Cf. Koken v. Fidelity Mut. Life Ins. Co.*, 803 A.2d 807, 826-827 (Pa. Commw. 2002). (rehabilitation plan provided that “FLIC obtain all necessary regulatory approvals to do business in the respective states”). The Plan’s displacement of other states’ regulatory authority exceeds statutory authority and is likely to be reversed.

2. The Full Faith & Credit Clause Protects Other States’ Regulation Over Rates.

Finally, the State Insurance Regulators have compelling arguments that the Court’s ruling concerning the Full Faith and Credit Clause is erroneous. The clause “was to alter the status of the several states as independent foreign sovereignties, each free to ignore obligations created under the laws or by the judicial proceedings of the others.” *Baker ex rel. Thomas v. General Motors Corp.*, 522 U.S. 222, 232 (1998) (quoting *Milwaukee Cnty. v. M.E. White Co.*, 296

U.S. 268, 277 (1935)). The Court’s view that it can set rates in other states and supersede their statutes requiring review by their officials violates this command.

Insurance rates are a matter of particularly local concern and regulation, and the States have placed responsibility for rates on their own insurance officials. *See* page 31 above. The cases cited by the Court do not support extraterritorial jurisdiction to set rates in other states. The Plan works more than a “change[] in forum” (Op. 58), and the Court’s assertion that the rate setting statutes are all essentially alike (Opp. 57) ignores the evidence that rates have historically varied across states, and that state rate setting practices differ. *See* Ex. RP-55 at 88; Tr. 413-414 (SIR App. 115; 290-291). *See* Op. 14, 28. A Pennsylvania court cannot dictate to other States what rates are to be applied to policies issued in those States, nor can it require that they “surrender[]” (Tr. 169) (SIR App. 257) their authority and substitute itself (or the Pennsylvania Commissioner) for the officials designated to review rates.

The Court’s decision reflects hostility to state-based rate setting and the different rates that may result from it. *See* Op. 14-15 (describing rate structure resulting from different responses of state regulators to SHIP’s requested rate increases as “discriminatory” and “inequitable”), 43, 60, 80. Indeed, the Court states an intent to use the Full Faith and Credit Clause as a sword to compel other states to respect its judgment to disregard their statutes and arrogate to itself the

power to set rates. Op. 61-62. It thus seeks to “require a State to substitute for its own statute, applicable to persons and events within it, the statute of another State reflecting a conflicting and opposed policy.” *See Franchise Tax Bd. Of Cal. v. Hyatt*, 136 S. Ct. 1277, 1281 (2016) (quoting *Carroll v. Lanza*, 349 U.S. 408, 412 (1955)).

The Court also erred in holding that the Plan’s “issue state rate approval” section cured the constitutional violation by allowing state insurance regulators to “opt-out” of the Plan’s rate-setting mechanism. That provision does not allow state regulators to apply their statutes and meaningfully review rates. The undisputed evidence is that it imposes requirements as to timing and methodology for the various states to follow, and penalties if they do not. Ex. RP-55 at 111; Tr. 410-414 (SIR App. 138; 287-291). It requires that “opt-out” states approve the Rehabilitator’s seriatim rate application in full within 60 days, absent which their policyholders will face different options from policyholders in other states. The Court downplays the differences by allowing only that the options under the provision “are not exactly the same” (Op. 58). This disregards the evidence. The Plan itself acknowledges that the options are likely to be worse, Ex. RP-55 at 109 (SIR App. 136), and the Special Deputy Rehabilitator testified that “[i]n terms of policyholders, we think that [states opting out] will be harmful.” Tr. 170 (SIR

App. 258).¹² Indeed, the Rehabilitator has recently advised regulators that in her view opting out “may not be in the best interest of the affected policyholders.” *See* Rehabilitator’s Letter to Commissioners dated August 26, 2021 at 1 (SIR App. 20). *See also* Special Deputy Rehabilitator’s Letter to Commissioners dated September 30, 2021 at 6 (Q1), 7-8 (Q8, Q9) (SIR App. 14, 15-16).

This is coercive. The Plan seeks to present the appearance of deference to State rate review while in fact requiring the States to approve the Rehabilitator’s rates, in full, on pain of punishing policyholders in the State.

II. ABSENT A STAY, REGULATORS AND POLICYHOLDERS WILL SUFFER IRREPARABLE INJURY.

The Rehabilitator is moving to implement the Plan. *See* Notice of Filing of Approved Plan, Ex. A at 19; Special Deputy Rehabilitator’s September 30 Letter (SIR App. 7; 9). This is likely to irreparably harm both policyholders and regulators because they will be forced to make decisions that may not be reversible even if the Court’s decision is reversed. (The Court’s narrow focus on the State Insurance Regulators, *see* Stay Op. 8, allowed it to avoid addressing the impact of the Plan and the denial of a stay on policyholders. This is anomalous.

¹² The Court asserts that the State Insurance Regulators did not offer evidence concerning the “opt out” provision (Stay Op. 8), implicitly suggesting that the State Insurance Regulators were obligated to call a witness. That is incorrect. As discussed above, the Plan and the testimony (direct and cross) of the Rehabilitator’s witnesses provides all the necessary evidentiary record for the State Insurance Regulators’ position.

Policyholders should be the central consideration in rehabilitation plan proceedings.)

First, most imminently, state insurance regulators face the November 15, 2021 “opt-out” deadline. By that date, the State Insurance Regulators and other regulators across the country will be required to decide whether or not to “opt-out” of the Plan’s rate approval provision. A regulator can only “opt-out” before the opt-out deadline; otherwise he or she is deemed to have “opted” into the Plan. Ex. RP-55 at 109-110 (SIR App. 136-137).

This requires insurance regulators to decide whether to nominally retain the appearance of rate review under their states’ laws at the expense of policyholders in the State. As noted above, if an “opt-out” regulator does anything other than approve the Rehabilitator’s rate proposal in full within 60 days (*see* Ex. RP-55 at 111) (SIR App. 138), the policyholders in the State will be disadvantaged by being left with options that are worse than those available in other states. This is spelled out in the Plan (Ex. RP-55 at 109) (SIR App. 136) and in the Frequently Asked Questions attachment to the Special Deputy Rehabilitator’s September 30, 2021 Letter at 6, 7-8 (SIR App. 14, 15-16).¹³

¹³ FAQ Responses “Q1” and “Q8” note that “opt-out policyholders” in opt-out states will not have the same options as “opt-in policyholders” in that three options will not be available to them. Response “Q1” notes that in certain circumstances, opt-out policyholders may end up paying a higher premium than they would if the state had not opted out. Response “Q9” states

The Plan thus requires insurance regulators to act on behalf of the policyholders whose policies were issued in their states. It positions regulators to either acquiesce in the Rehabilitator's and Court's usurpation of their role in reviewing rates or to approve the rates in full within sixty days on pain of placing policyholders in their states in a worse position than policyholders in other states.

Second, starting around year-end 2021 and through March 2022, SHIP's policyholders will be required to select options under the Plan that will permanently reduce their contract benefits. *See* Ex. RP-55 at 14, 92 (SIR App. 41, 119). This reduces their rights not only against SHIP but also against guaranty associations. As stated in the Plan:

Policyholder Elections under the Plan will be permanent. This means that if the Plan does not succeed in rehabilitating SHIP fully and the Company has to be placed in liquidation, the policies to which guaranty association coverage and limits . . . will apply will be those as modified as a result of the Policyholder Elections.

Ex. RP-55 at 14 (SIR App. 41). Options 1 through 3 under the Plan reduce policy benefits, so policyholders who elect those options will be placed in a worse position in the event SHIP is liquidated after Phase One. As discussed above in connection with feasibility, it appears that liquidation is inevitable.

that opting out “is generally expected to be disadvantageous to affected policyholders.” (Emphasis added).

The Rehabilitator has contended that the \$800 million in guaranty association support will still be available if SHIP is liquidated after the Plan is implemented. This is erroneous. The \$800 million in guaranty association support is calculated based on the existing SHIP policy obligations. If those obligations are reduced by policyholders selecting options under the Plan, then the contribution of guaranty associations in a liquidation will also be reduced. Policyholder elections that reduce policyholders' contract benefits reduce their rights as against SHIP and also against guaranty associations in the liquidation that will inevitably follow, potentially by hundreds of millions of dollars.

Thus, absent a stay, the Plan will impair the contract rights of the affected policyholders and require regulators to take steps that may be detrimental to policyholders in their states. The required elections and "opt-outs" under the Plan will fix contractual rights, and they are intended to be permanent. They will be "effective" sometime around April 2022, at which point the policyholders will begin receiving reduced benefits and paying revised premiums in accordance with the Plan. *See* Notice of Approved Plan, Ex. A at 19 (SIR App. 7).

These steps could potentially be undone by deeming the policyholder elections and regulator opt-outs nullities in the event the Court's approval is reversed. However, it will be administratively difficult and confusing to the

policyholders and regulators to undo those steps. A stay preserving the *status quo* would prevent such problems.

The Rehabilitator contended, with respect to state rate approval, that the harm to the State Insurance Regulators is reparable if the Plan is reversed. Rehabilitator's Opposition at 31. The Court agreed. Stay Op. 8. However, neither the Rehabilitator nor the Court clearly contended that the harm to policyholders is reparable. The State Insurance Regulators expressed concern that the Rehabilitator may later contend that the Plan has been "substantially consummated" so that the appeal should be dismissed under the doctrine of equitable mootness. *See, e.g., In re Tribune Media Co.*, 799 F.3d 272, 277 (3d Cir. 2015). The Rehabilitator responded by carefully noting that the doctrine rests on equitable considerations and expressly taking "no position" on its potential applicability. Rehabilitator's Opposition at 31-32. The Court also declined to express any view on potential equitable mootness. Stay Op. 9, n.7.

The State Insurance Regulators believe that the equitable mootness doctrine should not apply. There is a "strong presumption that appeals from confirmation orders of reorganization plans . . . need to be decided," *Tribune Media*, 799 F.3d at 278. Further, "third parties with interests protected by equitable mootness generally rely on the emergence of a reorganized entity from court supervision," *Id.* at 280, and that will not happen here for a long time if ever, as the

implementation of the Plan is subject to the continuing jurisdiction of the Court. However, given the significant contractual interests at stake for the policyholders and the important regulatory interests at stake for the regulators, the possibility that review could be denied if the Plan goes forward warrants a stay.

III. ISSUANCE OF A STAY WILL NOT HARM OTHER INTERESTED PERSONS.

Issuance of a stay pending appeal will not harm other interested persons. It will preserve the *status quo*. SHIP's policyholders have paid the lawfully approved rates for their coverage, and they will continue to do so. Policyholders who are on claim will continue to receive claim payments as they have during the pendency of the Rehabilitator's application for approval of the Plan. The intervenor agents and brokers have settled. The intervenor health insurers will not need to pay guaranty association assessments.

The Rehabilitator contended that SHIP's insolvency will increase during the appeal, and that this will reduce amounts that can be paid to policyholders. The Court agreed. Stay Op. 9-10. However, this reflects the intended working of the Plan, which places the entire burden of SHIP's insolvency on policyholders through benefits cuts and premium increases and specifically avoids triggering guaranty associations. *See* Op. 45, 63. The State Insurance Regulators' appeal, by contrast, seeks to protect policyholders by triggering guaranty associations.

The Court responded to this by citing an abstract preference for rehabilitation. *See* Stay Op. 10. But that fails to address the concrete harm from the Plan, which places the burden of insolvency on the policyholders. By contrast, if the State Insurance Regulators are correct and guaranty associations must be triggered, then an additional \$800 million in support for policyholders will be available. *See* Op. 31-32. The balance of a somewhat deeper insolvency against the benefit of reversal weighs in favor of a stay. Under the Plan, the policyholders will bear the full existing \$1.2 billion deficit, while a successful appeal will bring \$800 million in guaranty association support and reduce the burden of insolvency on policyholders to approximately \$400 million.

IV. ISSUANCE OF A STAY WILL NOT HARM THE PUBLIC INTEREST.

Nor will a stay adversely affect the public interest. The State Insurance Regulators pursue this appeal to protect the financial interests of policyholders that are intended to be protected by the rehabilitation statutes and the guaranty association system, and also the interests of regulators in their statutory role in reviewing the rates charged for policies issued in their states.

The Rehabilitator contends that delaying benefit cuts and premium increases under the Plan will increase SHIP's insolvency and thus the burden on the guaranty associations, their member insurers and, in many States, on taxpayers when SHIP is liquidated. That is not cognizable "harm" to the public interest. As described

above, the guaranty associations were created specifically to protect policyholders in the event of an insolvency (*see, e.g.*, 40 P.S. § 991.1701) by honoring the insurer's contractual obligations, subject to specific limits. *E.g.*, 40 P.S. § 991.1703, § 991.1706(b). The legislatures determined how to allocate the burden of that protection. *See, e.g.*, 40 P.S. § 991.1707, § 991.1711. Where the legislatures have chosen to provide protection to policyholders and how to fund that protection, allowing that process to work is not contrary to the public interest. Similarly, the legislatures have chosen to place rate review with their regulatory officials, and protecting that statutory choice and the application of the States' rate approval statutes is not contrary to the public interest.

CONCLUSION

For the above reasons, the State Insurance Regulators request that the Supreme Court issue an order staying the trial court's Orders approving the Plan pending appeal.

November 8, 2021

Respectfully submitted,

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/s/ Stephen G. Harvey

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**IN THE
SUPREME COURT OF PENNSYLVANIA**

**IN RE: SENIOR HEALTH :
INSURANCE COMPANY OF :
PENNSYLVANIA (IN : No. 71 MAP 2021
REHABILITATION)**

**APPEAL OF: THE SUPERINTENDENT OF
INSURANCE OF THE STATE OF MAINE,
THE COMMISSIONER OF INSURANCE OF
THE COMMONWEALTH OF
MASSACHUSETTS, AND THE INSURANCE
COMMISSIONER OF THE STATE OF
WASHINGTON**

**STATE INSURANCE REGULATORS' APPENDIX
REGARDING APPLICATION FOR STAY PENDING APPEAL
INCLUDING BRIEFS USED IN THE TRIAL COURT**

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No.	Material Cited in SIR Application for Stay Pending Appeal	SIR App. Page
1	Notice of Filing of Approved Plan of Rehabilitation (September 24, 2021) with page 19 from Exhibit A (the Approved Plan as substituted by Praeceptum to Substitute Approved Plan of Rehabilitation (September 30, 2021) and directed by Order dated October 28, 2021)	4
2	Special Deputy Liquidator's Letter to Commissioners dated September 30, 2021 (Exhibit 1 to State Insurance Regulators' Application for Expedited Ruling on Application for Stay (November 2, 2021))	8
3	Rehabilitator's Email to Commissioners dated September 20, 2021 (Exhibit A to State Insurance Regulators' Application for Stay Pending Appeal (October 1, 2021))	19
4	Rehabilitator's Letter to Commissioners dated August 26, 2021 (Exhibit B to State Insurance Regulators' Application for Stay Pending Appeal (October 1, 2021))	20
5	Rehabilitator's Application for Approval of Plan of Rehabilitation (April 22, 2020), without exhibit	22
6	Hearing Ex. RP-55 (the Second Amended Plan of Rehabilitation)	28
7	Hearing Ex. SIR 5-1	224
8	Hearing Ex. SIR 5-2	225
9	Hearing Ex. RP-7	226
10	Excerpts from Transcript of Hearing held May 17-21, 2021	228
11	State Insurance Regulators' Application for Stay Pending Appeal (October 1, 2021) (Exhibits omitted, see above)	314
12	Rehabilitator's Answer and Brief in Opposition to the Intervenor State Insurance Regulators' Application for Stay Pending Appeal (October 15, 2021)	351

13	The Health Insurers' Response to the Intervening Regulators' Application for Stay Pending Appeal (October 15, 2021)	394
14	State Insurance Regulators' Application for Expedited Ruling on Application for Stay Pending Appeal (November 2, 2021)	428
15	Memorandum Opinion and Order Denying State Insurance Regulators' Application for Stay Pending Appeal (November 4, 2021)	433
16	Order Amending Memorandum Opinion Filed August 24, 2021 (November 4, 2021)	445
17	Amended Opinion and Order (November 4, 2021)	446
18	Order Designating Amended Memorandum Opinion as Opinion (November 4, 2021)	533
19	Joint Application for Intervention of the Maine Superintendent of Insurance and the Massachusetts Commissioner of Insurance (July 31, 2020)	534
20	Joinder of the Washington Insurance Commissioner in the Joint Application for Intervention of the Maine Superintendent of Insurance and the Massachusetts Commissioner of Insurance (September 15, 2020)	555
21	Order Granting Application for Intervention of the Maine Superintendent of Insurance and the Massachusetts Commissioner of Insurance (September 15, 2020)	568
22	Order Granting Joinder of the Washington Insurance Commissioner in the Joint Application for Intervention of the Maine Superintendent of Insurance and the Massachusetts Commissioner of Insurance (September 18, 2020)	569
23	Verification of Robert A. Wake (November 5, 2021)	570

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

In Re: Senior Health Insurance : No. 1 SHP 2020
Company of Pennsylvania in :
Rehabilitation :

NOTICE OF FILING OF APPROVED REHABILITATION PLAN

Jessica K. Altman, Insurance Commissioner of the Commonwealth of Pennsylvania, in her capacity as the Statutory Rehabilitator (“Rehabilitator”) of Senior Health Insurance Company of Pennsylvania (“SHIP”), hereby provides notice to all interested parties that she is filing with the Court the Approved Rehabilitation Plan for SHIP (“Approved Plan,” attached hereto as Exhibit A).

The Second Amended Plan filed on May 3, 2021, was approved by this Court’s Memorandum Opinion and Order docketed August 25, 2021. In the September 13, 2021, Memorandum Opinion and Order approving the Settlement Agreement between the Rehabilitator and Intervening Agents and Brokers (the “Settlement Approval Order”), the Court directed the Rehabilitator to file with the Court an amended rehabilitation plan containing the modification approved therein. The Rehabilitator hereby files that amended plan as the Approved Plan. The Approved Plan will be posted to SHIP’s court documents website at <https://www.shipltc.com/court-documents>.

In addition to the amendment required by the Settlement Approval Order, the Approved Plan includes edits made by the Rehabilitator to the Second Amended Plan of Rehabilitation to convert it from a proposed plan to an approved plan and to cure some ambiguities and errors. None of these edits constitutes a material change in the Plan. The Rehabilitator also submits with this notice a version of the Approved Plan “redlined” to reflect the changes from the Second Amended Plan. (Redline attached as Exhibit B.) The redline omits the illustrations contained at pages 69 to 80 of the Approved Plan for administrative convenience. The illustrations have not changed.

Dated: September 24, 2021

Respectfully submitted,

/s/ Michael J. Broadbent

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Pennsylvania, as Statutory Rehabilitator of
SENIOR HEALTH INSURANCE COMPANY
OF PENNSYLVANIA*

EXHIBIT A

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

D. TIMELINE

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

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

E. RATIONALE FOR THE PLAN

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

Exhibit 1



September 30, 2021

Via U.S. Mail and Email

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

Dear Commissioner:

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

Background

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

Senior Health Insurance Company of Pennsylvania (In Rehabilitation)
550 Congressional Boulevard, Suite 200, Carmel, IN 46032

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

Issue-State Rate Approvals Introduction

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

The Opt-out deadline is November 15, 2021.

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

Process to Opt-Out of the Plan

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

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

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

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

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

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

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

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

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

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

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

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

Policyholder Data Available to Assist in Making Your Decision

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

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

Access to the SHIP Rehabilitation Plan Secure Data Site

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

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

Updated Information

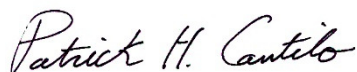
SHIP's website will continue to be updated regularly with Court documents and related rehabilitation materials. You are encouraged to visit the website regularly for updated information.

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

We strongly encourage you to contact us if you have any questions about these matters. You can reach me at [REDACTED] and Robert L. Robinson, SHIP's chief rehabilitation officer, at [REDACTED] and [REDACTED]

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

Sincerely yours,



Patrick H. Cantilo
Special Deputy Rehabilitator

Enclosures



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

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

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

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

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

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

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

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

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

Senior Health Insurance Company of Pennsylvania (In Rehabilitation)
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Q4. What happens when a state opts out of the Plan?

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

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

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

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

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

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

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

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

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

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

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

Q9. How will states opting out affect the Plan?

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

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

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

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

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



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

STATE OPT-OUT ELECTION FORM

Senior Health Insurance Company of Pennsylvania (In Rehabilitation)

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

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

Printed Name: _____

Signature: _____

Title: _____

Date: _____

State of _____

County of _____

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

Notary public in and for _____

[NOTARY SEAL]

My commission expires _____

This form should be returned to:

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

SIR App. 17

PROOF OF SERVICE

I hereby certify that on this day I caused the foregoing document to be served on the Rehabilitator by electronic delivery to the Rehabilitator's counsel and the Special Deputy Rehabilitator at the below addresses.

Cozen O'Connor
shipcomments@cozen.com
rehabilitation@shipltc.com

Patrick Cantilo
service@cb-firm.com

A copy of the foregoing was also served by electronic transmission via PacFile and was served upon the email addresses shown on the master service list available as of the date of filing, and upon the persons admitted as intervenors, with address by U.S. mail on:

James F. Lapinski
P.O. Box 291395
Port Orange, FL 32129

Georgianna Parisi
257 Regency Ridge Drive
Dayton, OH 45459

Dated: November 2, 2021

/s/ Stephen G. Harvey
Stephen G. Harvey

From: [REDACTED]
Sent: Monday, September 20, 2021 10:57 AM
To: [REDACTED]
Subject: NAIC: Commissioners and Receivership Contacts regarding SHIP

CAUTION: This email originated from a sender outside of the Commonwealth of Massachusetts mail system. Do not click on links or open attachments unless you recognize the sender and know the content is safe.

On behalf of the Pennsylvania Insurance Department, this message is delivered to the Commissioners & Assistants distribution list.

Good morning.

We have received questions concerning the timing of the SHIP Rehabilitation. States will have at least until November 15, 2021 to decide about the opt-out provision of the SHIP Rehabilitation Plan. A letter is coming in the next few weeks explaining the opt-out procedure, including a robust Frequently Asked Questions document for your use in making a decision. Additionally, we remain available to answer any of your questions at any time. You may reach out to me at: [REDACTED] or [REDACTED] with questions or to set up a call. We will send further communication regarding the timeline as soon as it is available. However, you will not need to make a decision on opt-out prior to November 15 in any circumstance.

Warm regards,
Laura

Laura Lyon Slaymaker, Esquire | Deputy Insurance Commissioner
Pennsylvania Insurance Department | Office of Liquidations, Rehabilitations and Special Funds
Capitol Associates Building | 901 N. 7th Street Harrisburg PA 17102
Phone: [REDACTED] | Cell: [REDACTED] | Fax: [REDACTED]
www.insurance.pa.gov

Twitter: [@PAInsuranceDept](https://twitter.com/PAInsuranceDept)

Facebook: [Facebook.com/PAInsuranceDepartment](https://facebook.com/PAInsuranceDepartment)

Virtual Meetings Available Upon Request



August 26, 2021

Via E-Mail

Re: Senior Health Insurance Company of Pennsylvania, In Rehabilitation

Dear Commissioner,

As you know, we have sent you several communications in addition to the numerous conversations we have had regarding the Rehabilitation proceeding for Senior Health Insurance Company of Pennsylvania (SHIP). In October 2020, and again in March of this year, we wrote you about our inclusion in the Proposed Rehabilitation Plan of a new "Issue-state Rate Approval" section that would permit states to opt out of the Plan's premium rate approval process. Most recently we wrote to notify you that on May 3, 2021, we filed the Second Amended Rehabilitation Plan just before the hearing on the Plan commenced in the Commonwealth Court of Pennsylvania (the Court) on May 17, 2021. That amendment remains available on SHIP's website, www.shipltc.com.

I write you now to advise you that, on August 25, 2021, the Court entered its Order Approving the Rehabilitation Plan (Approval Order), which, subject to certain specified modifications, approved the Second Amended Rehabilitation Plan (the "Approved Plan"). The [Approval Order](#) is also available on SHIP's website. The issue-state rate approval section remains in the Approved Plan, unchanged from the Second Amended Rehabilitation Plan.

As provided in that section, in the next few weeks we expect to send you formal notice of each state's opportunity to opt out of the rate approval provisions of the Approved Plan. That notice will advise you of the "Opt-out Deadline" and the precise method by which you must advise the Rehabilitator if you elect to opt out of the rate approval provisions of the Approved Plan with respect to the SHIP long-term care (LTC) insurance policies issued in your state. States that do not properly elect to opt-out by the Opt-out Deadline will be deemed to have opted into that section of the Approved Plan.

We believe strongly that the Approved Plan, including its premium rate adjustment provisions, is reasonable and fair and is in the best interest of SHIP LTC policyholders. As you are probably aware, the Approved Plan is the product of extensive analysis and actuarial modeling and of careful thought and balancing of difficult competing interests. It is our view that opting out of the rate approval provisions of the Approved Plan may not be in the best interest of the affected policyholders. We encourage every Commissioner, Director, or Superintendent to evaluate

this matter carefully, including the possible disadvantages of opting out. This matter is discussed at length in Section V. beginning at page 108 of the Approved Plan.

We thought it would be helpful to give you advance notice that you will soon be required to make that decision. Of course, you will not need to do anything if you do not wish to opt out of the rate approval provisions of the Approved Plan. We would be happy to discuss this matter with you in more detail if that would be of value. To do that, please send an email to Deputy Commissioner Laura Lyon Slaymaker at [REDACTED]. Moreover, we can provide you an updated seriatim file for LTC policies issued in your state with the projected if knew premium. Please let Special Deputy Rehabilitator Patrick Cantilo [REDACTED] know if you would like such a file.

In closing, let me confirm that I am very pleased that the Commonwealth Court has approved the rehabilitation plan. Arriving at the Plan was a challenging process that required many difficult decisions. This Plan represents what we and our team of experts think is the best solution to a problem that is not likely to go away soon. I am extremely grateful for all the support that we have received from so many of you and your staff along the way.

With warm regards,



Jessica K. Altman

Pennsylvania Insurance Commissioner

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

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

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

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

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

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

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

- a) reduction of the Funding Gap by appropriately increasing, maintaining and, in some instances, reducing premium rates to more accurately reflect the cost of benefits;
- b) allowing policyholders to elect to maintain or reduce the level of benefits from their policy;
- c) allowing policyholders to choose between Option One, Option Two, Option Three and Option Four relating to the premium paid and level of benefit received;
- d) implementation of the corrective action in three distinct phases;
- e) the suspension of payments of commissions to Agents;
- f) investigation and analysis of the past operations and business dealings of the Company; and

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

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

VI. OTHER MATTERS

- A. ABOUT SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA**
- B. LONG-TERM CARE INSURANCE**
- C. FINANCIAL CONDITION**
- D. REHABILITATION PROCEEDING**
- E. SENIOR HEALTHCARE OVERSIGHT TRUST**
- F. FUZION ANALYTICS**
- G. LTCG, INC.**
- L. REINSURANCE**
- M. COMMISSIONS**

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

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

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

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

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

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

Respectfully submitted,

/s/James R. Potts
James R. Potts
Attorney I.D. No. 73704
Dexter R. Hamilton
Attorney I.D. No. 50225
Michael Broadbent
Attorney I.D. No. 309798
COZEN O'CONNOR
1650 Market Street, Suite 2800
Philadelphia, PA 19103
(215) 665-2000

and

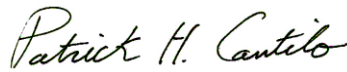
Leslie M. Greenspan
Attorney I.D. No. 91639
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Attorney No. 327557
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1801 Market Street, Suite 2500
Philadelphia, PA 19103

Counsel for Applicant,
JESSICA K. ALTMAN, Insurance
Commissioner of the Commonwealth of
Pennsylvania as Rehabilitator of
SENIOR HEALTH INSURANCE
COMPANY OF PENNSYLVANIA

VERIFICATION

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

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

A handwritten signature in cursive script that reads "Patrick H. Cantilo".

Patrick H. Cantilo
Special Deputy Rehabilitator

Dated: April 22, 2020

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

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

SECOND AMENDED REHABILITATION PLAN
 SENIOR HEALTH INSURANCE COMPANY
 OF PENNSYLVANIA, IN REHABILITATION

MAY 3, 2021

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

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

HOW TO PROVIDE COMMENTS AND OBJECTIONS

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

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

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

IMPORTANT NOTICE

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

THE PLAN PROPOSES THE IDENTIFICATION OF THOSE SHIP POLICIES OF LONG-TERM CARE INSURANCE THAT ARE ACTUARIALLY PROJECTED TO BE UNDERPRICED IN PHASE ONE AND NON-SELF-SUSTAINING IN PHASE TWO, AS DEFINED IN THE PLAN DOCUMENT. THIS PLAN DOCUMENT ALSO DESCRIBES THE METHODOLOGY BY WHICH POLICYHOLDERS WHO HAVE SUCH UNDERPRICED OR NON-SELF-SUSTAINING LONG-TERM CARE POLICIES MAY ELECT FROM AMONG SEVERAL OPTIONS TO MAKE SUCH POLICIES APPROPRIATELY PRICED OR SELF-SUSTAINING. SOME POLICYHOLDERS WILL BE FOUND TO HAVE POLICIES THAT ARE ADEQUATELY PRICED OR SELF-SUSTAINING. THESE POLICYHOLDERS WILL NOT BE REQUIRED TO MODIFY THEIR POLICIES BUT WILL HAVE THE OPTION TO DO SO IF THEY SO CHOOSE. FOR POLICYHOLDERS WHO ARE REQUIRED TO MAKE SUCH ELECTIONS BUT FAIL TO DO SO, THE PLAN INCLUDES AUTOMATIC DEFAULT OPTIONS.

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

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

THE PLAN IS DESIGNED TO REDUCE OR ELIMINATE THE SHORTFALL BETWEEN SHIP'S PROJECTED LIABILITIES AND THE ASSETS AND PREMIUMS PROJECTED TO BE AVAILABLE TO FUND SUCH LIABILITIES. THERE CAN BE NO ASSURANCE THAT THE PLAN WILL SUCCEED IN THIS GOAL. IF THE PLAN FAILS IN THIS RESPECT, IT IS POSSIBLE THAT SHIP WILL BE PLACED IN LIQUIDATION. IN THAT EVENT, THERE CAN BE NO ASSURANCE THAT SHIP WILL BE ABLE TO FULFILL THE CONTRACTUAL OBLIGATIONS ENTAILED IN LTC POLICIES MODIFIED UNDER THE PLAN TO THE EXTENT THAT SUCH OBLIGATIONS INCLUDE UNCOVERED BENEFITS AS DEFINED IN THE PLAN DOCUMENT.

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

REHABILITATION PLAN DOCUMENT

I. BASIC INFORMATION ABOUT THE PLAN

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

The Rehabilitation Order required that the Rehabilitator file a preliminary plan of rehabilitation by April 22, 2020. The Rehabilitator complied with this requirement and has since received many comments, formal and informal, about that preliminary plan of rehabilitation. In addition, the Special Deputy Rehabilitator and the rehabilitation team have continued their analysis of the many issues raised by the plan. As a result, on October 21, 2020, the Rehabilitator filed the **Amended Rehabilitation Plan**, among other things, addressing many of the issues raised in those comments. Additional comments have been received following the filing of the Amended Rehabilitation Plan and work has continued to improve the plan. This document is the **Second Amended Rehabilitation Plan** which will be presented to the Commonwealth Court for approval at the hearing scheduled for May 17, 2021.

This document (“Plan Document”) is intended to provide a sufficient description of the proposed rehabilitation plan (the “Plan” or the “Second Amended Rehabilitation Plan”) to enable policyholders and interested parties to understand the Plan, and the Commonwealth Court to determine whether to approve, modify and approve, or disapprove the Plan.

Necessarily, many of the details of the Plan will have to be resolved during the implementation period. It is not possible to anticipate all of the implications of every aspect of the Plan before it is put in place. Nonetheless, this Plan Document provides a detailed description of how the changes contemplated by the Plan, if approved as proposed, are expected to be implemented. Many or most existing company practices will continue if the Plan is approved and implemented, and those current practices are largely not discussed in this document.

The actual choices for, and projected impact upon, each policyholder will not be known until after the Plan is finalized and its provisions are calculated by the Company’s systems. Those calculations may produce materially different results depending on the passage of time and changes in both general and policyholder-specific circumstances. The cost and delay attendant to making the

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

UNTIL THE PLAN EFFECTIVE DATE, EVEN AFTER THE PLAN IS APPROVED WITH OR WITHOUT MODIFICATION, POLICYHOLDERS WILL HAVE THE SAME RIGHTS, BENEFITS, OPTIONS, AND OBLIGATIONS AS THEY DO NOW UNLESS THE PLAN SPECIFICALLY PROVIDES OTHERWISE.

A. SUMMARY DESCRIPTION OF THE PLAN

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

1. GOAL AND PHASES OF THE PLAN

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

The Plan is designed to operate in three phases. ***Phase One***, commencing immediately following final approval, is the principal phase and will strive to reduce substantially or eliminate the Funding Gap. In this phase it will be determined which policies require modification because their Current Premium is below the ***If Knew Premium*** for the benefits offered by the policies. The If Knew Premium is an accepted methodology for setting premiums for long-term care insurance ("LTCP") policies, more fully explained at page 27. Policyholders with Current Premium (see page 121) below the If Knew Premium will have to increase their premiums or reduce their benefits so that the premium will be adequate on an If Knew Premium basis. Policyholders whose Current Premium is at or above the If Knew Premium will not be required to modify their policies (increase their premiums or reduce their benefits) but may choose to make some such modifications if they prefer to do so, as explained below.

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

- a. Their premiums are not already Self-sustaining,
- b. They are not **Fully Covered** (*i.e.*, they are not within the limits of, or otherwise not covered by, the applicable Guaranty Association - see page 123), and
- c. The policyholders have not selected **Option Two (a or b)** or **Option Three** (described below) in Phase One.

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

2. POLICYHOLDER ELECTIONS

This section describes the key elements of these policyholder options. They are described in full detail beginning on page 23. In Phase One every policyholder whose Current Premium (including the premium they would be paying but for a premium waiver) is below the If Knew Premium for the policy's benefits will be required to elect one of four options. Those whose Current Premium (including the premium they would be paying but for a premium waiver) is at or above the If Knew Premium may keep their current policies without modification or may elect Option Two or Option Three, described below.

- a. Option One will be to continue paying the Current Premium or to maintain the premium waiver if one is in effect, but if Current or waived Premium is less than the If Knew Premium have benefits reduced in accordance with Plan provisions so that the premium for the reduced benefits (including waived premium) is equal on an If Knew Premium basis to the Current Premium. The benefit reductions will be selected automatically by the Plan.
- b. Option Two will be to select certain policy endorsements that provide selected essential benefits (sometimes greater than the benefits provided by Option One) at a lower premium than Option Four. This option, of which an enhanced alternative will also be available, will not be subject to further rate increases or benefit reductions in Phase Two of the Plan. Option Two is designed to provide reasonable coverage at reasonable premium rates.

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

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

Before being required to make an election, each policyholder will receive information detailing the premiums and benefits of each option. Special rules apply to policyholders who are not currently paying premium due to a Premium Waiver provision in their or their spouses' policies. These are explained fully beginning at page 31. Generally, such policyholders who elect Option Two or Option Four and whose Current Premium (the premium they would be paying but for the waiver) is lower than the If Knew Premium, will be required to pay a Differential Premium. The Differential Premium consists of the difference between (1) the premium they would be paying if there were not a waiver in effect (the Current Premium), and (2) the If Knew Premium corresponding to the policy. See Section II.E.7, page 28. If the Premium Waiver terminates, such policyholders will be required to pay the full applicable If Knew Premium (or Self-sustaining Premium if in Phase Two). Substantially the same options will be offered to policyholders on claim.

3. NO WORSE THAN LIQUIDATION

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

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

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

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

4. DEFAULT OPTIONS

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

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

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

5. CHANGES IN POLICYHOLDER ELECTIONS

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

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

6. PHASE TWO ELECTIONS

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

7. EFFECT OF ELECTIONS

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

B. KEY CONSIDERATIONS FOR POLICYHOLDERS

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

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

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

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

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

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

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

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

C. COVID-19

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

The full impact of the COVID-19 pandemic on the U.S. insurance industry remains to be determined. The life insurance industry makes the following observations. Between March 2020 and February 2021, the number of actual deaths was 120% higher than the number of expected deaths.¹ This led to a 14% increase in mortality rates among group life claimants in the first quarter of 2020.² Excess deaths were concentrated "among those in the preferred underwriting class, particularly those ages 60 and older."³ However, this has not increased life insurance premiums or decreased policy offerings.⁴

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

² Id.

³ Id.

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

The impact on health insurers differs somewhat. Due to unemployment caused by COVID-19, between 3.1 and 27 million Americans lost employer-sponsored health insurance in 2020.⁵ Health spending also dropped considerably, because of the cancellation of elective surgeries.⁶ This loss was concentrated in the first half of 2020 but persisted enough to cause a 2.7% drop in non-prescription medical spending from 2019 to 2020.⁷ This drop in spending could result in higher-than-average premium rebates for insureds.⁸ Overall, health insurers fared well, with average gross margins at the end of the third quarter of 2020 for individual market and fully-insured group market plans almost 25% higher than in 2019.⁹ Medicaid Advantage plans saw a 35% average gross margin increase over the same time period.¹⁰ As a result, 2021 health insurance premiums are expected to remain largely unchanged.¹¹

For long-term care insurance, the effects of the pandemic have been mixed. COVID-19 seemed to reduce long-term care insurance costs by (1) shortening the amount of time some insureds used benefits either because they died or because they left long-term care facilities, or (2) preventing some insureds from starting to use long-term care services.¹² A Fitch Ratings report indicates that the long-term care insurance industry gained roughly \$2.5 billion in net operating profits from 2019 to 2020.¹³ Actuaries are unsure about what effect COVID-19 will have on long-term care insurance over the long run, as COVID-19 could have “accelerated the deaths of people who were likely to die

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

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

⁷ Id.

⁸ Id.

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

¹⁰ Id.

¹¹ Cox, *supra* note 12.

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

¹³ Id.

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

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

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

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

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

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

¹⁴ Keshner, *supra* note [5](#).

¹⁵ *Id.*

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

¹⁷ *Id.*

¹⁸ *Id.*

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

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

D. TIMELINE

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

At page 35 is a sequence of past and expected events in the presentation and implementation of the Plan. While it is difficult to predict future events in a matter of this complexity and under the current exceptional circumstances, a hearing on the Plan has been scheduled for May 17, 2021. Depending on the outcome of that hearing, implementation of the Plan might commence late in 2021. In that event, policyholders may be asked to make their elections in the fall of 2021. However, this matter is complex and delays in this timetable remain possible.

E. RATIONALE FOR THE PLAN

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

1. The Plan gives policyholders more control over their fates, allowing each to elect the path best suited to his or her circumstances.
2. All policyholders will have at least one option for preserving their current coverage and at least one option for preserving their Current Premium.
3. Target premiums under the Plan take rate increase history and product differences into account, improving the equity of the premium rate structure. Generally, policyholders whose

policies were issued in states that have approved comparatively more rate increases over preceding years will face lower premium increases or benefit reductions under the Plan.

4. It is important to note that Plan premium rate increases are not based on state of issue or state of residence. They are based exclusively on the characteristics of each individual policy, including the difference between Current Premium and If Knew Premium (in Phase One) or Self-sustaining Premiums (in Phase Two).
5. In every case, policyholders will have at least one option (Option Two) calibrated to provide outcomes no less favorable than liquidation, including applicable Guaranty Association benefits.
6. The revenue from rate increases under the Plan will go to pay claims and expenses of implementing the Plan whereas, in liquidation, Guaranty Association rate increases have historically been used to reduce assessment burdens for member insurers and not to increase the ability to pay claims.
7. Though certainly not guaranteed, the Plan structure inherently creates the possibility of greatly reducing, if not eliminating, the Company's deficit.

F. PLAN PROJECTIONS

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

1. If 100% of disabled SHIP LTC policyholders and 80% of active SHIP LTC policyholders elect Option Four (retaining the current policy benefits and paying the rate increases necessary to reach If Knew Premium), the Funding Gap will be reduced by about \$500 million, less than 50%, and a substantial additional reduction will have to be generated by Phase Two of the Plan. This scenario assumes that the remaining 20% of active policyholders would select Options One, Two or Three.
2. If 100% of disabled policyholders and 65% of active policyholders elected Option Four (the remaining 35% of active policyholders electing one of the other Options), the Funding Gap would be reduced by \$650 million, an additional \$150 million, a bit over half of the deficit.

3. If 100% of disabled policyholders elected Option Four and 100% of active policyholders elected one of Options One, Two or Three, the Funding Gap would be reduced by between 73% (over \$850 million) and 86% (over \$1 billion).
4. In any of these scenarios, election of an option other than Option Four by a material number of disabled policyholders would materially improve the results of the Plan in reducing the Funding Gap.
5. If 100% of SHIP's active and disabled policyholders elect either Option Two or Option Three, the entire Funding Gap would be eliminated and Phase Two would be unnecessary. If they elected Option One, about 93% of the Funding Gap would be eliminated.

As these projections suggest, the probability of the Plan's success increases materially the more policyholders elect to give up their benefit-rich policies and elect more affordable options. That anticipated probability of success does not vary nearly as substantially by choices among Options One, Two or Three as it does by choices between any of the other options vs. Option Four.

G. ORDER OF DISBURSEMENTS

Apart from the amounts owed to policyholders for benefits under long-term care insurance policies for which it is directly responsible, SHIP has a variety of other debts. For purposes of the Plan all of SHIP's debts are classified as falling into one of five categories, described in more detail below. These categories are consistent with the order of distribution promulgated in 40 P.S. § 221.44, governing distributions in liquidation. While SHIP is not in liquidation, the rehabilitation plan is designed to provide creditor distribution priorities that respect the order therein promulgated and to avoid unintended advantages and disadvantages in the payment of SHIP's debts. Payments will not be made to debts in a particular category until all debts owed to a higher category have been paid in full or reasonable provision has been made for their full payment. Creditors who are not paid in full retain the right to assert claims for unpaid amounts owed to them. Creditors in each category will receive pro-rata distributions of the amounts owed to them as assets become available for the payment of debts in that category.

1. ADMINISTRATIVE EXPENSES

This category, corresponding to that established in 40 P.S. § 221.44(a), includes the costs of conducting SHIP's business, including development and implementation of the Plan. Payments to vendors for goods or services procured by the Rehabilitator are within this category. That includes employee salaries and benefits, consultant and counsel fees, office and equipment leases, utilities, bills for operating supplies, and other debts incurred in the course of operating SHIP's business.

2. POLICYHOLDER LIABILITIES

This category, corresponding to that established in 40 P.S. § 221.44(b), includes all claims for benefits arising under long-term care insurance policies issued directly by SHIP or its

predecessors: American Travelers Life Insurance Company, Conseco Senior Health Insurance Company, and Teachers Protective Mutual Insurance Company. It does not include policies reinsured by SHIP but not issued by SHIP or its predecessors. See Section VI.M.7, page 98. It also does not include claims arising under SHIP's 46,000 non-long-term care insurance policies, for which Conseco Life Insurance Company is responsible. See Section VI.M.5, page 97.

3. CERTAIN FEDERAL PRIORITY CLAIMS

This category, corresponding to that established in 40 P.S. § 221.44(c), includes all claims of the federal government other than those owed to it as a policyholder, which would fall in Category 2, above. However, the Rehabilitator does not believe that SHIP has any insurance policy obligations to the federal government.

4. GENERAL CREDITOR CLAIMS

This category, corresponding to those established in 40 P.S. § 221.44(d-h) includes all other debts owed by SHIP except those described in Category 5, below. It encompasses, among other debts:

- a. all employee benefits accrued pre-rehabilitation for employees separated from the Company (including retiree claims - see Section VI.O, page 100),
- b. claims of state and local governments,
- c. agent and broker commissions (see Section VI.N, page 99),
- d. claims of ceding insurers under reinsurance treaties (see Section VI.M.7, page 98),
- e. surplus note contribution claims, and
- f. other claims not specifically enumerated in this Section.

The Rehabilitator does not contemplate establishing a new claim filing procedure and instead creditors may continue submitting bills and invoices in the ordinary course of business.

5. EQUITY CLAIMS

This category, corresponding to that established in 40 P.S. § 221.44(1). Includes the claims of shareholders and owners. As to SHIP, this would only be the claims of Conseco and the Senior Health Care Oversight Trust.

II. GENERAL PLAN DETAILS AND TECHNICAL INFORMATION

This Section of the Plan Document provides detailed and technical explanations of proposed Rehabilitation Plan provisions for modification of SHIP's long-term care insurance policies. As modeling and analysis continue, additional refinements are possible. However, the fundamental Plan

structure is unlikely to change unless the Court requires it. The following notes may aid in understanding this structure.

A. PLAN PHASES

The Plan is contemplated to occur in three phases. In ***Phase One***, all LTC policies that are not in Non-forfeiture Option status will be evaluated and the holders of those the premiums of which are below the If Knew Premium level will be required to elect options to modify premiums or benefits, or some combination of the two. The results of this phase for the Company can vary materially depending on Policyholder Elections. They will be monitored and evaluated after Phase One becomes effective to gauge the results. In due course a decision will be made as to whether and, if so, how to implement Phase Two. ***Phase Two*** will be aimed at narrowing or eliminating any remaining deficit and its timing will depend on the results achieved in Phase One. Under the terms of the Plan, in Phase Two only policies the holders of which have not elected Option Two (Basic Policy Endorsements - see section III.A.2.d) or Option Three (Non-forfeiture Option - see Section III.A.3), that are not Self-sustaining (see definition at page 126), and which would not be Fully Covered by Guaranty Associations, will be affected. Holders of these remaining policies will again be asked to “right-size” them by modifying premiums or benefits, or a combination of the two. For that purpose, they will be offered options similar to those offered in Phase One. Depending on the results of Phase One, Phase Two may also include additional remedial measures. In ***Phase Three*** SHIP will conclude the run-off of its business in force, as modified by the Plan. In the event that funds are available, payment will be made to agents, ceding companies, policyholders, and other creditors on account of sums owed to them.

B. POLICYHOLDER CATEGORIES

1. For Plan implementation purposes, policyholders are sorted into eight main categories, four each in Phase One and in Phase Two:
 - (1) Active - premium paying;
 - (2) Active - not premium paying (further segregated between lifetime or dual Premium Waiver);
 - (3) Disabled - premium paying; and
 - (4) Disabled - not premium paying.
2. There may be some policyholders who do not fit neatly into the Plan’s defined policyholder categories in each Phase, though none have yet been identified. If so, those will be addressed on an *ad hoc* basis.

C. POLICYHOLDER OPTIONS

1. In each category, policyholders whose Current Premiums are below the If Knew Premium rate for their policies will have four choices, including the ability to take a Non-forfeiture

Option (NFO) on which no additional premium will be due. No other cash-out or buy-back option will be included. Generally, the choices provided by the Plan will be:

- a. **Option One** - Keep the Current Premium (or Premium Waiver) and downgrade the policy to specified reduced benefits in a manner determined automatically by the Plan. The **Downgrade Process** is explained beginning at page 42. This will be solely a benefit reduction option;
 - b. **Option Two** - Elect **Basic Policy Endorsements** (making the policy one designed to provide reasonable benefits and premiums - see Section III.A.2.d, page 48) at If Knew Premium (as defined below) in Phase One or at Self-sustaining Premium if elected in Phase Two. The Basic Policy Endorsements convert the existing policy to one with generally more affordable premiums than would be charged for the current policy benefits on an If Knew basis and more limited benefits when compared to the current policy. This option may entail both premium increases and benefit reductions for many policyholders, but premium increases will almost always be lower than under Option Four. For some policyholders it may entail a premium reduction. Many policyholders will be offered two variations of this option, a standard version and an enhanced alternative. Details of its provisions are laid out in Section III.A.2.d, page 48, below. As explained below, policyholders who elect this option in Phase One will not be asked to make Policy Modifications in Phase Two;
 - c. **Option Three** - Elect a limited benefit Non-forfeiture Option, a reduced paid up policy on which no additional premium will ever be paid (see Section III.A.3, page 50); and
 - d. **Option Four** - Keep the current policy benefits and accept a premium increase. The new premium will be (as defined below) the **Phase One Premium** (see page 127) in Phase One and the Self-sustaining Premium in Phase Two. This will be solely a premium increase option.
2. In summary, under the Plan, policyholders whose Current Premiums are below the If Knew Premium for their policies will be able to: (a) keep their Current Premium with downgraded benefits, (b) choose Basic Policy Endorsements, (c) take a NFO, or (d) to keep their current benefits and pay additional premium. These will be the only options available under the Plan. Other options that are sometimes available in particular states in response to approved rate increases are not offered under the Plan.
 3. As noted above, a Default Option will apply if a policyholder required to do so fails to make a valid election by the applicable deadline. For policyholders who are paying premium, Option Two (the Basic Policy Endorsements) will be the Default Option. For policyholders on Premium Waiver, the Default Option will be Option One (the downgrade) unless the NFO would provide these policyholders better benefits.

4. In Phase One, the estimated 25% to 40% of policyholders whose Current Premium on the Determination Date (see page 122) will be at or above the If Knew Premium for the benefits offered by their policies need not modify their policies, and their policies would not be changed by selecting Option One or Option Four. Such policyholders may choose to do nothing, or they may select Option Two or Option Three if they wish to do so to accommodate their individual circumstances, for example to reduce their premiums or to avoid the possibility of a Phase Two rate increase. The Default Option for these policyholders will be that their policies remain unchanged.
5. NOTE THAT A POLICYHOLDER WITH PREMIUM AT OR ABOVE IF KNEW PREMIUM MAY NONETHELESS HAVE A NON-SELF-SUSTAINING POLICY (SEE PAGE 126) AND THEREFORE BE REQUIRED TO MAKE AN ELECTION IN PHASE TWO. SUCH A POLICYHOLDER WILL NOT HAVE TO MAKE A PHASE TWO ELECTION IF HE OR SHE HAS SELECTED OPTION TWO OR OPTION THREE IN PHASE ONE OR IF HIS OR HER POLICY IS FULLY COVERED (SEE PAGE 123).
6. Subject to the orders of the Commonwealth Court, the Plan contemplates that Basic Policy Endorsements elected in Phase One (Option Two) will be immune from Phase Two changes unless the Company is placed in liquidation. Policyholders who elect this option in Phase One generally will not face premium rate increases or additional benefit reductions in Phase Two of the Plan.
7. However, certain policyholders paying the lower *Phase One Differential Premium* or *If Knew Differential Premium* due to a Premium Waiver may be required to begin paying the full Phase One Premium or If Knew Premium if the Premium Waiver no longer applies (for example because a policyholder on claim recovers). Similarly, in Phase Two certain policyholders paying the *Self-sustaining Differential Premium* due to a Premium Waiver may be required to begin paying the full Self-sustaining Premium if the Premium Waiver no longer applies (again, for example, because a policyholder on claim recovers). See Section III.A.2.c, page 48.
8. Non-forfeiture Options elected in Phase One will not be subject to change thereafter, including in Phase Two or if the Company is placed in liquidation.
9. It is important to note, and policyholders will be advised before making such elections, that policies for which Options One or Option Four are chosen in Phase One may be subject to additional modifications in Phase Two. Moreover, the timing and details of the modifications that may be required in Phase Two will not be known to policyholders when they make their Phase One elections. In particular, policyholders will be advised that options to retain benefits that generate low premium rate increases in Phase One may result in additional premium rate increases or benefit reductions in Phase Two due to differences in the methodologies used to calculate premium rates in each phase.

10. The exceptions to this possibility of changes in Phase Two are the election of Basic Policy Endorsements or NFO (Options Two and Three, respectively) in Phase One. As noted below (see Section III.A.2.c, page 48), so long as the Plan remains in effect, and unless the Commonwealth Court orders otherwise, the Basic Policy Endorsements elected in Phase One will be immune from Phase Two changes except that (as explained above in Section II.C.6) certain policyholders on premium waiver (or their spouses) may be required to pay full Phase One Premium or If Knew Premium (instead of differential premium) when the waiver ceases to apply. The NFO is expected to remain permanent through policy termination.
11. The approximately 8,900 policyholders who have already chosen to replace their policies with Non-forfeiture Options before the Plan is implemented will not be asked, or have the ability, to make any changes to their policies as part of the Plan.
12. Beginning on the applicable Effective Date and while the Rehabilitation Plan is in effect, policyholders who fail to pay their premiums when due, or who otherwise terminate or lapse their policies voluntarily, will receive a notice that, as of the date on which the unpaid premium was due, or as of the date of their termination request or lapse notice, their policies will be converted to Non-forfeiture Options. However, they may request in writing that their policies be fully terminated. This would not apply to policyholders who have converted their policies to NFOs, from whom no premium is due.

D. CLAIM STATUS

For purposes of Policyholder Elections:

1. After the Plan is approved, a policyholder will be deemed to be on claim if he or she is receiving health care services that would be reimbursable by the Company were it not for an ***Elimination Period*** (EP) that has not been satisfied. Such a policyholder will be expected to begin receiving indemnity or reimbursement payments as soon as the EP is satisfied.
2. The Company may also determine that a policyholder has been on claim as of an earlier date when that policyholder has been receiving health care services reimbursable by the Company but has not reported such services to the Company. Such a policyholder is expected to be reimbursed for prior covered services when they are reported to the Company, subject to policy terms and conditions and applicable law.

E. PREMIUM RATE DETERMINATIONS

1. The Plan contemplates using different target premium rates in each phase. In the first phase, the target premium will be the Phase One Premium (a variation of If Knew Premium that can be no less than the Current Premium) for policyholders electing Option Four (retain their current benefits). Since in Option One, the premium remains the same, benefits are reduced to what that premium would “buy” at If Knew Premium rates as explained on page 42. For

policyholders selecting Option One (retain Current Premium) or Option Two (Basic Policy Endorsements), the target premium will be the If Knew Premium for the policy's benefits. In Phase Two the target premium will be the Self-sustaining Premium.

2. The **If Knew Premium** rate is the rate that, if charged from inception, would have produced the greater of the initial target loss ratio or the minimum loss ratio applicable to the policy form. For the sake of simplicity, under the Plan this will be assumed to be 60%. If Knew Premium rates are intended to price policies adequately on a lifetime basis, but not to recoup losses due to inadequate pricing in the past.
3. For each policy for which the Current Premium is more than the If Knew Premium, the Phase One Premium will be the Current Premium. In short, in Phase One that policyholder can (but is not required to) retain the current policy at Current Premium without change. Correspondingly, for policies with a Current Premium lower than the If Knew Premium (which in this case would be the Phase One Premium), the downgrade required to maintain the Current Premium will be a reduction in benefits to a level that produces an If Knew Premium equal to the Current Premium as explained beginning on page 42.
4. Self-sustaining Premium is the premium calculated after evaluating the results of Phase One by determining the amount of premium required to eliminate a policy's **Shortfall Amount** in Phase Two.
 - a. The Shortfall Amount is the difference between the policy's **Projected Benefit Amount** (PBA) and its **Projected Credit Amount** (PCA) where the difference is more than zero. The Shortfall Amount can also be expressed as a policy's **Gross Premium Reserve** (GPR) less its **Allocated Assets**. If the difference is zero or less there is no shortfall and the policy is Self-sustaining.
 - b. The PBA is the present value as of the valuation date of the sum of (1) unpaid expected policy benefits and (2) unpaid expected policy expenses. For purposes of this determination "expected" consists of best estimate assumptions.
 - c. The PCA is the sum of (1) the present value as of the valuation date of expected premiums, adjusted for future premium increases reasonably expected to be put into effect and (2) the assets allocated to that policy as described below in subparagraph II.E.4.e, page 28. Again, for purposes of this determination "expected" consists of best estimate assumptions.
 - d. **Allocable Assets** is a notional determination consisting of the Company's invested assets less reserves for costs of administration, contingencies, and certain debts of higher priority. The **Asset/Premium Ratio** is the ratio of Allocable Assets to the aggregate Accumulated Premiums for all LTC policies. **Accumulated Premium** is the total Gross Premiums paid, and premiums waived, under a policy or group of policies from inception until the valuation date.

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

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

5. For policyholders on claim in Phase Two, the Self-sustaining Premium will be determined as if they were not on claim. For this purpose, assets will be allocated notionally to policies on claim as explained above.
6. Although this Plan Document assumes that in Phase Two determinations will be based on Self-sustaining Premiums, it is possible that, depending on the outcome of Phase One and other relevant considerations, in Phase Two the Plan will utilize an alternative premium structure. That determination will be made before policyholders are required to make elections in Phase Two and the results of that determination will be included in information provided to policyholders before they are required to make such elections.
7. In certain instances the Plan uses a Differential Premium, which in each case is the difference between the target premium (Phase One Premium, If Knew Premium, or Self-sustaining Premium, depending on the option elected and whether this occurs in Phase One or Phase Two) and the Current Premium the policyholder would be paying if not on waiver. This element of the Plan is intended to avoid having premium-paying policyholders subsidize

policyholders on premium waiver unfairly. Because the Phase One Differential Premium calculation is also based on If Knew Premium, policies on waiver that would require their holders to pay premium at or above If Knew Premium but for the waiver would not require Differential Premium. Thus, Differential Premium would only be charged to policies the waived premium of which would be deemed inadequate under Plan provisions. Differential Premium can never be less than zero. In cases in which the Current Premium is higher than the target rate, there would be no Differential Premium.

- a. Thus, in Phase One the Plan requires policyholders not paying premium, who elected Option Four (retain current benefits), to pay the Phase One Differential Premium consisting of the Phase One Premium less the Current Premium they would be paying if they were not on waiver (but not less than zero).
- b. Policyholders not paying premium who chose Option Two (Basic Policy Endorsements) in Phase One and whose current (waived) premium before making that election was lower than the If Knew Premium for the Basic Policy Endorsements will be required to pay the If Knew Differential Premium. This is the difference between the If Knew Premium corresponding to the benefits provided by the policy after implementing the Basic Policy Endorsements and the Current (waived) Premium for the policy, both of which are set as if the policyholder did not have a Premium Waiver in effect.
- c. Similarly, in Phase Two the Plan requires policyholders not paying premium who selected Option Two (Basic Policy Endorsements) or Option Four (retain current benefits) to pay the Self-sustaining Differential Premium consisting of the Self-sustaining Premium less the Current Premium they would be paying if they were not on waiver (but not less than zero).

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

8. For a policy's Shortfall Amount to be eliminated completely, the policyholder would need to pay the entire Self-sustaining Premium. The result of policyholders on premium waiver only paying Self-sustaining Differential Premiums is that the premiums charged for these policies are insufficient to cover their Shortfall Amount. To address the remaining shortfall that is not covered by these policies, a ***Self-sustaining Adjustment Factor*** will be calculated.
 - a. The Self-sustaining adjustment factor will be a multiplicative adjustment applied to all policies' Self-sustaining premiums. It will be calculated to ensure that the sum of total premiums paid are sufficient to cover the total Shortfall Amount.
 - b. The Self-sustaining Adjustment Factor will be calculated for all policies in the aggregate. The same adjustment will be applied to all policies' Self-sustaining Premiums.
 - c. Policies on premium waiver are required to pay the Self-sustaining Differential Premium consisting of the Self-sustaining Premium less the Current Premium they would be paying if they were not on waiver (but not less than zero). The Self-sustaining Adjustment Factor will be calculated to ensure that the sum of Self-sustaining Premiums paid by premium-paying policyholders and Self-sustaining Differential Premiums paid by policyholders on waiver are sufficient to cover the total Shortfall Amount.

F. PENDING RATE INCREASES

There are a number of LTC policies for which SHIP has sought regulatory approval of premium rate increases that has been granted but the approved premium rate increases have not yet become effective. The following guidelines apply to such pending rate increases.

1. The Plan will assume that the approved premium rate increases will be implemented on the earlier of (a) the date on which they would have been implemented absent the Plan, and (b) the Plan Effective Date for each policy.
2. The ***Policyholder Election Package*** (see page 128) will describe premium rates for each option under the Plan reflecting implementation of the approved rate increases. Thus, for some policyholders the Current Premium shown in the Policyholder Election Package will be higher than the policyholder's actual current premium by the amount of the pending approved premium rate increase. This will be true for policyholders for whom, if the Plan were not implemented, the approved premium rate increase would not take effect until after the Plan Effective Date.

G. PREMIUM WAIVERS

1. SHIP LTC policies may contain one or more **Premium Waiver** provisions under which a policyholder is permitted to discontinue paying premiums and maintain the policy in force during a period of covered care or under circumstances specified in the policy.
 - a. Under a **Claim Waiver of Premium** (WOP) provision, a policyholder who receives benefits under his or her policy for a specified period of time (such as 90 days) is no longer required to pay premiums for coverage after that time period as long as the policyholder remains eligible for benefits and/or receives a specified level of care. Once the policyholder's eligibility for benefits ends, the policyholder is required to resume paying premiums in order to keep the policy in force.
 - b. Under a **Dual Waiver of Premium** (DWOP) provision, also called "Spousal Waiver of Premium," a policyholder may suspend premium payments during the time that a spouse qualifies for waiver of premium.
 - c. The **Lifetime Waiver of Premium** provision permits suspension of premium payments upon the death of a covered spouse after a qualifying period (typically five, seven, or ten years). The Lifetime Waiver of Premium provision, as the name implies, is permanent.
2. The Plan affects these Waiver of Premium provisions in specific ways. Policyholders who took a Non-forfeiture Option before the Plan became effective, or who do so under the Plan, do not pay premium and are not affected by Waiver of Premium provisions.
 - a. **Claim Waiver of Premium.** Policyholders on Claim Waiver of Premium on the Policyholder Election Date will be treated as if that waiver continues with respect to the premium in effect at that time (the Current Premium).
 - (1) If such policyholders elect Option One (downgrade), which does not entail a premium increase, the Current Premium remains waived and no Differential Premium is applicable. If such policyholders recover, their Current Premium must again be paid but their policies will remain downgraded.
 - (2) If policyholders on Claim Waiver make an election under the Plan that increases their premiums (Option Two or Option Four, see page 23), the waiver does not apply to the increase and they will be required to pay Differential Premium consisting of the difference between the premium under the elected Plan option and the Current (waived) Premium. When such policyholders recover and the Claim Waiver of Premium terminates, they must begin paying the full Plan premium. If such policyholders go on claim again following a specified period of recovery and their policy retains the Claim Waiver of Premium provision, the full **Plan Premium** (Phase One

Premium, If Knew Premium, or Self-Sustaining Premium, depending on the circumstances) will be waived while they are on claim.

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

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

- (1) If the policyholder has selected Option One, is not paying any premium due to the Spousal Waiver, and his or her spouse recovers, he or she must begin paying the Current Premium but his or her policy will remain downgraded.
- (2) If the policyholder has selected Option Two, is paying only the If Knew Differential Premium due to the waiver, and his or her spouse recovers, the policyholder must begin paying the full If Knew Premium.
- (3) If the policyholder has selected Option Four, is paying only the Phase One Differential Premium due to the waiver, and his or her spouse recovers, such policyholder must begin paying the full Phase One Premium.
- (4) If the policyholder is on Dual Waiver, has a policy with Claim Waiver of Premium, selects Option Four, is paying Phase One Differential Premium or If Knew Differential Premium, and goes on claim after the Effective Date, the Differential Premium will then be waived under the Claim Waiver of Premium provision so that the policyholder will not have to pay any premium while on claim, even if the spouse recovers during that period. Once the policyholder recovers, he or she will be required to resume paying the Differential Premium if the spouse remains on claim and the dual waiver of premium is still effective. If the spouse has also recovered or the dual waiver of premium is otherwise no longer effective, the policyholder will be required to pay the full Phase One Premium or If Knew Premium upon recovery. If both policyholders whose policies contain a Dual Waiver provision select Option Four while neither is on claim, and one goes on claim after the Effective Date, the full Phase One Premium for both policies would be waived.

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

- (1) If such a policyholder elects Option Four, the Lifetime Waiver of Premium does not apply to the increased portion of the premium and he or she will be required to pay Differential Premium consisting of the difference between the Current Premium and the premium under Option Four (the If Knew Premium). Of course, if the If Knew Differential Premium for that policyholder is zero, he or she need not pay any additional premium.
- (2) If an active policyholder is on lifetime waiver, has a policy with Claim Waiver of Premium benefit, selects Option Four, and goes on claim after the Effective Date, the Differential Premium will then be waived under the Claim Waiver of Premium provision so that the policyholder will not have to pay any premium while on claim.

H. CERTAIN “NON-CORE” POLICY BENEFITS UNAFFECTED

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

1. Bed Reservation Benefit,
2. Respite Care,
3. Caregiver Training,
4. Medic Alert,
5. Prescription Drug Benefit,
6. Homemaker Services,
7. Personal Needs Benefit,
8. Accidental Death Benefit,
9. Helping Hands Benefit,
10. Adult Foster Care,
11. Ambulance Services,
12. Transportation Benefit,
13. Home Delivered Meals,
14. Assistive Equipment, and
15. Remodeling.

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

I. RATE APPROVALS

1. Rate increases and Policy Modifications will be submitted to Commonwealth Court of Pennsylvania for approval as part of the Plan. The Rehabilitator will not seek separate approval of rate increases or benefit reductions from insurance regulators in the states in which the policies were issued.

2. The rate increases will not necessarily be limited by, or adhere to, filed rate cards. Rate cards are issued by insurers and approved by regulators to describe the premium rates applicable under specified circumstances or for specific types of coverage. They are inapplicable to the Plan.
3. Premium increases and Policy Modifications will not be submitted to individual insurance departments for approval. The Rehabilitation team believes that this is consistent with the established insurance rehabilitation practice in the U.S. under which the domiciliary regulator as domiciliary rehabilitator may, with only rehabilitation court approval and no approval from individual states, implement a rehabilitation plan, including one that might modify or terminate insurance policies issued by the delinquent insurer throughout the country. If its premium rates were subject to approval in each state, the Plan could not meet its goal of eliminating “subsidies” by having policyholders with substantially similar policies generally pay substantially similar premium regardless of the state in which the policyholder resides or in which the policy was issued. Moreover, the delay and expense of “traditional” state-by-state rate or benefit approval would make the Plan unfeasible. Finally, the state-by-state approval process might perpetuate or increase the nation-wide premium rate variations the Plan strives to eliminate.

J. NFOs AND PAID-UP POLICIES

The Plan will not affect the approximately 8,900 policyholders who have already taken NFOs. Their policies will never pay premium and their benefits will not be reduced further by the Plan. The Plan also will not affect paid-up policies for which only a specified number of premium payments were required, including those for which some of those payments remain to be made.

K. PARTNERSHIP-QUALIFIED POLICIES

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

L. PLAN TIMING

1. The Plan is designed for implementation of Phase One as rapidly as possible, with more time available for implementation of Phase Two. At the conclusion of Phase One and continuously thereafter its results will be evaluated and, in due course, a determination will be made as to whether and, if so how, Phase Two should be implemented.
2. Table 3 provides a high-level sequence for the Plan.

TABLE 3: PLAN SEQUENCE	
1.	April 22, 2020 - Filing of Proposed Rehabilitation Plan and request for approval of notice
2.	June 12, 2020 - Case Management Order
3.	July 31, 2020 - Deadline for intervention applications
4.	August 21, 2020 - Deadline for responses to intervention applications
5.	September 15, 2020 - Deadline for Objections and Comments
6.	October 21, 2020 - Filing of Amended Proposed Rehabilitation Plan
7.	October 30, 2020 - Deadline for authorized interveners to file description of intended testimony and exhibits
8.	February 25, 2021 Scheduling Order
9.	May 3, 2021 Deadline for filing of Final Plan Amendments
10.	May 17, 2021 Hearing on Rehabilitation Plan
11.	[TBD] Order Approving, Modifying or Disapproving Plan
12.	[TBD] Final Approval Date (assuming approval)
13.	Plan Preparation Period
14.	[TBD] Determination Date
15.	Begin Policyholder Transition Period
16.	[TBD] Policyholder Election Package
17.	[TBD] Policyholder Election Deadline
18.	Evaluation of Policyholder Elections

19.	[TBD] End Policyholder Transition Period
20.	[TBD] Initial Plan Effective Date
21.	[TBD] Supplemental Policyholder Election Package
22.	[TBD] Supplemental Policyholder Election Date
23.	[TBD] Supplemental Plan Effective Date
24.	Evaluation of Phase One
25.	[TBD] Decision on Phase Two
26.	[TBD] Phase Two Policyholder Election Package
27.	[TBD] Phase Two Policyholder Election Deadline
28.	[TBD] Phase Two Effective Date
29.	Evaluation of Plan performance
30.	[TBD] Phase Three, if justified.

- a. The Plan will be submitted to the Commonwealth Court for approval, modification, or disapproval. Policyholders and interested parties have been provided an opportunity to offer comments about, or object to, the Plan. The Commonwealth Court will hold a hearing on the Plan beginning on May 17, 2021. Following the hearing, the Court will approve, modify, or disapprove the proposed Plan. If the Plan is approved (with or without modification), the date upon which such approval becomes final (including exhaustion of appeals, if any) will be the ***Final Approval Date***. It will commence the ***Plan Preparation Period***, which will end with the ***Initial Plan Effective Date***. During the Plan Preparation Period:
- (1) SHIP's LTC insurance policies will be restructured as described in Section VI.H, page 91. This restructuring will not affect the options available to policyholders under the Plan.
 - (2) The Company will make all the determinations and perform the calculations required to construct the options available to each policyholder. All determinations will be made as of a ***Determination Date*** which may vary from policyholder to policyholder but which will always be before the Policyholder Election Date defined below.

- (3) The Policyholder Election Package (containing the information required for policyholders to make their elections) and the ***Policyholder Election Forms*** (upon which they will do so) will be prepared and distributed.
 - (4) Except as noted below in Section II.L.3, page 37, the Policyholder Elections must be made by the Policyholder Election Date and will be collected and evaluated by the Company as received.
 - (5) On the ***Initial Plan Effective Date*** all the Policyholder Elections, other than those addressed in Section II.L.3.c, below, will be implemented and the premium and policy changes will take effect.
 - (6) The Initial Plan Effective Date may vary from policyholder to policyholder. For each policyholder the Initial Plan Effective Date will be the policy's ***Monthiversary Date*** occurring during the ***Initial Plan Effective Month***. See definitions, pages 125 and 126.
- b. The Plan Preparation Period may be several months long in order to provide time for the calculations and other steps necessary to implement the Plan. This includes the period necessary to advise policyholders of their options and to enable them to make the necessary elections.
3. Changes in policyholder circumstances occurring between the applicable Plan Determination Date and the Initial Plan Effective Date (the ***Policyholder Transition Period***) will not affect policyholders' elections except as follows:
- a. Policyholders who have qualified for a Premium Waiver which has not yet become effective as of the Policyholder Election Date due to a waiting period or premium paying modal factor will be treated as if they were not paying premium on the Policyholder Election Date and will be required to elect from among the options available to policyholders not paying premiums. If their policies have ***Dual Waiver of Premium*** (DWOP) the same will be true for their spouses. If such policyholders (or their spouses eligible for DWOP) elect Option Two (Basic Policy Endorsements - see Section II.C.1.b, page 24), or Option Four (retain current benefits at Phase One Premium - see Section II.C.1.d, page 24), they will be required to pay the full Phase One Premium or If Knew Premium, respectively, until the waiver becomes effective and to pay the Phase One Differential Premium or If Knew Differential Premium, respectively, thereafter.
 - b. Policyholders who have been deemed eligible for benefits, but the benefits are pending and they have therefore not yet gone on claim, will be treated as if they were on claim and be required to elect from among the options available to policyholders on claim, including the availability of Premium Waiver. Note that during the ***Policyholder Transition Period***, when policyholders whose policies contain DWOP

are deemed eligible for benefits which are pending and therefore have not yet gone on claim, and are treated as if on claim, their spouses will also be treated as if on Dual Waiver of Premium.

- c. Policyholders and the DWOP spouses of such policyholders who, during the Policyholder Transition Period, experience any of the following ***Transitional Events***:
- (1) discontinue paying premium due to the activation of a Premium Waiver other than those described in subparagraph (a), above),
 - (2) go on claim (other than those described in subparagraph (b), above),
 - (3) recover and cease being on claim, or
 - (4) resume paying premium due to the deactivation of a Premium Waiver,

will all be required to elect new options from among those available to policyholders in their new circumstances. They will be provided new Policyholder Election Forms after the Policyholder Election Date, will have an opportunity to make new elections from among options applicable to policyholders in their new circumstances, and will have those elections implemented on a ***Supplemental Plan Effective Date***. If such a policyholder experiences a Transitional Event during the Policyholder Transition Period but the Company doesn't learn of it until after the policyholder has submitted an apparently valid Policyholder Election Form or after the Initial Plan Effective Date, the policyholder's election will be invalidated by the Transitional Event and the policyholder will be required to submit a new Policyholder Election Package before the Supplemental Plan Effective Date. If the Company learns of the Transitional Event after the Supplemental Plan Effective Date then the policy will be modified to implement the Default Option that would have applied had the Company learned of the Transitional Event before the Supplemental Plan Effective Date and the policyholder failed to make a valid election.

M. POLICYHOLDER INFORMATION

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

with the law applicable to liquidations. Policyholders with more than one policy will be advised that they are required to make independent elections for each policy.

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

N. CALCULATION NOTES

1. The assets allocated on an Accumulated Premium basis for determination of Self-sustaining Premium for purposes of Phase Two calculations will be those remaining after provision is made for administrative costs and contingencies as more fully explained above at Section II.E.4.d, page 27.
2. Whenever the Plan calls for adjustment of the ***Maximum Benefit Period*** (MBP) it will be calculated in increments of whole days.
3. Whenever the Plan calls for matching an existing premium rate, it may be by rounding the premium to the nearest dollar.
4. In calculating the Phase One Premium, the If Knew Premium, and other Plan provisions, periods on claim (including those followed by recovery) prior to the Initial Plan Effective Date will be taken into account and reduce the remaining benefit period. The operative benefit period for the policy will be what remains on the applicable Plan Determination Date. Thus, a policyholder whose initial Maximum Benefit Period was eight years when the policy was issued, but who has used five years of benefits (whether in one or more periods on claim) that were not restored or eligible for restoration, and therefore has three years remaining as of the Determination Date, will be deemed to have a Maximum Benefit Period of three years for Plan calculation purposes. The Phase One Premium and If Knew Premium will be calculated using the remaining benefit period. Thus, for this hypothetical policyholder, the premium will be calculated for a policy with a three year MBP.
5. In calculating reductions of the Maximum Benefit Period, for policies with two different pools of money, one (typically of two years) for Home Health Care and one (often longer, part of which may have been utilized) for Assisted Living Facility Care or Nursing Home Care:
 - a. The Plan will treat the policy as having a single benefit period equal to the longer of those provided by the pools. The benefit periods provided by the pools will not be aggregated. Thus, the Maximum Benefit Period for Assisted Living Facility Care cannot be increased by adding the unused benefit period for Home Health Care or *vice versa*.

- b. Benefits paid under the policy, regardless of site of care, will reduce the new single benefit period.
 - c. Pools shorter than four years will not be adjusted by the Plan. If benefits have reduced the benefit period below four years as of the Effective Date, it will remain at that level for Plan calculation purposes.
- 6. Policies that share a pool of benefits before the Policyholder Election Date, so that a policyholder whose benefit period is exhausted may continue receiving benefits under the shared pool until it is exhausted, will be treated for purposes of calculating premiums under the Plan as having a benefit period equal to the sum of the policy's benefit period and half of the shared pool's benefit period. Such policies will continue sharing a pool after the Plan. Elections made under the Plan will affect only the policy's benefit period, not the value of the shared pool. When such a policyholder goes on claim after the applicable Plan Effective Date, the claim will reduce the policy's benefit period first and then the shared pool. Policyholders sharing a pool need not make the same elections under the Plan.
 - a. For a policyholder who elects Option One, the downgrade will affect only the policy's benefit period (which cannot be reduced below four years unless it is already below that) and not the shared pool.
 - b. For a policyholder who elects Option Two, the policy's benefit period may be reduced but it will retain the possibility of benefits under the shared pool.
 - c. The premium for a policyholder who elects Option Four will be calculated as if the policy had a benefit period equal to the sum of the policy's current benefit period plus half of the shared pool.
- 7. In determining a policy's **Maximum Policy Value** (MPV), which is the product of a policy's Maximum Benefit Period (MBP) times its **Maximum Daily Benefit** (MDB), changes attributable to claims and benefits (such as inflation protection) will be taken into account. For Plan purposes, MPV will be calculated as if the policyholder went on claim on the Plan Effective Date. A policy with an unlimited benefit period will be deemed to have an unlimited MPV. The MPV for current (pre-election) benefits will be used to determine the floor for the Basic Policy Endorsements. A policy's MPV will be newly determined after giving effect to modifications resulting from policyholder elections and the resulting MPV will be used to determine whether the policy is subject to change in Phase Two.
- 8. The Plan contemplates that the minimum premium for Basic Policy Endorsements in Phase Two will be 110% of the Basic Policy If Knew Premium to discourage delaying the selection of Basic Policy Endorsements to Phase Two. See Sections IV.B.2.c, IV.C.1.b, IV.C.2.b.(4), IV.E.2.b, and IV.D.2.

9. Premium paying modalities (*i.e.*, monthly or quarterly payments) in effect before the Plan will be unchanged by the Plan unless necessary to give effect to a policyholder's election. If a policyholder is not paying premium prior to the applicable Plan Effective Date due to a waiver, and under the Plan he or she must begin paying a premium (such as a Differential Premium), the premium modality in effect prior to the waiver becoming effective will apply to the premium under the Plan.
10. Fees charged before commencement of the rehabilitation to premium payments based on modality (such as additional fees for monthly premiums) will continue to apply to premiums paid under the Plan on the same basis.

O. DRAFTING NOTES

1. As endorsements are drafted to implement policy changes, provisions not intended to be substantively affected will be left unchanged unless editing is necessary to implement the modifications selected.
2. As a result, for example, if a policy has an unlimited benefit period and a Restoration of Benefit provision, shortening the benefit period will not remove the Restoration of Benefit provision. However, the Restoration of Benefits provision cannot extend the benefit period beyond the newly shortened Maximum Benefit Period. Similarly, policies with limits in terms of days-of-care will remain so and not be converted to pool-of-money policies except by operation of the Downgrade Process or if the Basic Policy Endorsement is elected.
3. Replacement language to implement modifications will strive to eliminate ambiguities and add clarity.
4. If the language of the current policy does not differentiate clearly between Nursing Home and Assisted Living Facilities (ALF) coverage so that SHIP is now covering ALF care within the Nursing Home provision in those policies, electing the Basic Policy Endorsements will not eliminate ALF coverage but the Maximum Daily Benefits for ALF care will be limited to 75% of the policy's MDB for Nursing Home benefits.

III. DETAILS OF PHASE ONE OF THE PLAN

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

Policyholders who, as of the Phase One Policyholder Election Date, are paying premiums and are not disabled or eligible for benefits will have the following options.

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

- a. Such policyholders can keep their Current Premium but will have policy benefits reduced if the Current Premium is less than the If Knew Premium for their policy benefits.
- b. The ***Downgrade Target Premium*** (see page 122) for this option is the Phase One Premium, which is the higher of the Current Premium and the If Knew Premium. For policyholders whose Current Premium equals or exceeds the If Knew Premium for their policies, no downgrade will be necessary because they are already paying the Downgrade Target Premium and Options One and Four will produce the same result - no change in their policies. For policyholders that elect Option One and whose Current Premium is lower than the If Knew Premium for their current policies, the benefit reductions will be calibrated to produce benefits for which the premium on an If Knew Premium basis will be within 2% of the Current Premium, *i.e.*, no lower than 98% nor higher than 102% of the Current Premium. A description of the Downgrade Process follows Table 4.

TABLE 4: IS DOWNGRADE NECESSARY?		
IF:	CASE 1	CASE 2
1. THE CURRENT PREMIUM IS	\$3,000	\$3,200
and		
2. THE IF KNEW PREMIUM FOR THE CURRENT BENEFITS IS	\$2,800	\$5,000
THEN:		
IN CASE 1, SINCE THE IF KNEW PREMIUM IS LOWER THAN THE CURRENT PREMIUM, THERE WILL BE NO BENEFIT REDUCTIONS.	NO	
IN CASE 2, SINCE THE IF KNEW PREMIUM IS MORE THAN THE CURRENT PREMIUM, BENEFITS WILL BE REDUCED 36% TO THE CURRENT PREMIUM.		YES

- c. DOWNGRADE PROCESS: A single combination of one or more of the benefit reductions described in Section III.A.1.f, page 45 below, will be selected by the Rehabilitator in accordance with the Plan provisions to reduce the policy's benefits to a combination with an If Knew Premium within 2% of the Current Premium. Policyholders will not have the ability to select specific benefit reductions.
 - (1) Not all of the benefit reductions on the list below will be applicable to all policies. For example, eliminating inflation protection features would not be applicable to a policy that has no such benefits. Similarly, shortening

the Maximum Benefit Period would not be applicable to a policy with a benefit period that does not exceed four years. Thus, the list of potentially applicable benefit reductions may vary from policy to policy.

- (2) Each benefit reduction option is expected to have a materially different effect on premiums, some reducing the required If Knew Premium more than others. The result of a particular benefit reduction may vary among different policies. Benefit reductions will be selected sequentially, beginning with the first potentially applicable benefit reduction for the policy in question. However, in some cases the Rehabilitator may skip over one or more possible benefit reductions (for example, because they are inapplicable, produce too large a reduction, or are non-scalable) in order to produce the If Knew Premium closest to the Current Premium.
- (3) The Rehabilitator may also adjust a potentially applicable scalable benefit reduction up or down to simplify the process, for example by enabling fewer benefit reductions to be effected to achieve the desired premium level. Efforts will be made to minimize the number of benefit reductions applied to each policy.
- (4) Except as noted in the next paragraph, benefits will not be scaled above or below **Plan Limits**. Plan Limits for benefit period are a minimum of four years (unless the policy already has a lower MBP) and a maximum of 6 Years. Plan Limits for Daily Benefit are:
 - (a) For Nursing Home Care, a minimum of the lesser of (a) 80% of current level or (b) \$300, and a maximum \$600;
 - (b) For Facility Care, a minimum of the lesser of (a) 80% of current level or (b) \$225, and a maximum \$450; and
 - (c) For Home Health Care, a minimum of the lesser of (a) 80% of current level or (b) \$150, and a maximum \$300.
- (5) In order to achieve the Downgrade Target Premium (which is equal to the Current Premium), for some policyholders for whom other Benefit Reductions have not achieved the desired premium level, the MBP may be reduced below Plan Limits. For those policyholders for whom the Downgrade Option (Option One) is the default, the NFO serves as a safety net against reduction of the Maximum Benefit Period below the lesser of the current Benefit Period and 30 months. For other policyholders who select Option One and it produces a lower Benefit Period than the NFO or other Options, electing one of the other Options may be preferable.

- d. The default mode will be to evaluate the potentially applicable benefit reductions in the order in which they are included in the Plan.
- (1) If the first potentially applicable benefit reduction produces an If Knew Premium that is higher than 98% of the Current Premium it will be selected.
 - (a) If that first potentially applicable benefit reduction produces an If Knew Premium that is between 98% and 102% of the Current Premium, that will be the only benefit reduction and downgrade necessary for the policy in order to implement Option One.
 - (b) If the benefit reduction produces an If Knew Premium above 102 % of the Current Premium, is scalable, and can be scaled down sufficiently to produce an If Knew Premium no higher than 102% of the Current Premium without going below Plan Limits for MDB and MBP, then it will be scaled down sufficiently to achieve that result and that will be the only benefit reduction for the policy.
 - (2) If the first potentially applicable benefit reduction will not suffice (with or without scaling, if applicable) to reach an If Knew Premium within 2% of the Current Premium, the next potentially applicable benefit reduction will then be evaluated in the same manner, taking into account the effect of the previously selected potentially applicable benefit reduction.
 - (3) If the result is still an If Knew Premium that is higher than 102% of the Current Premium, that reduction will also be selected and the next potentially applicable benefit reduction will then be evaluated, again taking into account the effects of the previously selected potentially applicable benefit reductions.
 - (4) This process will continue until the resulting If Knew Premium is within 2% of the Current Premium. If it is within 2% of the Current Premium the process is complete and the potentially applicable benefit reductions selected will constitute the downgrade option for that policy.
 - (5) If the benefit reductions selected, in combination, produce an If Knew Premium that is lower than 98% of the Current Premium, the policy's MDB and MBP can be increased (subject to Plan Limits) to produce (in combination with previously selected benefit reductions) an If Knew Premium within 2% of the Current Premium. If raising the MDB and MBP (in combination with previously selected benefit reductions) still does not produce an If Knew Premium within 2% of the Current Premium, the policy's premium can be reduced so that the resulting If Knew Premium is within 2% of the Current Premium.

- (6) If all of the benefit reductions selected in combination produce an If Knew Premium that is higher than 102% of the Current Premium, then in addition, the Maximum Benefit Period will be shortened to the extent necessary to produce an If Knew Premium within 2% of the Current Premium.
 - (7) In the unlikely event that after all these steps the If Knew Premium for the reduced benefits remains higher than 102% of the Current Premium, there will be no further reductions and those will be the downgraded benefits and the premium charged for those benefits will be the Current Premium.
- e. Each policyholder will only receive one downgrade option, calculated as described in this Section. The Rehabilitator may develop algorithms, tables or other tools that will facilitate implementation of this process through classification of the existing policies. Policy provisions not identified in this Section will not be affected by the Downgrade unless necessary to implement the specified option.
- f. ***Benefit Reductions:***
 - (1) ***Benefit Reduction One:*** Elimination of Restoration of Benefits (ROB) provisions. This is a binary and non-scalable benefit reduction.
 - (2) ***Benefit Reduction Two:*** Elimination of Extension of Benefits provisions. This is a binary and non-scalable benefit reduction.
 - (3) ***Benefit Reduction Three:*** For policies with less restrictive triggers, adoption of the ***TQ Trigger***. See Section III.A.2.d.(7), page 48. This is a binary and non-scalable benefit reduction.
 - (4) ***Benefit Reduction Four:*** Discontinuation of Return of Premium (ROP) provisions. As of the Plan Effective Date, policies with Return of Premium benefit to which this reduction applies will cease accruing returnable premium. However, for policies which provide that returnable premiums accrue over several years and are then paid, or which make some past premium returnable upon specified events, ROP benefits accrued prior to the Effective Date will not be lost and will be calculated up to the applicable Plan Effective Date. Such returnable premium accrued prior to the Effective Date will be repaid at or around the time when the payment would have been due absent modification under the Plan. This is a binary and non-scalable benefit reduction.
 - (5) ***Benefit Reduction Five:*** Removal of inflation and “locking” of MDB at their current levels. This is a binary and non-scalable benefit reduction.

- (6) **Benefit Reduction Six:** Conversion of indemnity to reimbursement. See Section VI.B.12, page 85. This is a binary and non-scalable benefit reduction.
 - (7) **Benefit Reduction Seven:** Reduction of the policy's MDB to the lesser of 80% of current level and \$300 for Nursing Home Care; the lesser of (a) 80% of current level or (b) \$225 for Facility Care; and the lesser of (a) 80% of current level or (b) \$150 for Home Health Care. This is a scalable benefit reduction (that can be increased or decreased) so long as the resulting MDB is within Plan Limits.
 - (8) **Benefit Reduction Eight:** Extension of the EP to 90 days. If the current EP is 90 days or more it will not be modified. The EP will apply to each period of care. This will be treated as a binary and non-scalable benefit reduction.
 - (9) **Benefit Reduction Nine:** Reduction of the policy's MBP to no more than four years (from the applicable Plan Effective Date). If the current MBP is less than four years it will not be modified. As long as the resulting MBP is above the lesser of (a) the current period, or (b) four years, this is a scalable benefit reduction.
 - (10) **Benefit Reduction Ten:** Elimination of all Waiver of Premium provisions. For purposes of the Plan this is a binary and non-scalable benefit reduction. The Plan will not allow elimination of fewer than all available Premium Waiver provisions. The elimination will be prospective only and will not apply to the current waiver. It will apply to any waiver that would otherwise first have become effective after the downgrade.
 - (11) **Benefit Reduction Eleven:** Conversion to pool of money (unless the policy is already pool of money) and reduction of the Maximum Benefit Period to the amount required to achieve the Current Premium.
- g. The Downgrade is generally the Default Option for policyholders on Premium Waiver. In those cases, for those policyholders for whom the benefits that result from the Downgrade Process are lower than the benefits offered by the NFO, the NFO will be deemed the Default Option.

TABLE 5: DOWNGRADE PROCESS

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

1. Hypothetically, Benefit reductions One, Two, Three, and Four (BR1, BR2, BR3, and BR4) are inapplicable because the policy already has TQ Triggers, and no EOB, ROB or ROP benefits. Benefit Reduction Five (BR5) - Removal of inflation and “locking” of MDB at current level - hypothetically produces an If Knew Premium of \$2,720, a 15% reduction. The If Knew Premium is still above \$2,040, 102% of the Current Premium. This benefit reduction would be selected.
2. Benefit Reduction Six (BR6) would be inapplicable because this is already a reimbursement policy. Benefit Reduction Seven (BR7) - reduction of MDB to the lesser of 80% of current level or \$300 - is evaluated in combination with previously selected BR5 and the result of reducing the MDB is hypothetically an If Knew Premium of \$2,144 (a combined 33% reduction). The If Knew Premium remains above \$2,040, 102% of the Current Premium. BR7 would also be selected and BR8 would be the next to be evaluated.
4. Benefit Reduction Eight (BR8) - Extension of the EP to not less than 90 days - is then evaluated in combination with BR5 and BR7, and the result of extending the EP to 90 days (in combination with BR5 and BR7) is hypothetically an If Knew Premium of \$1,920 (a combined reduction of 40%). This reduces the premium below the target of 37.5%.
5. BR7 is then scaled up by increasing the MDB (but not above \$600) to the point at which the If Knew Premium is \$2,000, equal to the Current Premium, amounting to a 4% increase in the If Knew Premium of \$1,920 produced by BR5, BR7, and BR8.

2. OPTION TWO - TAKE BASIC POLICY ENDORSEMENTS AT CORRESPONDING IF KNEW PREMIUM.
 - a. Active-paying policyholders will have the option to have their current policy endorsed to provide benefits substantially similar to a newly designed Basic Policy.

- b. The new premium for the policy will be the If Knew Premium corresponding to the benefits provided by the policy after implementing the Basic Policy Endorsements.
- c. **THIS OPTION WILL BE IMMUNE FROM PHASE TWO CHANGES. Policyholders who elect this option will not face premium rate increases or benefit reductions in Phase Two of the Plan.** However, under certain circumstances a policyholder who is paying the If Knew Differential Premium for the Basic Policy Endorsements because he or she is on Premium Waiver may be required to pay the full If Knew Premium if the waiver ceases to apply, for example due to recovery of the policyholder on claim.
- d. Key provisions of the Basic Policy Endorsements are:
 - (1) MBP equal to the lesser of (a) the current benefit period, and (b) four years (beginning on the applicable Plan Effective Date);
 - (2) Minimum EP equal to the longer of (a) 90 calendar days, or (b) the current EP;
 - (3) Removal (discontinuation) of Return of Premium (ROP) benefit. As of the Plan Effective Date, policies with Return of Premium benefit will cease accruing returnable premium. However, for policies which provide that returnable premiums accrue over several years and are then paid, or which make some past premium returnable upon specified events, ROP benefits accrued prior to the Effective Date will not be lost and will be calculated up to the applicable Plan Effective Date. Such returnable premium accrued prior to the Effective Date will be repaid at the time when the payment would have been due absent modification under the Plan.
 - (4) Removal of Extension of Benefits provisions.
 - (5) For policies with annual inflation adjustment in MDB above 1.5%, reduction of the adjustment to 1.5%, retaining the original type (simple or compound);
 - (6) Reduction and adjustment of MDB by site of care. The MDB for Nursing Home Care will be the lesser of 80% of the MDB for such care in the current policy and \$300. The MDB for Facility Care other than Nursing Home Care will be the lesser of 80% of the MDB for such care in the current policy and \$225. The MDB for Home Health Care will be the lesser of 80% of the MDB for such care in the current policy and \$150;
 - (7) Adoption of ***Tax Qualified*** (TQ) Triggers. Tax Qualified or TQ Triggers require that a person 1) be expected to require care for at least 90 days, and be unable to perform 2 or more Activities of Daily Living (ADL - eating,

dressings, bathing, transferring, toileting, and continence) without substantial assistance (hands on or standby); or 2) for at least 90 days, need substantial assistance due to a severe cognitive impairment. In either case a licensed healthcare professional must certify a plan of care;

- (8) Conversion of reimbursement policies to indemnity;
 - (9) Conversion of “Days of Care” policies to “Pool of Money;”
 - (10) Removal of Restoration of Benefits (ROB) provisions; and
 - (11) Elimination of all Premium Waivers.
- e. This will be the Default Option for policyholders in this category (active-paying) whose Current Premium is lower than the If Knew Premium.
 - f. Unless the benefits of their current policies are lower, policyholders will also be offered an “Enhanced Basic Policy Endorsement” at higher If Knew Premium with the terms described above but caps at a five-year benefit period and 2% inflation. In Phase Two the premium for the Enhanced Basic Policy Endorsements will be at Self-sustaining Premium rates. For a policyholder whose current policy has a Maximum Benefit Period of less than five years but inflation above 2%, the Enhanced Basic Policy Endorsements will only affect the inflation benefit. For a policyholder whose current policy has inflation below 2% but a Maximum Benefit Period of more than five years, the Enhanced Basic Policy Endorsements will only affect the Maximum Benefit Period. The inflation type (simple or compound) will be the same as the current policy.
 - g. Except as noted in the next paragraph, and with the exception of the change from reimbursement to indemnity, benefits in the Basic Policy Endorsements (even in the Enhanced Basic Policy Endorsements) cannot exceed those in the current policy. If a particular component of the Basic Policy Endorsements provides more coverage than the current policy’s corresponding provision, that provision of the current policy will not be modified by endorsement. Thus, for example, if the MBP of the current policy is three years, the Basic Policy Endorsements for that policy will incorporate a Maximum Benefit Period of three, not four or five, years.
 - h. For those policies with an MPV that is currently above their applicable Guaranty Association (GA) limits, the endorsed policy’s MPV will be adjusted so that it is at least equal to the applicable GA limit. For those policies with an MPV below the applicable GA limits, the MPV of the endorsed policies will be adjusted so that it is at least equal to the current MPV. The adjustments will be made by lengthening the MBP.

3. OPTION THREE - NFO.

- a. Active-paying policyholders can elect a Non-forfeiture option (NFO) policy under which the MBP will be the lesser of 2.5 years and the policy's current MBP.
 - (1) Like the Basic Policy Endorsements, this will be an indemnity policy (not reimbursement);
 - (2) It will not have Extension of Benefits provisions;
 - (3) It will not have Return of Premium provisions;
 - (4) It will not have Restoration of Benefits provisions;
 - (5) It will convert "Days of Care" policies to "Pool of Money;"
 - (6) It will have a minimum 90-day elimination period;
 - (7) It will have TQ triggers;
 - (8) It will not have an inflation protection feature; and
 - (9) The Maximum Daily Benefit (MDB) will be reduced and adjusted for site of care. The MDB for Nursing Home Care will be the lesser of 80% of the MDB for such care in the current policy and \$300. The MDB for Facility Care other than Nursing Home Care will be the lesser of 80% of the MDB for such care in the current policy and \$225. The MDB for Home Health Care will be the lesser of 80% of the MDB for such care in the current policy and \$150.
- b. In those rare cases in which the specific policy provides for an NFO that has greater benefits than the Plan NFO, the policy-specific NFO will be offered instead.
- c. No additional premiums will be due for this policy and it will never lapse.
- d. Generally, this policy offers more benefits than traditional NFOs. It cannot be upgraded later.
- e. The selection of indemnity, rather than reimbursement, modality for Options Two and Three is expected to be of significant value to policyholders.

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

- a. Active-paying policyholders can elect to keep their current benefits and their premiums will increase to the corresponding Phase One Premium. See Section I.A.1.a.(1)(a)i)a)69), page 127, above. Policyholders whose Current Premiums equal or exceed the If Knew Premium for their policies will continue to pay their Current Premiums. For those policyholders, this option, like Option One, does not result in any change.
- b. Policyholders selecting this option may also face substantial rate increases or Benefit reductions in Phase Two.

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

Policyholders who, as of the Phase One election date, are NOT paying premiums due to the applicability of a premium waiver provision, but who are not disabled or eligible for benefits will have the following options.

- 1. **LIFETIME WAIVER** - Policyholders not paying premium due to Lifetime Waiver of Premium (because of the death of a spouse) will have essentially the same four options as premium paying active lives (see Section, III.A, page 41) with the following modifications:
 - a. **OPTION ONE - KEEP PREMIUM WAIVER AND DOWNGRADE POLICY BENEFITS.** If the Current (waived) Premium is equal to or greater than the If Knew Premium, the policyholder need not make any election, there will be no default downgrade, and Options One and Four will produce the same result - no change in their policies. If the Current Premium is less than the If Knew Premium the policy will be downgraded as follows.
 - (1) Due to the Premium Waiver the policyholder will continue not paying premium.
 - (2) The Downgrade Process will be the same as for premium-paying active lives (see Section III.A.1.c, page 42, above).
 - (3) The specific possible benefit reductions will be the ones described in Section III.A.1.f, page 45, above.
 - (4) The benefit reductions will be calibrated to the Current Premium as explained in Section III.A.1.b, page 42.
 - (5) This will be the Default Option for these policyholders. However, for those policyholders for whom the benefits that result from the Downgrade Process

in Option One are lower than those offered by the NFO, the NFO will be the Default Option.

- b. **OPTION TWO - TAKE BASIC POLICY ENDORSEMENTS AT IF KNEW DIFFERENTIAL PREMIUM** (rather than the If Knew Premium).
 - (1) The If Knew Differential Premium for this option is the difference between the If Knew Premium corresponding to the benefits provided by the policy after implementing the Basic Policy Endorsements and the Current (waived) Premium for the policy, both of which are set as if the policyholder did not have a Premium Waiver in effect. If the If Knew Differential Premium is less than zero, the policyholder will not be required to pay any additional premium for the Basic Policy Endorsements.
 - (2) Policyholders will also be offered an “Enhanced Basic Policy Endorsement” at higher If Knew Premiums. See Section III.A.2.f, page 49.
 - (3) Policyholders who elect this option in Phase One will not face premium rate increases or additional benefit reductions in Phase Two of the Plan.
 - (4) If the current policy provides benefits (has an MPV) above the applicable Guaranty Association limits, the Guaranty Association floor on benefit reductions will be applied to these policyholders as described in Section III.A.2.h, page 49. If the current policy has an MPV below the applicable GA limits, the benefits of the endorsed policy will be adjusted so that the resulting MPV is at least equal to the current MPV.
 - c. **OPTION THREE - NFO** (see Section III.A.3, page 50).
 - d. **OPTION FOUR - KEEP THE CURRENT BENEFITS AND PAY PHASE ONE DIFFERENTIAL PREMIUM.**
 - (1) The If Knew Differential Premium for this option is the difference between the If Knew Premium and the Current (waived) Premium for the policy, both of which are set as if the policyholder did not have a Premium Waiver in effect. If the If Knew Differential Premium is less than zero, the policyholder will not be required to pay any additional premium.
 - (2) Policyholders who elect this Option may also face substantial rate increases in Phase Two.
2. **DUAL WAIVER** - The options for a policyholder not on claim but not paying premium due to a Dual Waiver (because his or her spouse is on claim) will be the same as for a policyholder not on claim with a Lifetime Waiver except that the premium he or she must

pay will be determined in part by the spouse's claim status. The default for these policyholders will be Option One (Downgrade). However, for those policyholders for whom the benefits that result from the Downgrade Process are lower than those offered by the NFO, Option Three, the NFO, will be the Default Option.

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

- (1) The Downgrade Process will be as described in Section III.A.1.c, page 42 subject to the following provisions.
- (2) The same possible benefit reductions will apply, as described in Section III.A.1.f, page 45. Benefit reductions for each policyholder to whom this option applies will be calibrated to produce an If Knew Premium within 2% of the Current Premium for the policy (see Section III.A.1.b, page 42). However, because of the waiver, the policyholder will not be required to pay any premium.
- (3) If the disabled spouse resumes paying premiums, the active spouse will also be required to resume paying premiums at the premium rate he or she would be paying if not on waiver, but if the policy has been downgraded it will remain downgraded.

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

- (1) The policy will be modified through the Basic Policy Endorsements (See Section III.A.2.d, page 48). The policyholder will be required to pay the If Knew Differential Premium. The If Knew Differential Premium for this Option is the difference between the If Knew Premium corresponding to the benefits provided by the policy after implementing the Basic Policy Endorsements and the Current (waived) Premium for the policy, both of which are set as if the policyholder did not have a Premium Waiver in effect. If the If Knew Differential Premium is less than zero, the policyholder will not be required to pay any additional premium for the Basic Policy Endorsements.
- (2) Policyholders will also be offered an "Enhanced Basic Policy Endorsement" at higher If Knew Premiums. See Section III.A.2.f, page 49.

- (3) If the current policies provide benefits above the applicable Guaranty Association limits, the Guaranty Association floor on benefit reductions will be applied to these policyholders as described in Section III.A.2.h, page 49. For those policies with an MPV below the applicable GA limits, the benefits of the endorsed policies will be adjusted so that the resulting MPV is at least equal to the current MPV. The adjustments will be made by lengthening the MBP.
 - (4) Policyholders who elect this option in Phase One will not face premium rate increases or additional benefit reductions in Phase Two of the Plan, except as noted below.
 - (5) If the disabled spouse recovers, the active spouse will be required to begin paying the full If Knew Premium corresponding to the benefits provided by the policy after implementing the Basic Policy Endorsements.
- c. **OPTION THREE - NFO.**
- (1) The policyholder can select a NFO. See Section III.A.3.
- d. **OPTION FOUR - KEEP CURRENT BENEFITS AND PAY PHASE ONE DIFFERENTIAL PREMIUM:** The policyholder will retain the current policy benefits and pay the Phase One Differential Premium (see Section II.E.7.b, page 29). However, if the disabled spouse recovers, the active spouse will be required to begin paying the full Phase One Premium. As noted, if the Current (waived) Premium is equal to or greater than the If Knew Premium, the policyholder will not be required to make an election or pay a Differential Premium.

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

Policyholders on claim, who are paying premiums, will have the same options as active lives paying premiums (see Section III.A, page 41), subject to the following conditions:

- 1. **OPTION ONE - KEEP CURRENT PREMIUM AND DOWNGRADE POLICY BENEFITS.**
 - a. Policyholders will preserve their Current Premium. For policyholders whose Current Premiums equal or exceed the If Knew Premium for their policies, no election will be necessary and no default downgrade would apply because they are already paying the Downgrade Target Premium and Options One and Four will produce the same result - no change in their policies. However, if the Current Premium is less than the If Knew Premium, the policy will be downgraded using the Downgrade Process and benefit reductions described in Sections III.A.1.c, page 42, and III.A.1.f, page 45, above, subject to the following provisions.

- b. The following Benefit Reductions would apply to new benefit periods after recovery:
 - (1) The changes in triggers described in Benefit Reduction Three;
 - (2) The change to reimbursement described in Benefit Reduction Six;
 - (3) The extension of elimination period described in Benefit Reduction Eight; and
 - (4) The elimination of premium waiver provisions in Benefit Reduction Ten.
 - c. The reductions will be calibrated to produce an If Knew Premium within 2% of the Current Premium for the policy (see Section III.A.1.b, page 42).
 - d. Note that the Downgrade Process does not increase the premium being paid prior to the downgrade, although in a few cases it may be reduced slightly.
2. **OPTION TWO - TAKE BASIC POLICY ENDORSEMENTS AT IF KNEW PREMIUM.** The policy will be endorsed as described in Section III.A.2.d, page 48, at If Knew Premium.
- a. For those policies with an MPV that is currently above their applicable Guaranty Association limits, the endorsed policy's benefits will be adjusted to produce an MPV at least equal to the applicable Guaranty Association limits. For those policies with MPV below the applicable GA limits, the benefits of the endorsed policies will be adjusted so that the resulting MPV is at least equal to the current MPV. The adjustments will be made by lengthening the MBP.
 - b. Policyholders will also be offered an "Enhanced Basic Policy Endorsement" at higher If Knew Premiums. See Section III.A.2.f, page 49.
 - c. Changes in EP and benefit trigger would apply to subsequent periods of care following recovery.
 - d. This will be the default for these policyholders if their Current Premium is lower than the If Knew Premium.
3. **OPTION THREE - NFO.** See Section III.A.3.
4. **OPTION FOUR - KEEP CURRENT BENEFITS AND PAY PHASE ONE PREMIUM.** Policyholders can elect to keep their current benefits and their premiums will increase to the Phase One Premium. Policyholders whose Current Premiums equal or exceed the If Knew Premium for their policies will continue to pay their Current Premiums. Policyholders who elect this Option may also face substantial rate increases in Phase Two.
5. In some cases, options like the Downgrade or Basic Policy Endorsements may result in a reduction of the benefits being received by the policyholder on claim at the time of the

election. It is also possible that the If Knew Premium for the Basic Policy Endorsements will be lower than the policyholder's Current Premium.

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

Policyholders who, as of the Phase One Policyholder Election Date, are not paying premiums due to a premium waiver provision and are disabled or eligible for benefits will have the following options.

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

- a. These policyholders will preserve their Premium Waiver but, if the Current Premium they would be paying in the absence of waiver is less than the If Knew Premium, the policies will be downgraded. The Downgrade Process will be as described in Section III.A.1.c, page 42, and the benefit reductions described in Section III.A.1.f, page 45, above.
- b. This is the Default Option for policyholders on claim with waiver of premium in Phase One. However, for those policyholders for whom the benefits that result from the Downgrade Process are lower than those offered by the NFO, the NFO (Option Three) will be the Default Option.
- c. The reductions will be calibrated to produce an If Knew Premium within 2% of the Current Premium for the policy (see Section III.A.1.b, page 42). However, because of the waiver, the policyholder will not be required to pay any premium.
- d. If the policyholder is required to resume paying premiums, the premiums will be at the rate the policyholder would be paying if not on waiver, but the policy will remain downgraded. Note that the Downgrade Process does not increase the premium being paid prior to the downgrade.
- e. The following Benefit Reductions would apply to new benefit periods after recovery:
 - (1) The changes in triggers described in Benefit Reduction Three;
 - (2) The change to reimbursement described in Benefit Reduction Six;
 - (3) The extension of elimination period described in Benefit Reduction Eight; and
 - (4) The elimination of premium waiver provisions in Benefit Reduction Ten.
- f. The reductions will be calibrated to produce an If Knew Premium within 2% of the Current Premium for the policy (see Section III.A.1.b, page 42).

2. OPTION TWO - TAKE BASIC POLICY ENDORSEMENTS AT IF KNEW DIFFERENTIAL PREMIUM.
- a. These policyholder will have the option to have the current policy endorsed to provide benefits substantially similar to a newly designed Basic Policy. See Section III.A.2.d, page 48, above.
 - b. Policyholders will also be offered an “Enhanced Basic Policy Endorsement” at higher If Knew Premiums. See Section III.A.2.f, page 49.
 - c. Changes in EP and benefit trigger would apply to subsequent periods of care following recovery.
 - d. With the exception of the change from reimbursement to indemnity, no component of the endorsed policy can be richer than the current policy.
 - e. If the Current Premium the policyholder would be paying but for the waiver is less than the If Knew Premium for this policy, the policyholder must begin paying the If Knew Differential Premium. The If Knew Differential Premium for this option is the difference between the If Knew Premium corresponding to the benefits provided by the policy after implementing the Basic Policy Endorsements and the current premium for the policy, both of which are set as if the policyholder did not have a premium waiver in effect. As noted, if the If Knew Differential Premium is less than zero, the policyholder will not be required to pay any additional premium for the Basic Policy Endorsements.
 - f. If the disabled policyholder recovers, the waiver of premium benefit will no longer be applicable or available in the future, and he or she will be required to begin paying the full If Knew Premium corresponding to the benefits provided by the policy after implementing the Basic Policy Endorsements, even if it is lower than the current waived premium.
 - g. Although they will be required to pay the full If Knew Premium rather than the Differential Premium upon recovery, policyholders who elect this option in Phase One will not face other premium rate increases or additional benefit reductions in Phase Two of the Plan.
 - h. For those policies with an MPV that is currently above their applicable GA limits, the endorsed policy’s benefits will be adjusted to produce an MPV at least equal to the applicable Guaranty Association limits. For those policies with MPV below the applicable GA limits, the benefits of the endorsed policies will be adjusted so that they produce MPVs at least equal to the current MPVs. The adjustments will be made by lengthening the MBP.

3. **OPTION THREE - NFO.** Policyholders can elect a Non-forfeiture Option (NFO). See Section III.A.3.
4. **OPTION FOUR - KEEP CURRENT BENEFITS AND PAY PHASE ONE DIFFERENTIAL PREMIUM.** If the Current Premium the policyholder would be paying in the absence of waiver is equal to or greater than the If Knew Premium, the policyholder will not be required to make an election or pay a Differential Premium.
 - a. Policyholders on claim with Premium Waiver (whose waived premium is below the If Knew Premium) can keep their current policy benefits.
 - b. Their Premium Waiver (including Lifetime and Dual) will apply only to the Current Premium they would be paying absent the waiver. If the Current Premium the policyholders would be paying but for the waiver is less than the If Knew Premium for this policy, they will be required to begin paying the corresponding Phase One Differential Premium. (See Section II.E.7.b, page 29).
 - c. If the policyholders recover, they will be required to begin paying the full Phase One Premium.

IV. DETAILS OF PHASE TWO OF THE PLAN

Phase Two will be implemented as and when deemed necessary by the Rehabilitator depending on the results of Phase One. As currently contemplated, it will be similar in structure to Phase One though based on Self-sustaining premiums rather than If Knew Premium. THE DETAILS OF PHASE TWO CALCULATIONS ARE SUBJECT TO CHANGE AND REFINEMENT DEPENDING ON THE RESULTS OF PHASE ONE AND INTERVENING EVENTS. POLICYHOLDERS WHO WERE REQUIRED TO PAY MODERATELY HIGHER PREMIUMS FOR OPTION FOUR IN PHASE ONE MAY BE REQUIRED TO PAY MATERIALLY HIGHER PREMIUMS TO PRESERVE THEIR COVERAGE IN PHASE TWO.

A. APPLICATION

1. Throughout the period that follows implementation of Phase One, the Company's financial condition will be monitored with emphasis on projected changes in the Company's deficit.
2. The evaluation of the Company's condition will include a determination of the magnitude of additional remedial measures required to eliminate any projected remaining deficit. The evaluation will include projections of the effect of Phase One over time.
3. A decision will then be made as to whether, when, and how Phase Two should be implemented.

4. Phase Two adjustments will only be made to policies that:
 - a. Are not Fully Covered by the applicable Guaranty Association limits (*i.e.*, have Uncovered Benefits),
 - b. Are not Self-sustaining (because the sum of projected benefits and expenses exceeds the sum of allocated assets and projected premium), and
 - c. Did not elect Option Two (Basic Policy Endorsements) or Option Three (NFO) in Phase One.
5. Phase Two adjustments will be calculated after the results of Phase One adjustments have been incorporated.
6. While policy modifications in Phase Two will largely be based on Self-sustaining Premiums rather than If Knew Premium, it is possible that, depending on the outcome of Phase One and other relevant considerations, an alternative premium structure will be used in Phase Two. That determination will be made before policyholders are required to make elections in Phase Two and the results of that determination will be included in information provided to policyholders before they are required to make such elections.

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

Policyholders who, as of the Phase Two Policyholder Election Date, are paying premiums and are not disabled or eligible for benefits will have the following options.

1. **OPTION ONE - KEEP CURRENT PREMIUM AND DOWNGRADE POLICY BENEFITS.**
 - a. Such policyholders not on claim paying premium can elect in Phase Two to keep the premium rate resulting from Phase One and reduce benefits to eliminate the policy shortfall.
 - b. The benefit reduction process and options will be the same as in Phase One (see Section III.A.1.c page 42) but the current benefits will be reduced so that they produce a Self-sustaining Premium that is within 2% of the policyholder's Current Premium.
 - c. As in Phase One, each policyholder will only receive one downgrade option, calculated as described in Section III.A.1.c.

2. **OPTION TWO - TAKE BASIC POLICY ENDORSEMENTS AT SELF-SUSTAINING PREMIUM.**
 - a. Active-paying policyholders can choose to have their current policy endorsed to provide benefits substantially similar to a newly designed Basic Policy. See Section III.A.2.d, page 48.
 - b. This is the Default Option for premium paying active lives in Phase Two.
 - c. Premiums will be set to the corresponding Self-sustaining Premium level. The premium for this option will be no less than 110% of the Basic Policy If Knew Premium for this policy reflecting the cost of delay in making this election until Phase Two.
 - d. Policyholders will also be offered an “Enhanced Basic Policy Endorsement” at higher Self-sustaining Premiums. See Section III.A.2.f, page 49.
 - e. With the exception of the change from reimbursement to indemnity, post-endorsement benefits cannot exceed those in the current policy. If a particular component of the Basic Policy Endorsements provides more coverage than the current policy’s corresponding provision, that provision of the current policy will not be modified by endorsement.
 - f. For those policies with an MPV that is currently above their applicable GA limits, the endorsed policy’s benefits will be adjusted to produce an MPV at least equal to the applicable Guaranty Association limits. For those policies with an MPV below the applicable GA limits, the benefits of the endorsed policies will be adjusted so that they produce MPVs at least equal to the current MPVs. The adjustments will be made by lengthening the MBP.
3. **OPTION THREE - NFO.** Such policyholders can elect a Non-forfeiture Option. See Section III.A.3.
4. **OPTION FOUR - KEEP CURRENT BENEFITS AND PAY SELF-SUSTAINING PREMIUM.**
 - a. These policyholders can elect to maintain the current policy benefits but will be required to pay Self-sustaining Premiums.
 - b. As noted previously, the Self-sustaining Premium is the premium calculated to eliminate any Shortfall Amount in the policy. The shortfall is the excess of the sum of projected benefits and expenses (the PBA) over the sum of projected premiums and Allocated Assets (the PCA). See Section II.E.4, page 27, above.

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

Policyholders who, as of the Phase Two Policyholder Election Date, are not paying premiums due to a premium waiver provision, but who are not disabled or eligible for benefits will have the following options.

1. LIFETIME WAIVER - Such policyholders on lifetime waiver (due to the death of a spouse) will have essentially the same four options as premium paying policyholders not on claim (See Section IV.B, page 59) with the following modifications:
 - a. OPTION ONE - KEEP PREMIUM WAIVER AND DOWNGRADE POLICY BENEFITS. This will be the Default Option for these policyholders. However, for those policyholders for whom the benefits that result from the Downgrade Process are lower than those offered by the NFO, the NFO (Option Three) will be the Default Option.
 - (1) Due to the Premium Waiver the policyholder will continue not paying premium.
 - (2) The Downgrade Process will be the same as for premium-paying active lives in Phase One (see Section III.A.1.c, page 42, above).
 - (3) The specific possible benefit reductions will be the ones described in Section III.A.1.f, page 45, above,
 - (4) In this case the benefit reductions will be calibrated such that the projected benefits and expenses (the PBA) are equal to the sum of projected premiums and the assets allocated to the policy on an accumulated premium basis (the PCA).
 - b. OPTION TWO - TAKE BASIC POLICY ENDORSEMENTS AT SELF-SUSTAINING DIFFERENTIAL PREMIUM. If the current policies provide benefits above the applicable Guaranty Association limits, the Guaranty Association floor on benefit reductions will be applied to these policyholders as described in Section III.A.2.h, page 49. For those policies with MPV below the applicable GA limits, the benefits of the endorsed policies will be adjusted so that they produce MPVs at least equal to the current MPVs. The adjustments will be made by lengthening the MBP.
 - (1) The Self-sustaining Premium used for the calculation for this option will be no less than 110% of the Basic Policy If Knew Premium for this policy reflecting the cost of delay in making this election until Phase Two.

- (2) Policyholders will also be offered an “Enhanced Basic Policy Endorsement”. See Section III.A.2.f, page 49 at higher Self-sustaining Differential Premiums. The Self-sustaining Premium used for the calculation for this option will be no less than 110% of the Basic Policy If Knew Premium for this policy reflecting the cost of delay in making this election until Phase Two.
 - c. OPTION THREE - NFO (see Section III.A.3, page 50).
 - d. OPTION FOUR - KEEP CURRENT BENEFITS AND PAY SELF-SUSTAINING DIFFERENTIAL PREMIUM. The new premium will be the Self-sustaining Differential Premium described in the next paragraph.
 - e. The *Self-sustaining Differential Premium* is the difference between (1) the corresponding Self-sustaining Premium set as if the policyholder were not on claim and (2) the Current Premium the policyholder would be paying if he or she were not on Premium Waiver. The Self-sustaining Differential Premium will never be less than zero.
2. DUAL WAIVER - The options for a policyholder not on claim but not paying premium due to a dual waiver (because his or her spouse is on claim) will be the same as for a policyholder not on claim with a lifetime waiver except that the premium he or she must pay will be determined in part by the spouse’s claim status. The default for these policyholders will be Option One (Downgrade). However, for those policyholders for whom the benefits that result from the Downgrade Process are lower than those offered by the NFO, the NFO (Option Three) will be the Default Option.
- a. OPTION ONE - KEEP PREMIUM WAIVER AND DOWNGRADE POLICY BENEFITS. The policyholder will retain the Current Premium Waiver but the policy will be downgraded.
 - (1) The Downgrade Process will be as described in Section III.A.1.c, page 42 subject to the following provisions.
 - (2) The Benefit Reductions will apply, as described in Section III.A.1.f, page 45. Benefit reductions for each policyholder to whom this option applies will be calibrated to produce a Self-sustaining Premium equal to the premium the policyholder would be paying if not on waiver (the Current Premium). However, because of the waiver, the policyholder will not be required to pay any premium.
 - (3) If the disabled spouse resumes paying premiums, the active spouse will also be required to resume paying premiums at the premium rate he or she would be paying if not on waiver, but the policy will remain downgraded.

- b. **OPTION TWO - TAKE BASIC POLICY ENDORSEMENTS AT SELF-SUSTAINING DIFFERENTIAL PREMIUM.**
- (1) The policy will be modified through the Basic Policy Endorsements (See Section III.A.2.d, page 48). The policyholder will be required to pay the Self-sustaining Differential Premium.
 - (2) If the current policies provide benefits above the applicable Guaranty Association limits, the Guaranty Association floor on benefit reductions will be applied to these policyholders as described in Section III.A.2.h, page 49. For those policies with MPV below the applicable GA limits, the benefits of the endorsed policies will be adjusted so that they produce MPVs at least equal to the current MPVs. The adjustments will be made by lengthening the MBP.
 - (3) Policyholders will also be offered an “Enhanced Basic Policy Endorsement” at higher Self-sustaining Premiums. See Section III.A.2.f, page 49.
 - (4) The Self-sustaining Premium used for the calculation for this option will be no less than 110% of the Basic Policy If Knew Premium for this policy, reflecting the cost of delay in making this election until Phase Two
 - (5) If the disabled spouse recovers the active spouse will be required to begin paying the full Self-Sustaining Premium corresponding to the benefits provided by the policy after implementing the Basic Policy Endorsements.
- c. **OPTION THREE - NFO.** The policyholders can elect a Non-forfeiture Option. See Section III.A.3.
- d. **OPTION FOUR - KEEP CURRENT BENEFITS AND PAY SELF-SUSTAINING DIFFERENTIAL PREMIUM.** The policyholder will retain the current policy benefits and pay the Self-sustaining Differential Premium (see Section IV.C.1.e, page 62).
- (1) If the disabled spouse recovers the active spouse will be required to begin paying the full Self-sustaining Premium.
 - (2) The Self-sustaining Differential Premium cannot be less than zero.

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

Policyholders on claim who are paying premiums will have the same options as active lives paying premiums (see Section IV.B, page 59) subject to the following conditions.

1. **OPTION ONE - KEEP CURRENT PREMIUM AND DOWNGRADE POLICY BENEFITS.** Keep the Current Premium rates but accept specified downgrades. The Downgrade process will be as described in Section III.A.1.c, page 42. The Benefit Reductions described in Section III.A.1.f, page 45 will apply, but the benefits will be reduced so that they produce a Self-Sustaining Premium within 2% of the Current Premium.
2. **OPTION TWO - TAKE BASIC POLICY ENDORSEMENTS AT SELF-SUSTAINING PREMIUM.** The policy will be endorsed as described in Section III.A.2.d, page 48, at Self-sustaining Premium
 - a. The Self-sustaining Premium used for the calculation for this option will be no less than 110% of the Basic Policy If Knew Premium for this policy reflecting the cost of delay in making this election until Phase Two.
 - b. Changes in EP and benefit trigger would apply to subsequent periods of care following recovery.
 - c. For those policies with MPVs that are currently above their applicable GA limits, the endorsed policy's benefits will be adjusted to produce MPVs at least equal to the applicable GA limits. For those policies with MPVs below the applicable GA limits, the benefits of the endorsed policies will be adjusted so that they produce MPVs at least equal to the current MPVs. The adjustments will be made by lengthening the MBP.
 - d. This will be the default for these policyholders.
 - e. Policyholders will also be offered an "Enhanced Basic Policy Endorsement" at higher Self-sustaining Premiums. See Section III.A.2.f, page 49.
3. **OPTION THREE - NFO.** See Section III.A.3.
4. **OPTION FOUR - KEEP CURRENT BENEFITS AND PAY SELF-SUSTAINING PREMIUM.** The Self-sustaining Premium will be set as if the policyholder were not on claim. However, in so doing assets will be allocated to the policyholders according to the method previously described for Disabled Lives.
5. In some cases, options like the Downgrade or Basic Policy Endorsements may result in a reduction of the benefits being received by the policyholder on claim at the time of the election.

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

Policyholders who, as of the Phase Two Policyholder Election Date, are not paying premiums due to a premium waiver provision, and who are disabled or eligible for benefits will have the following options.

1. **OPTION ONE - KEEP PREMIUM WAIVER AND DOWNGRADE POLICY BENEFITS.**
 - a. This is the Default Option for policyholders on claim with Premium Waiver in Phase Two. However, for those policyholders for whom the benefits that result from the Downgrade Process are lower than those offered by the NFO, the NFO (Option Three) will be the Default Option.
 - b. Policyholders may preserve their Premium Waiver and the policy will be downgraded. The Downgrade Process will be as described in Section III.A.1.c, page 42. The Benefit Reductions described in Section III.A.1.f, page 45, above, will apply but benefits will be reduced so that they produce a Self-sustaining premium that is within 2% of the Current Premium.
 - c. If the policyholder resumes paying premiums, the premiums will be at the rate the policyholder would be paying if not on waiver, but the policy will remain downgraded. Note that the Downgrade Process made that premium equal to the Self-sustaining Premium for the downgraded policy at the time of implementation of Phase Two.
 - d. If the policyholder regains active status, for future periods of care:
 - (1) The EP will be no less than 90 days. If the current EP is more than 90 days, the policy will retain the current EP;
 - (2) The EP will apply to each period of care; and
 - (3) TQ Triggers will apply. See Section III.A.2.d.(7), page 48.
2. **OPTION TWO - TAKE BASIC POLICY ENDORSEMENTS AT SELF-SUSTAINING DIFFERENTIAL PREMIUM.**
 - a. The policyholder will have the option to have the current policy endorsed to provide benefits substantially similar to a newly designed Basic Policy. See Section III.A.2.d, page 48.
 - b. The policyholder must begin paying the Self-sustaining Differential Premium corresponding to the Self-sustaining premium for the Basic Policy Endorsements set as if the policyholder were not on claim. The Self-sustaining Premium used for the

calculation for this option will be no less than 110% of the Basic Policy If Knew Premium for this policy reflecting the cost of delay in making this election in Phase Two.

- c. With the exception of the change from reimbursement to indemnity, no component of the endorsed policy can be richer than the current policy.
 - d. For those policies with MPVs that are currently above their applicable GA limits, the endorsed policy's benefits will be adjusted to produce MPVs at least equal to the applicable Guaranty Association limits. For those policies with MPVs below the applicable GA limits, the benefits of the endorsed policies will be adjusted so that they produce MPVs at least equal to the current MPVs. The adjustments will be made by lengthening the MBP.
 - e. Policyholders will also be offered an "Enhanced Basic Policy Endorsement" at higher Self-sustaining Premiums. See Section III.A.2.f, page 49.
 - f. Changes in EP and benefit trigger would apply to subsequent periods of care following recovery.
 - g. If the policyholder recovers, he or she will be required to begin paying the full Self-sustaining Premium.
3. OPTION THREE - NFO. Policyholders can elect a Non-forfeiture Option. See Section III.A.3.
4. OPTION FOUR - KEEP CURRENT BENEFITS AND PAY SELF-SUSTAINING DIFFERENTIAL PREMIUM.
- a. A policyholder on claim with Premium Waiver can keep the current policy benefits.
 - b. The Premium Waiver (including lifetime and dual) will apply only to the Current Premium. The policyholder will be required to begin paying the corresponding Self-sustaining Differential Premium (see Section IV.C.1.e, page 62). If the policyholder recovers he or she will be required to begin paying the full Self-sustaining Premium.

F. SUMMARY OF POLICYHOLDER OPTIONS

The following table summarizes all of the options available to policyholders under the Plan depending on their claim and premium-paying status in both Phase One and Phase Two.

TABLE 6: POLICYHOLDER OPTIONS		
	PHASE ONE	PHASE TWO
ACTIVE PAYING	1. KEEP PREMIUM - DOWNGRADE 2. BASIC POLICY - IF KNEW PREMIUM* 3. NFO 4. KEEP BENEFITS - PHASE ONE PREMIUM	1. KEEP PREMIUM - DOWNGRADE 2. BASIC POLICY - SELF SUSTAINING PREMIUM* 3. NFO 4. KEEP BENEFITS - SELF-SUSTAINING PREMIUM
ACTIVE WAIVER	1. DOWNGRADE - RETAIN PREMIUM WAIVER*‡ 2. BASIC POLICY - IF KNEW DIFFERENTIAL PREMIUM 3. NFO 4. KEEP BENEFITS - PHASE ONE DIFFERENTIAL PREMIUM DUAL WAIVER PREMIUM GOVERNED IN PART BY SPOUSE'S STATUS	1. DOWNGRADE - RETAIN PREMIUM WAIVER*‡ 2. BASIC POLICY - SELF SUSTAINING DIFFERENTIAL PREMIUM† 3. NFO 4. KEEP BENEFITS - SELF SUSTAINING DIFFERENTIAL PREMIUM† DUAL WAIVER PREMIUM GOVERNED IN PART BY SPOUSE'S STATUS
ON CLAIM PAYING	1. KEEP PREMIUM - DOWNGRADE 2. BASIC POLICY - IF KNEW PREMIUM* 3. NFO 4. KEEP BENEFITS - PHASE ONE PREMIUM	1. KEEP PREMIUM - DOWNGRADE 2. BASIC POLICY - SELF SUSTAINING PREMIUM*† 3. NFO 4. KEEP BENEFITS - SELF SUSTAINING PREMIUM†
ON CLAIM WAIVER	1. DOWNGRADE - RETAIN PREMIUM WAIVER*‡ 2. BASIC POLICY - IF KNEW DIFFERENTIAL PREMIUM 3. NFO 4. KEEP BENEFITS - PHASE ONE DIFFERENTIAL PREMIUM	1. - DOWNGRADE - RETAIN PREMIUM WAIVER*‡ 2. BASIC POLICY - SELF-SUSTAINING DIFFERENTIAL PREMIUM† 3. NFO 4. KEEP BENEFITS - SELF SUSTAINING DIFFERENTIAL PREMIUM†
*Default Option. †Self-sustaining premium calculated as if policyholder not on claim. ‡If the NFO provides greater benefits, that will be the Default Option. In Phase One, policyholders whose Current Premium is not less than the If Knew Premium need not change premiums or benefits. Option 2 preserves the GA floor for policyholders with benefits above that.		

G. POLICY ILLUSTRATIONS

The following twelve examples illustrate how these options work for some representative policies. The policies selected are actual in-force SHIP policies. They were selected to provide a representative variety of policy features. Reviewing sample policies resembling a particular policy will provide an indication of how the Plan will result in modifications to that policy. Because of the differences among the features in the sample policies, it may be helpful to review several sample policies to see how particular features are affected by the Plan.

ILLUSTRATIVE POLICYHOLDER GUIDANCE PAGE

This page is provided to assist you in comparing the Plan Options to each other and in selecting the best one for your individual circumstances. The yellow boxes contain the comparative data. The rest of this page provides explanations for that data.

YOUR CURRENT POLICY: These are the key details and characteristics of your current policy before modification under the Plan.

CURRENT PREMIUM	\$529	ILLUSTR. #	1	YEAR ISSUED	1988
MAXIMUM DAILY BENEFIT	\$160			AGE WHEN ISSUED	57
MAXIMUM BENEFIT PERIOD (in years)	2.0			CURRENT AGE	89
MAXIMUM POLICY VALUE	\$116,800			GUAR ASSN LIMIT ¹	\$300,000
INFLATION PROTECTION	0.0%			STATE OF ISSUE	PA
PREMIUM AND CLAIM STATUS	Premium paying	Active		STATE OF RESIDENCE	PA

COMPARISON OF RELATIVE VALUES: This chart shows the value of several metrics for your current policy and each Option available to you under the Plan. Each metric may have greater or lesser importance for a particular policyholder. The table should enable you to compare the metric(s) most important to you from Option to Option.

Policy Value Indicators^{2,3}

#	METRIC	DESCRIPTION	Current	Option 1	Option 2	Option 2a	Option 3	Option 4
			Your Policy Now	Downgrade	Basic Policy	Enhanced Basic Policy	Enhanced RPU	Phase I premium (Current Benefits)
1	PREMIUM FOR EACH OPTION	This is the actual premium for your current policy and for each Option available to you.	\$529	\$529	\$172	\$172	NO PREMIUM	\$618
2	PREMIUM INCREASE OR DECREASE FOR EACH OPTION	For each option, this shows the change from your current premium.	N/A	\$0 0.0%	-\$357 -67.5%	-\$357 -67.5%	-\$529 -100.0%	+\$89 +16.8%
3	MAXIMUM BENEFIT PERIOD⁴	This is the Maximum Benefit Period (years of care) available under your current policy and each Option.	2.0	2.0	2.5	2.5	2.0	2.0
4	MAXIMUM DAILY BENEFIT⁴	This the Maximum Daily Benefit as of the Plan Effective Date available under your policy and each Option.	\$160	\$149	\$128	\$128	\$128	\$160
5	MAXIMUM POLICY VALUE⁵	This is the maximum amount of coverage provided by your current policy and each Option, adjusted for inflation if applicable.	\$116,800	\$109,036	\$116,800	\$116,800	\$93,440	\$116,800
6	INFLATION	This is the degree of inflation protection provided by your policy and each option.	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
7	POTENTIAL UNCOVERED BENEFITS	This is the amount of your Maximum Policy Value that would not be covered by the applicable state insurance guaranty association in the event SHIP were placed in liquidation.	\$0	\$0	\$0	\$0	\$0	\$0

¹ In the event the Commonwealth Court of Pennsylvania places SHIP into liquidation, your guaranty association coverage would be limited to the statutory limit associated with your state of residence. In this scenario, you may be subject to a premium rate increase at the discretion of the guaranty association and subject to approval by the state in which your policy was issued. The expected premium rate requested by the guaranty association would be:

\$618

² If you elect Option 1 or Option 4 you may be subject to Phase II premium rate increases. For purposes of comparison, although it would be adjusted to reflect the effect of Phase 1, if it were calculated as of the Effective Date, the self sustaining premium for your policy would be:

\$2,835

³ Policy Value Indicators reflect policy status as of the Effective Date. All metric values will change subsequent to the effective date. The changes will be significant for active policyholders who become disabled and for disabled policyholders who become active.

⁴ Maximum Benefit Period and Maximum Daily Benefit are shown for the highest level of care covered by the policy. Nursing home is the highest level of care, assisted living facility is the second-highest level of care, and home-health care is the third-highest level of care.

⁵ Maximum Policy Value is the product of the policy's Maximum Benefit Period times its Maximum Daily Benefit, adjusted for inflation. For active policyholders, inflation is accounted for by assuming a claim is incurred on the Effective Date. Actual Maximum Policy Value will vary from policyholder to policyholder and will depend on when a claim is incurred.

The Proposed Rehabilitation Plan (the "Plan") is aimed at reducing or eliminating a very substantial "Funding Gap" or deficit arising from the excess of projected liabilities over the premium and assets projected to be available to fund them, in part by modifying many existing LTC policies while striving to provide policyholders meaningful choices. IF THE REHABILITATION PLAN FAILS TO REDUCE THE FUNDING GAP SUFFICIENTLY, IT IS POSSIBLE THAT SHIP WILL BE PLACED IN LIQUIDATION, POLICYHOLDERS WILL HAVE FEWER OPTIONS, AND SOME MAY LOSE SOME OR ALL OF THEIR COVERAGE IN EXCESS OF GUARANTY ASSOCIATION LIMITS. See discussion beginning at page 92 and especially page 95.

ILLUSTRATIVE POLICYHOLDER GUIDANCE PAGE

This page is provided to assist you in comparing the Plan Options to each other and in selecting the best one for your individual circumstances. The yellow boxes contain the comparative data. The rest of this page provides explanations for that data.

YOUR CURRENT POLICY: These are the key details and characteristics of your current policy before modification under the Plan.

CURRENT PREMIUM	\$4,116	ILLUSTR. #	2	YEAR ISSUED	1991
MAXIMUM DAILY BENEFIT	\$133			AGE WHEN ISSUED	60
MAXIMUM BENEFIT PERIOD (in years)	Unlimited			CURRENT AGE	88
MAXIMUM POLICY VALUE	Unlimited			GUAR ASSN LIMIT ¹	\$300,000
INFLATION PROTECTION	0.0%			STATE OF ISSUE	OK
PREMIUM AND CLAIM STATUS	Premium paying	Active		STATE OF RESIDENCE	TX

COMPARISON OF RELATIVE VALUES: This chart shows the value of several metrics for your current policy and each Option available to you under the Plan. Each metric may have greater or lesser importance for a particular policyholder. The table should enable you to compare the metric(s) most important to you from Option to Option.

Policy Value Indicators^{2,3}

#	METRIC	DESCRIPTION	Current	Option 1	Option 2	Option 2a	Option 3	Option 4
			Your Policy Now	Downgrade	Basic Policy	Enhanced Basic Policy	Enhanced RPU	Phase I premium (Current Benefits)
1	PREMIUM FOR EACH OPTION	This is the actual premium for your current policy and for each Option available to you.	\$4,116	\$4,116	\$4,758	\$4,758	NO PREMIUM	\$7,600
2	PREMIUM INCREASE OR DECREASE FOR EACH OPTION	For each option, this shows the change from your current premium.	N/A	\$0 0.0%	+\$642 +15.6%	+\$642 +15.6%	-\$4,116 -100.0%	+\$3,484 +84.6%
3	MAXIMUM BENEFIT PERIOD ⁴	This is the Maximum Benefit Period (years of care) available under your current policy and each Option.	Unlimited	2.2	7.7	7.7	2.5	Unlimited
4	MAXIMUM DAILY BENEFIT ⁴	This the Maximum Daily Benefit as of the Plan Effective Date available under your policy and each Option.	\$133	\$106	\$106	\$106	\$106	\$133
5	MAXIMUM POLICY VALUE ⁵	This is the maximum amount of coverage provided by your current policy and each Option, adjusted for inflation if applicable.	Unlimited	\$84,906	\$300,000	\$300,000	\$96,845	Unlimited
6	INFLATION	This is the degree of inflation protection provided by your policy and each option.	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
7	POTENTIAL UNCOVERED BENEFITS	This is the amount of your Maximum Policy Value that would not be covered by the applicable state insurance guaranty association in the event SHIP were placed in liquidation.	Unlimited	\$0	\$0	\$0	\$0	Unlimited

¹ In the event the Commonwealth Court of Pennsylvania places SHIP into liquidation, your guaranty association coverage would be limited to the statutory limit associated with your state of residence. In this scenario, you may be subject to a premium rate increase at the discretion of the guaranty association and subject to approval by the state in which your policy was issued. The expected premium rate requested by the guaranty association would be:

\$7,197

² If you elect Option 1 or Option 4 you may be subject to Phase II premium rate increases. For purposes of comparison, although it would be adjusted to reflect the effect of Phase 1, if it were calculated as of the Effective Date, the self sustaining premium for your policy would be:

\$6,039

³ Policy Value Indicators reflect policy status as of the Effective Date. All metric values will change subsequent to the effective date. The changes will be significant for active policyholders who become disabled and for disabled policyholders who become active.

⁴ Maximum Benefit Period and Maximum Daily Benefit are shown for the highest level of care covered by the policy. Nursing home is the highest level of care, assisted living facility is the second-highest level of care, and home-health care is the third-highest level of care.

⁵ Maximum Policy Value is the product of the policy's Maximum Benefit Period times its Maximum Daily Benefit, adjusted for inflation. For active policyholders, inflation is accounted for by assuming a claim is incurred on the Effective Date. Actual Maximum Policy Value will vary from policyholder to policyholder and will depend on when a claim is incurred.

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YOUR CURRENT POLICY: These are the key details and characteristics of your current policy before modification under the Plan.

CURRENT PREMIUM	NO PREMIUM	ILLUSTR. #	3	YEAR ISSUED	1995
MAXIMUM DAILY BENEFIT	\$159			AGE WHEN ISSUED	64
MAXIMUM BENEFIT PERIOD (in years)	2.0			CURRENT AGE	89
MAXIMUM POLICY VALUE	\$290,536			GUAR ASSN LIMIT ¹	\$300,000
INFLATION PROTECTION	0.0%			STATE OF ISSUE	GA
PREMIUM AND CLAIM STATUS	Lifetime waiver	Disabled		STATE OF RESIDENCE	GA

COMPARISON OF RELATIVE VALUES: This chart shows the value of several metrics for your current policy and each Option available to you under the Plan. Each metric may have greater or lesser importance for a particular policyholder. The table should enable you to compare the metric(s) most important to you from Option to Option.

Policy Value Indicators^{2,3}

#	METRIC	DESCRIPTION	Current	Option 1	Option 2	Option 2a	Option 3	Option 4
			Your Policy Now	Downgrade	Basic Policy	Enhanced Basic Policy	Enhanced RPU	Phase I premium (Current Benefits)
1	PREMIUM FOR EACH OPTION	This is the actual premium for your current policy and for each Option available to you.	NO PREMIUM	NO PREMIUM	NO PREMIUM	NO PREMIUM	NO PREMIUM	NO PREMIUM
2	PREMIUM INCREASE OR DECREASE FOR EACH OPTION	For each option, this shows the change from your current premium.	N/A	\$0 NA	\$0 NA	\$0 NA	\$0 NA	\$0 NA
3	MAXIMUM BENEFIT PERIOD ⁴	This is the Maximum Benefit Period (years of care) available under your current policy and each Option.	2.0	2.0	2.5	2.5	2.0	2.0
4	MAXIMUM DAILY BENEFIT ⁴	This the Maximum Daily Benefit as of the Plan Effective Date available under your policy and each Option.	\$159	\$159	\$127	\$127	\$127	\$159
5	MAXIMUM POLICY VALUE ⁵	This is the maximum amount of coverage provided by your current policy and each Option, adjusted for inflation if applicable.	\$290,536	\$290,536	\$290,536	\$290,536	\$116,215	\$290,536
6	INFLATION	This is the degree of inflation protection provided by your policy and each option.	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
7	POTENTIAL UNCOVERED BENEFITS	This is the amount of your Maximum Policy Value that would not be covered by the applicable state insurance guaranty association in the event SHIP were placed in liquidation.	\$0	\$0	\$0	\$0	\$0	\$0

¹ In the event the Commonwealth Court of Pennsylvania places SHIP into liquidation, your guaranty association coverage would be limited to the statutory limit associated with your state of residence. In this scenario, you may be subject to a premium rate increase at the discretion of the guaranty association and subject to approval by the state in which your policy was issued. The expected premium rate requested by the guaranty association would be:

\$0

² If you elect Option 1 or Option 4 you may be subject to Phase II premium rate increases. For purposes of comparison, although it would be adjusted to reflect the effect of Phase 1, if it were calculated as of the Effective Date, the self sustaining premium for your policy would be:

\$867

³ Policy Value Indicators reflect policy status as of the Effective Date. All metric values will change subsequent to the effective date. The changes will be significant for active policyholders who become disabled and for disabled policyholders who become active.

⁴ Maximum Benefit Period and Maximum Daily Benefit are shown for the highest level of care covered by the policy. Nursing home is the highest level of care, assisted living facility is the second-highest level of care, and home-health care is the third-highest level of care.

⁵ Maximum Policy Value is the product of the policy's Maximum Benefit Period times its Maximum Daily Benefit, adjusted for inflation. For active policyholders, inflation is accounted for by assuming a claim is incurred on the Effective Date. Actual Maximum Policy Value will vary from policyholder to policyholder and will depend on when a claim is incurred.

The Proposed Rehabilitation Plan (the "Plan") is aimed at reducing or eliminating a very substantial "Funding Gap" or deficit arising from the excess of projected liabilities over the premium and assets projected to be available to fund them, in part by modifying many existing LTC policies while striving to provide policyholders meaningful choices. IF THE REHABILITATION PLAN FAILS TO REDUCE THE FUNDING GAP SUFFICIENTLY, IT IS POSSIBLE THAT SHIP WILL BE PLACED IN LIQUIDATION, POLICYHOLDERS WILL HAVE FEWER OPTIONS, AND SOME MAY LOSE SOME OR ALL OF THEIR COVERAGE IN EXCESS OF GUARANTY ASSOCIATION LIMITS. See discussion beginning at page 92 and especially page 95.

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YOUR CURRENT POLICY: These are the key details and characteristics of your current policy before modification under the Plan.

CURRENT PREMIUM	\$2,614	ILLUSTR. #	4	YEAR ISSUED	2001
MAXIMUM DAILY BENEFIT	\$244			AGE WHEN ISSUED	64
MAXIMUM BENEFIT PERIOD (in years)	4.0			CURRENT AGE	82
MAXIMUM POLICY VALUE	\$354,774			GUAR ASSN LIMIT ¹	\$300,000
INFLATION PROTECTION	0.0%			STATE OF ISSUE	PA
PREMIUM AND CLAIM STATUS	Premium paying	Active		STATE OF RESIDENCE	FL

COMPARISON OF RELATIVE VALUES: This chart shows the value of several metrics for your current policy and each Option available to you under the Plan. Each metric may have greater or lesser importance for a particular policyholder. The table should enable you to compare the metric(s) most important to you from Option to Option.

Policy Value Indicators^{2,3}

#	METRIC	DESCRIPTION	Current	Option 1	Option 2	Option 2a	Option 3	Option 4
			Your Policy Now	Downgrade	Basic Policy	Enhanced Basic Policy	Enhanced RPU	Phase I premium (Current Benefits)
1	PREMIUM FOR EACH OPTION	This is the actual premium for your current policy and for each Option available to you.	\$2,614	\$2,614	\$3,520	\$3,520	NO PREMIUM	\$5,344
2	PREMIUM INCREASE OR DECREASE FOR EACH OPTION	For each option, this shows the change from your current premium.	N/A	\$0 0.0%	+\$906 +34.6%	+\$906 +34.6%	-\$2,614 -100.0%	+\$2,730 +104.4%
3	MAXIMUM BENEFIT PERIOD⁴	This is the Maximum Benefit Period (years of care) available under your current policy and each Option.	4.0	2.8	4.2	4.2	2.5	4.0
4	MAXIMUM DAILY BENEFIT⁴	This the Maximum Daily Benefit as of the Plan Effective Date available under your policy and each Option.	\$244	\$195	\$195	\$195	\$195	\$244
5	MAXIMUM POLICY VALUE⁵	This is the maximum amount of coverage provided by your current policy and each Option, adjusted for inflation if applicable.	\$354,774	\$197,227	\$300,000	\$300,000	\$178,365	\$354,774
6	INFLATION	This is the degree of inflation protection provided by your policy and each option.	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
7	POTENTIAL UNCOVERED BENEFITS	This is the amount of your Maximum Policy Value that would not be covered by the applicable state insurance guaranty association in the event SHIP were placed in liquidation.	\$54,774	\$0	\$0	\$0	\$0	\$54,774

¹ In the event the Commonwealth Court of Pennsylvania places SHIP into liquidation, your guaranty association coverage would be limited to the statutory limit associated with your state of residence. In this scenario, you may be subject to a premium rate increase at the discretion of the guaranty association and subject to approval by the state in which your policy was issued. The expected premium rate requested by the guaranty association would be:

\$5,047

² If you elect Option 1 or Option 4 you may be subject to Phase II premium rate increases. For purposes of comparison, although it would be adjusted to reflect the effect of Phase 1, if it were calculated as of the Effective Date, the self sustaining premium for your policy would be:

\$14,639

³ Policy Value Indicators reflect policy status as of the Effective Date. All metric values will change subsequent to the effective date. The changes will be significant for active policyholders who become disabled and for disabled policyholders who become active.

⁴ Maximum Benefit Period and Maximum Daily Benefit are shown for the highest level of care covered by the policy. Nursing home is the highest level of care, assisted living facility is the second-highest level of care, and home-health care is the third-highest level of care.

⁵ Maximum Policy Value is the product of the policy's Maximum Benefit Period times its Maximum Daily Benefit, adjusted for inflation. For active policyholders, inflation is accounted for by assuming a claim is incurred on the Effective Date. Actual Maximum Policy Value will vary from policyholder to policyholder and will depend on when a claim is incurred.

The Proposed Rehabilitation Plan (the "Plan") is aimed at reducing or eliminating a very substantial "Funding Gap" or deficit arising from the excess of projected liabilities over the premium and assets projected to be available to fund them, in part by modifying many existing LTC policies while striving to provide policyholders meaningful choices. IF THE REHABILITATION PLAN FAILS TO REDUCE THE FUNDING GAP SUFFICIENTLY, IT IS POSSIBLE THAT SHIP WILL BE PLACED IN LIQUIDATION, POLICYHOLDERS WILL HAVE FEWER OPTIONS, AND SOME MAY LOSE SOME OR ALL OF THEIR COVERAGE IN EXCESS OF GUARANTY ASSOCIATION LIMITS. See discussion beginning at page 92 and especially page 95.

ILLUSTRATIVE POLICYHOLDER GUIDANCE PAGE

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YOUR CURRENT POLICY: These are the key details and characteristics of your current policy before modification under the Plan.

CURRENT PREMIUM	\$6,306	ILLUSTR. #	5	YEAR ISSUED	1995
MAXIMUM DAILY BENEFIT	\$339			AGE WHEN ISSUED	64
MAXIMUM BENEFIT PERIOD (in years)	3.0			CURRENT AGE	89
MAXIMUM POLICY VALUE	\$395,961			GUAR ASSN LIMIT ¹	\$300,000
INFLATION PROTECTION	5.0%			STATE OF ISSUE	OH
PREMIUM AND CLAIM STATUS	Premium paying	Active		STATE OF RESIDENCE	OH

COMPARISON OF RELATIVE VALUES: This chart shows the value of several metrics for your current policy and each Option available to you under the Plan. Each metric may have greater or lesser importance for a particular policyholder. The table should enable you to compare the metric(s) most important to you from Option to Option.

Policy Value Indicators^{2,3}

#	METRIC	DESCRIPTION	Current	Option 1	Option 2	Option 2a	Option 3	Option 4
			Your Policy Now	Downgrade	Basic Policy	Enhanced Basic Policy	Enhanced RPU	Phase I premium (Current Benefits)
1	PREMIUM FOR EACH OPTION	This is the actual premium for your current policy and for each Option available to you.	\$6,306	\$6,306	\$8,146	\$8,169	NO PREMIUM	\$10,727
2	PREMIUM INCREASE OR DECREASE FOR EACH OPTION	For each option, this shows the change from your current premium.	N/A	\$0 0.0%	+\$1,840 +29.2%	+\$1,863 +29.5%	-\$6,306 -100.0%	+\$4,421 +70.1%
3	MAXIMUM BENEFIT PERIOD⁴	This is the Maximum Benefit Period (years of care) available under your current policy and each Option.	3.0	0.9	3.0	3.0	2.5	3.0
4	MAXIMUM DAILY BENEFIT⁴	This the Maximum Daily Benefit as of the Plan Effective Date available under your policy and each Option.	\$339	\$271	\$271	\$271	\$271	\$339
5	MAXIMUM POLICY VALUE⁵	This is the maximum amount of coverage provided by your current policy and each Option, adjusted for inflation if applicable.	\$395,961	\$92,110	\$302,598	\$304,598	\$247,207	\$395,961
6	INFLATION	This is the degree of inflation protection provided by your policy and each option.	5.0%	0.0%	1.5%	2.0%	0.0%	5.0%
7	POTENTIAL UNCOVERED BENEFITS	This is the amount of your Maximum Policy Value that would not be covered by the applicable state insurance guaranty association in the event SHIP were placed in liquidation.	\$95,961	\$0	\$2,598	\$4,598	\$0	\$95,961

¹ In the event the Commonwealth Court of Pennsylvania places SHIP into liquidation, your guaranty association coverage would be limited to the statutory limit associated with your state of residence. In this scenario, you may be subject to a premium rate increase at the discretion of the guaranty association and subject to approval by the state in which your policy was issued. The expected premium rate requested by the guaranty association would be: **\$10,259**

² If you elect Option 1 or Option 4 you may be subject to Phase II premium rate increases. For purposes of comparison, although it would be adjusted to reflect the effect of Phase 1, if it were calculated as of the Effective Date, the self sustaining premium for your policy would be: **\$18,830**

³ Policy Value Indicators reflect policy status as of the Effective Date. All metric values will change subsequent to the effective date. The changes will be significant for active policyholders who become disabled and for disabled policyholders who become active.

⁴ Maximum Benefit Period and Maximum Daily Benefit are shown for the highest level of care covered by the policy. Nursing home is the highest level of care, assisted living facility is the second-highest level of care, and home-health care is the third-highest level of care.

⁵ Maximum Policy Value is the product of the policy's Maximum Benefit Period times its Maximum Daily Benefit, adjusted for inflation. For active policyholders, inflation is accounted for by assuming a claim is incurred on the Effective Date. Actual Maximum Policy Value will vary from policyholder to policyholder and will depend on when a claim is incurred.

The Proposed Rehabilitation Plan (the "Plan") is aimed at reducing or eliminating a very substantial "Funding Gap" or deficit arising from the excess of projected liabilities over the premium and assets projected to be available to fund them, in part by modifying many existing LTC policies while striving to provide policyholders meaningful choices. IF THE REHABILITATION PLAN FAILS TO REDUCE THE FUNDING GAP SUFFICIENTLY, IT IS POSSIBLE THAT SHIP WILL BE PLACED IN LIQUIDATION, POLICYHOLDERS WILL HAVE FEWER OPTIONS, AND SOME MAY LOSE SOME OR ALL OF THEIR COVERAGE IN EXCESS OF GUARANTY ASSOCIATION LIMITS. See discussion beginning at page 92 and especially page 95.

ILLUSTRATIVE POLICYHOLDER GUIDANCE PAGE

This page is provided to assist you in comparing the Plan Options to each other and in selecting the best one for your individual circumstances. The yellow boxes contain the comparative data. The rest of this page provides explanations for that data.

YOUR CURRENT POLICY: These are the key details and characteristics of your current policy before modification under the Plan.

CURRENT PREMIUM	\$2,906	ILLUSTR. #	6	YEAR ISSUED	1996
MAXIMUM DAILY BENEFIT	\$307			AGE WHEN ISSUED	62
MAXIMUM BENEFIT PERIOD (in years)	3.0			CURRENT AGE	85
MAXIMUM POLICY VALUE	\$365,778			GUAR ASSN LIMIT ¹	\$300,000
INFLATION PROTECTION	5.0%			STATE OF ISSUE	PA
PREMIUM AND CLAIM STATUS	Premium paying	Active		STATE OF RESIDENCE	PA

COMPARISON OF RELATIVE VALUES: This chart shows the value of several metrics for your current policy and each Option available to you under the Plan. Each metric may have greater or lesser importance for a particular policyholder. The table should enable you to compare the metric(s) most important to you from Option to Option.

Policy Value Indicators^{2,3}

#	METRIC	DESCRIPTION	Current	Option 1	Option 2	Option 2a	Option 3	Option 4
			Your Policy Now	Downgrade	Basic Policy	Enhanced Basic Policy	Enhanced RPU	Phase I premium (Current Benefits)
1	PREMIUM FOR EACH OPTION	This is the actual premium for your current policy and for each Option available to you.	\$2,906	\$2,906	\$2,532	\$2,549	NO PREMIUM	\$4,972
2	PREMIUM INCREASE OR DECREASE FOR EACH OPTION	For each option, this shows the change from your current premium.	N/A	\$0 0.0%	-\$375 -12.9%	-\$357 -12.3%	-\$2,906 -100.0%	+\$2,066 +71.1%
3	MAXIMUM BENEFIT PERIOD⁴	This is the Maximum Benefit Period (years of care) available under your current policy and each Option.	3.0	3.0	3.3	3.2	2.5	3.0
4	MAXIMUM DAILY BENEFIT⁴	This the Maximum Daily Benefit as of the Plan Effective Date available under your policy and each Option.	\$307	\$246	\$246	\$246	\$246	\$307
5	MAXIMUM POLICY VALUE⁵	This is the maximum amount of coverage provided by your current policy and each Option, adjusted for inflation if applicable.	\$365,778	\$269,063	\$300,000	\$300,000	\$224,220	\$365,778
6	INFLATION	This is the degree of inflation protection provided by your policy and each option.	5.0%	0.0%	1.5%	2.0%	0.0%	5.0%
7	POTENTIAL UNCOVERED BENEFITS	This is the amount of your Maximum Policy Value that would not be covered by the applicable state insurance guaranty association in the event SHIP were placed in liquidation.	\$65,778	\$0	\$0	\$0	\$0	\$65,778

¹ In the event the Commonwealth Court of Pennsylvania places SHIP into liquidation, your guaranty association coverage would be limited to the statutory limit associated with your state of residence. In this scenario, you may be subject to a premium rate increase at the discretion of the guaranty association and subject to approval by the state in which your policy was issued. The expected premium rate requested by the guaranty association would be:

\$4,360

² If you elect Option 1 or Option 4 you may be subject to Phase II premium rate increases. For purposes of comparison, although it would be adjusted to reflect the effect of Phase 1, if it were calculated as of the Effective Date, the self sustaining premium for your policy would be:

\$21,738

³ Policy Value Indicators reflect policy status as of the Effective Date. All metric values will change subsequent to the effective date. The changes will be significant for active policyholders who become disabled and for disabled policyholders who become active.

⁴ Maximum Benefit Period and Maximum Daily Benefit are shown for the highest level of care covered by the policy. Nursing home is the highest level of care, assisted living facility is the second-highest level of care, and home-health care is the third-highest level of care.

⁵ Maximum Policy Value is the product of the policy's Maximum Benefit Period times its Maximum Daily Benefit, adjusted for inflation. For active policyholders, inflation is accounted for by assuming a claim is incurred on the Effective Date. Actual Maximum Policy Value will vary from policyholder to policyholder and will depend on when a claim is incurred.

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ILLUSTRATIVE POLICYHOLDER GUIDANCE PAGE

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YOUR CURRENT POLICY: These are the key details and characteristics of your current policy before modification under the Plan.

CURRENT PREMIUM	\$2,216	ILLUSTR. #	7	YEAR ISSUED	1997
MAXIMUM DAILY BENEFIT	\$246			AGE WHEN ISSUED	63
MAXIMUM BENEFIT PERIOD (in years)	3.0			CURRENT AGE	86
MAXIMUM POLICY VALUE	\$286,584			GUAR ASSN LIMIT ¹	\$300,000
INFLATION PROTECTION	5.0%			STATE OF ISSUE	IL
PREMIUM AND CLAIM STATUS	Premium paying	Active		STATE OF RESIDENCE	IL

COMPARISON OF RELATIVE VALUES: This chart shows the value of several metrics for your current policy and each Option available to you under the Plan. Each metric may have greater or lesser importance for a particular policyholder. The table should enable you to compare the metric(s) most important to you from Option to Option.

Policy Value Indicators^{2,3}

#	METRIC	DESCRIPTION	Current	Option 1	Option 2	Option 2a	Option 3	Option 4
			Your Policy Now	Downgrade	Basic Policy	Enhanced Basic Policy	Enhanced RPU	Phase I premium (Current Benefits)
1	PREMIUM FOR EACH OPTION	This is the actual premium for your current policy and for each Option available to you.	\$2,216	\$2,216	\$2,814	\$2,831	NO PREMIUM	\$3,597
2	PREMIUM INCREASE OR DECREASE FOR EACH OPTION	For each option, this shows the change from your current premium.	N/A	\$0 0.0%	+\$598 +27.0%	+\$615 +27.7%	-\$2,216 -100.0%	+\$1,381 +62.3%
3	MAXIMUM BENEFIT PERIOD⁴	This is the Maximum Benefit Period (years of care) available under your current policy and each Option.	3.0	3.0	3.9	3.9	2.5	3.0
4	MAXIMUM DAILY BENEFIT⁴	This the Maximum Daily Benefit as of the Plan Effective Date available under your policy and each Option.	\$246	\$197	\$197	\$197	\$197	\$246
5	MAXIMUM POLICY VALUE⁵	This is the maximum amount of coverage provided by your current policy and each Option, adjusted for inflation if applicable.	\$286,584	\$215,251	\$286,584	\$286,584	\$179,376	\$286,584
6	INFLATION	This is the degree of inflation protection provided by your policy and each option.	5.0%	0.0%	1.5%	2.0%	0.0%	5.0%
7	POTENTIAL UNCOVERED BENEFITS	This is the amount of your Maximum Policy Value that would not be covered by the applicable state insurance guaranty association in the event SHIP were placed in liquidation.	\$0	\$0	\$0	\$0	\$0	\$0

¹ In the event the Commonwealth Court of Pennsylvania places SHIP into liquidation, your guaranty association coverage would be limited to the statutory limit associated with your state of residence. In this scenario, you may be subject to a premium rate increase at the discretion of the guaranty association and subject to approval by the state in which your policy was issued. The expected premium rate requested by the guaranty association would be:

\$3,398

² If you elect Option 1 or Option 4 you may be subject to Phase II premium rate increases. For purposes of comparison, although it would be adjusted to reflect the effect of Phase 1, if it were calculated as of the Effective Date, the self sustaining premium for your policy would be:

\$13,297

³ Policy Value Indicators reflect policy status as of the Effective Date. All metric values will change subsequent to the effective date. The changes will be significant for active policyholders who become disabled and for disabled policyholders who become active.

⁴ Maximum Benefit Period and Maximum Daily Benefit are shown for the highest level of care covered by the policy. Nursing home is the highest level of care, assisted living facility is the second-highest level of care, and home-health care is the third-highest level of care.

⁵ Maximum Policy Value is the product of the policy's Maximum Benefit Period times its Maximum Daily Benefit, adjusted for inflation. For active policyholders, inflation is accounted for by assuming a claim is incurred on the Effective Date. Actual Maximum Policy Value will vary from policyholder to policyholder and will depend on when a claim is incurred.

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ILLUSTRATIVE POLICYHOLDER GUIDANCE PAGE

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YOUR CURRENT POLICY: These are the key details and characteristics of your current policy before modification under the Plan.

CURRENT PREMIUM	\$2,995	ILLUSTR. #	8	YEAR ISSUED	1997
MAXIMUM DAILY BENEFIT	\$205			AGE WHEN ISSUED	64
MAXIMUM BENEFIT PERIOD (in years)	5.0			CURRENT AGE	86
MAXIMUM POLICY VALUE	\$432,370			GUAR ASSN LIMIT ¹	\$300,000
INFLATION PROTECTION	5.0%			STATE OF ISSUE	OK
PREMIUM AND CLAIM STATUS	Premium paying	Active		STATE OF RESIDENCE	OK

COMPARISON OF RELATIVE VALUES: This chart shows the value of several metrics for your current policy and each Option available to you under the Plan. Each metric may have greater or lesser importance for a particular policyholder. The table should enable you to compare the metric(s) most important to you from Option to Option.

Policy Value Indicators^{2,3}

#	METRIC	DESCRIPTION	Current	Option 1	Option 2	Option 2a	Option 3	Option 4
			Your Policy Now	Downgrade	Basic Policy	Enhanced Basic Policy	Enhanced RPU	Phase I premium (Current Benefits)
1	PREMIUM FOR EACH OPTION	This is the actual premium for your current policy and for each Option available to you.	\$2,995	\$2,995	\$1,522	\$1,526	NO PREMIUM	\$2,995
2	PREMIUM INCREASE OR DECREASE FOR EACH OPTION	For each option, this shows the change from your current premium.	N/A	\$0 0.0%	-\$1,473 -49.2%	-\$1,468 -49.0%	-\$2,995 -100.0%	\$0 0.0%
3	MAXIMUM BENEFIT PERIOD ⁴	This is the Maximum Benefit Period (years of care) available under your current policy and each Option.	5.0	5.0	4.8	5.0	2.5	5.0
4	MAXIMUM DAILY BENEFIT ⁴	This the Maximum Daily Benefit as of the Plan Effective Date available under your policy and each Option.	\$205	\$205	\$164	\$164	\$164	\$205
5	MAXIMUM POLICY VALUE ⁵	This is the maximum amount of coverage provided by your current policy and each Option, adjusted for inflation if applicable.	\$432,370	\$432,370	\$300,000	\$317,011	\$149,483	\$432,370
6	INFLATION	This is the degree of inflation protection provided by your policy and each option.	5.0%	5.0%	1.5%	2.0%	0.0%	5.0%
7	POTENTIAL UNCOVERED BENEFITS	This is the amount of your Maximum Policy Value that would not be covered by the applicable state insurance guaranty association in the event SHIP were placed in liquidation.	\$132,370	\$132,370	\$0	\$17,011	\$0	\$132,370

¹ In the event the Commonwealth Court of Pennsylvania places SHIP into liquidation, your guaranty association coverage would be limited to the statutory limit associated with your state of residence. In this scenario, you may be subject to a premium rate increase at the discretion of the guaranty association and subject to approval by the state in which your policy was issued. The expected premium rate requested by the guaranty association would be:

\$2,995

² If you elect Option 1 or Option 4 you may be subject to Phase II premium rate increases. For purposes of comparison, although it would be adjusted to reflect the effect of Phase 1, if it were calculated as of the Effective Date, the self sustaining premium for your policy would be:

\$4,393

³ Policy Value Indicators reflect policy status as of the Effective Date. All metric values will change subsequent to the effective date. The changes will be significant for active policyholders who become disabled and for disabled policyholders who become active.

⁴ Maximum Benefit Period and Maximum Daily Benefit are shown for the highest level of care covered by the policy. Nursing home is the highest level of care, assisted living facility is the second-highest level of care, and home-health care is the third-highest level of care.

⁵ Maximum Policy Value is the product of the policy's Maximum Benefit Period times its Maximum Daily Benefit, adjusted for inflation. For active policyholders, inflation is accounted for by assuming a claim is incurred on the Effective Date. Actual Maximum Policy Value will vary from policyholder to policyholder and will depend on when a claim is incurred.

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ILLUSTRATIVE POLICYHOLDER GUIDANCE PAGE

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YOUR CURRENT POLICY: These are the key details and characteristics of your current policy before modification under the Plan.

CURRENT PREMIUM	NO PREMIUM	ILLUSTR. #	9	YEAR ISSUED	1999
MAXIMUM DAILY BENEFIT	\$60			AGE WHEN ISSUED	67
MAXIMUM BENEFIT PERIOD (in years)	3.0			CURRENT AGE	88
MAXIMUM POLICY VALUE	\$65,700			GUAR ASSN LIMIT ¹	\$300,000
INFLATION PROTECTION	0.0%			STATE OF ISSUE	TX
PREMIUM AND CLAIM STATUS	Lifetime waiver	Active		STATE OF RESIDENCE	TX

COMPARISON OF RELATIVE VALUES: This chart shows the value of several metrics for your current policy and each Option available to you under the Plan. Each metric may have greater or lesser importance for a particular policyholder. The table should enable you to compare the metric(s) most important to you from Option to Option.

Policy Value Indicators^{2,3}

#	METRIC	DESCRIPTION	Current	Option 1	Option 2	Option 2a	Option 3	Option 4
			Your Policy Now	Downgrade	Basic Policy	Enhanced Basic Policy	Enhanced RPU	Phase I premium (Current Benefits)
1	PREMIUM FOR EACH OPTION	This is the actual premium for your current policy and for each Option available to you.	NO PREMIUM	NO PREMIUM	NO PREMIUM	NO PREMIUM	NO PREMIUM	NO PREMIUM
2	PREMIUM INCREASE OR DECREASE FOR EACH OPTION	For each option, this shows the change from your current premium.	N/A	\$0 NA	\$0 NA	\$0 NA	\$0 NA	\$0 NA
3	MAXIMUM BENEFIT PERIOD ⁴	This is the Maximum Benefit Period (years of care) available under your current policy and each Option.	3.0	3.0	3.8	3.8	2.5	3.0
4	MAXIMUM DAILY BENEFIT ⁴	This the Maximum Daily Benefit as of the Plan Effective Date available under your policy and each Option.	\$60	\$60	\$48	\$48	\$48	\$60
5	MAXIMUM POLICY VALUE ⁵	This is the maximum amount of coverage provided by your current policy and each Option, adjusted for inflation if applicable.	\$65,700	\$65,700	\$65,700	\$65,700	\$43,800	\$65,700
6	INFLATION	This is the degree of inflation protection provided by your policy and each option.	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
7	POTENTIAL UNCOVERED BENEFITS	This is the amount of your Maximum Policy Value that would not be covered by the applicable state insurance guaranty association in the event SHIP were placed in liquidation.	\$0	\$0	\$0	\$0	\$0	\$0

¹ In the event the Commonwealth Court of Pennsylvania places SHIP into liquidation, your guaranty association coverage would be limited to the statutory limit associated with your state of residence. In this scenario, you may be subject to a premium rate increase at the discretion of the guaranty association and subject to approval by the state in which your policy was issued. The expected premium rate requested by the guaranty association would be:

\$0

² If you elect Option 1 or Option 4 you may be subject to Phase II premium rate increases. For purposes of comparison, although it would be adjusted to reflect the effect of Phase 1, if it were calculated as of the Effective Date, the self sustaining premium for your policy would be:

\$757

³ Policy Value Indicators reflect policy status as of the Effective Date. All metric values will change subsequent to the effective date. The changes will be significant for active policyholders who become disabled and for disabled policyholders who become active.

⁴ Maximum Benefit Period and Maximum Daily Benefit are shown for the highest level of care covered by the policy. Nursing home is the highest level of care, assisted living facility is the second-highest level of care, and home-health care is the third-highest level of care.

⁵ Maximum Policy Value is the product of the policy's Maximum Benefit Period times its Maximum Daily Benefit, adjusted for inflation. For active policyholders, inflation is accounted for by assuming a claim is incurred on the Effective Date. Actual Maximum Policy Value will vary from policyholder to policyholder and will depend on when a claim is incurred.

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ILLUSTRATIVE POLICYHOLDER GUIDANCE PAGE

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YOUR CURRENT POLICY: These are the key details and characteristics of your current policy before modification under the Plan.

CURRENT PREMIUM	\$6,336	ILLUSTR. #	10	YEAR ISSUED	1995
MAXIMUM DAILY BENEFIT	\$174			AGE WHEN ISSUED	67
MAXIMUM BENEFIT PERIOD (in years)	Unlimited			CURRENT AGE	92
MAXIMUM POLICY VALUE	Unlimited			GUAR ASSN LIMIT ¹	\$300,000
INFLATION PROTECTION	0.0%			STATE OF ISSUE	NC
PREMIUM AND CLAIM STATUS	Premium paying	Active		STATE OF RESIDENCE	NC

COMPARISON OF RELATIVE VALUES: This chart shows the value of several metrics for your current policy and each Option available to you under the Plan. Each metric may have greater or lesser importance for a particular policyholder. The table should enable you to compare the metric(s) most important to you from Option to Option.

Policy Value Indicators^{2,3}

#	METRIC	DESCRIPTION	Current	Option 1	Option 2	Option 2a	Option 3	Option 4
			Your Policy Now	Downgrade	Basic Policy	Enhanced Basic Policy	Enhanced RPU	Phase I premium (Current Benefits)
1	PREMIUM FOR EACH OPTION	This is the actual premium for your current policy and for each Option available to you.	\$6,336	\$6,336	\$2,886	\$2,886	NO PREMIUM	\$7,695
2	PREMIUM INCREASE OR DECREASE FOR EACH OPTION	For each option, this shows the change from your current premium.	N/A	\$0	-\$3,450	-\$3,450	-\$6,336	+\$1,359
				0.0%	-54.4%	-54.4%	-100.0%	+21.4%
3	MAXIMUM BENEFIT PERIOD⁴	This is the Maximum Benefit Period (years of care) available under your current policy and each Option.	Unlimited	Unlimited	5.9	5.9	2.5	Unlimited
4	MAXIMUM DAILY BENEFIT⁴	This the Maximum Daily Benefit as of the Plan Effective Date available under your policy and each Option.	\$174	\$174	\$139	\$139	\$139	\$174
5	MAXIMUM POLICY VALUE⁵	This is the maximum amount of coverage provided by your current policy and each Option, adjusted for inflation if applicable.	Unlimited	Unlimited	\$300,000	\$300,000	\$126,801	Unlimited
6	INFLATION	This is the degree of inflation protection provided by your policy and each option.	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
7	POTENTIAL UNCOVERED BENEFITS	This is the amount of your Maximum Policy Value that would not be covered by the applicable state insurance guaranty association in the event SHIP were placed in liquidation.	Unlimited	Unlimited	\$0	\$0	\$0	Unlimited

¹ In the event the Commonwealth Court of Pennsylvania places SHIP into liquidation, your guaranty association coverage would be limited to the statutory limit associated with your state of residence. In this scenario, you may be subject to a premium rate increase at the discretion of the guaranty association and subject to approval by the state in which your policy was issued. The expected premium rate requested by the guaranty association would be:

\$6,336

² If you elect Option 1 or Option 4 you may be subject to Phase II premium rate increases. For purposes of comparison, although it would be adjusted to reflect the effect of Phase 1, if it were calculated as of the Effective Date, the self sustaining premium for your policy would be:

\$9,296

³ Policy Value Indicators reflect policy status as of the Effective Date. All metric values will change subsequent to the effective date. The changes will be significant for active policyholders who become disabled and for disabled policyholders who become active.

⁴ Maximum Benefit Period and Maximum Daily Benefit are shown for the highest level of care covered by the policy. Nursing home is the highest level of care, assisted living facility is the second-highest level of care, and home-health care is the third-highest level of care.

⁵ Maximum Policy Value is the product of the policy's Maximum Benefit Period times its Maximum Daily Benefit, adjusted for inflation. For active policyholders, inflation is accounted for by assuming a claim is incurred on the Effective Date. Actual Maximum Policy Value will vary from policyholder to policyholder and will depend on when a claim is incurred.

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YOUR CURRENT POLICY: These are the key details and characteristics of your current policy before modification under the Plan.

CURRENT PREMIUM	NO PREMIUM	ILLUSTR. #	11	YEAR ISSUED	1991
MAXIMUM DAILY BENEFIT	\$206			AGE WHEN ISSUED	55
MAXIMUM BENEFIT PERIOD (in years)	Unlimited			CURRENT AGE	84
MAXIMUM POLICY VALUE	Unlimited			GUAR ASSN LIMIT ¹	\$300,000
INFLATION PROTECTION	5.0%			STATE OF ISSUE	TX
PREMIUM AND CLAIM STATUS	Claim waiver	Disabled		STATE OF RESIDENCE	TX

COMPARISON OF RELATIVE VALUES: This chart shows the value of several metrics for your current policy and each Option available to you under the Plan. Each metric may have greater or lesser importance for a particular policyholder. The table should enable you to compare the metric(s) most important to you from Option to Option.

Policy Value Indicators^{2,3}

#	METRIC	DESCRIPTION	Current	Option 1	Option 2	Option 2a	Option 3	Option 4
			Your Policy Now	Downgrade	Basic Policy	Enhanced Basic Policy	Enhanced RPU	Phase I premium (Current Benefits)
1	PREMIUM FOR EACH OPTION	This is the actual premium for your current policy and for each Option available to you.	NO PREMIUM	NO PREMIUM	NO PREMIUM	NO PREMIUM	NO PREMIUM	\$864
2	PREMIUM INCREASE OR DECREASE FOR EACH OPTION	For each option, this shows the change from your current premium.	N/A	\$0	\$0	\$0	\$0	+\$864
				NA	NA	NA	NA	NA
3	MAXIMUM BENEFIT PERIOD ⁴	This is the Maximum Benefit Period (years of care) available under your current policy and each Option.	Unlimited	Unlimited	4.8	5.0	2.5	Unlimited
4	MAXIMUM DAILY BENEFIT ⁴	This the Maximum Daily Benefit as of the Plan Effective Date available under your policy and each Option.	\$206	\$185	\$165	\$165	\$165	\$206
5	MAXIMUM POLICY VALUE ⁵	This is the maximum amount of coverage provided by your current policy and each Option, adjusted for inflation if applicable.	Unlimited	Unlimited	\$300,000	\$314,012	\$150,238	Unlimited
6	INFLATION	This is the degree of inflation protection provided by your policy and each option.	5.0%	0.0%	1.5%	2.0%	0.0%	5.0%
7	POTENTIAL UNCOVERED BENEFITS	This is the amount of your Maximum Policy Value that would not be covered by the applicable state insurance guaranty association in the event SHIP were placed in liquidation.	Unlimited	Unlimited	\$0	\$14,012	\$0	Unlimited

¹ In the event the Commonwealth Court of Pennsylvania places SHIP into liquidation, your guaranty association coverage would be limited to the statutory limit associated with your state of residence. In this scenario, you may be subject to a premium rate increase at the discretion of the guaranty association and subject to approval by the state in which your policy was issued. The expected premium rate requested by the guaranty association would be:

\$0

² If you elect Option 1 or Option 4 you may be subject to Phase II premium rate increases. For purposes of comparison, although it would be adjusted to reflect the effect of Phase 1, if it were calculated as of the Effective Date, the self sustaining premium for your policy would be:

\$14,325

³ Policy Value Indicators reflect policy status as of the Effective Date. All metric values will change subsequent to the effective date. The changes will be significant for active policyholders who become disabled and for disabled policyholders who become active.

⁴ Maximum Benefit Period and Maximum Daily Benefit are shown for the highest level of care covered by the policy. Nursing home is the highest level of care, assisted living facility is the second-highest level of care, and home-health care is the third-highest level of care.

⁵ Maximum Policy Value is the product of the policy's Maximum Benefit Period times its Maximum Daily Benefit, adjusted for inflation. For active policyholders, inflation is accounted for by assuming a claim is incurred on the Effective Date. Actual Maximum Policy Value will vary from policyholder to policyholder and will depend on when a claim is incurred.

The Proposed Rehabilitation Plan (the "Plan") is aimed at reducing or eliminating a very substantial "Funding Gap" or deficit arising from the excess of projected liabilities over the premium and assets projected to be available to fund them, in part by modifying many existing LTC policies while striving to provide policyholders meaningful choices. IF THE REHABILITATION PLAN FAILS TO REDUCE THE FUNDING GAP SUFFICIENTLY, IT IS POSSIBLE THAT SHIP WILL BE PLACED IN LIQUIDATION, POLICYHOLDERS WILL HAVE FEWER OPTIONS, AND SOME MAY LOSE SOME OR ALL OF THEIR COVERAGE IN EXCESS OF GUARANTY ASSOCIATION LIMITS. See discussion beginning at page 92 and especially page 95.

ILLUSTRATIVE POLICYHOLDER GUIDANCE PAGE

This page is provided to assist you in comparing the Plan Options to each other and in selecting the best one for your individual circumstances. The yellow boxes contain the comparative data. The rest of this page provides explanations for that data.

YOUR CURRENT POLICY: These are the key details and characteristics of your current policy before modification under the Plan.

CURRENT PREMIUM	\$1,198	ILLUSTR. #	12	YEAR ISSUED	1988
MAXIMUM DAILY BENEFIT	\$80			AGE WHEN ISSUED	56
MAXIMUM BENEFIT PERIOD (in years)	4.0			CURRENT AGE	88
MAXIMUM POLICY VALUE	\$116,800			GUAR ASSN LIMIT ¹	\$300,000
INFLATION PROTECTION	0.0%			STATE OF ISSUE	TX
PREMIUM AND CLAIM STATUS	Premium paying	Active		STATE OF RESIDENCE	TX

COMPARISON OF RELATIVE VALUES: This chart shows the value of several metrics for your current policy and each Option available to you under the Plan. Each metric may have greater or lesser importance for a particular policyholder. The table should enable you to compare the metric(s) most important to you from Option to Option.

Policy Value Indicators^{2,3}

#	METRIC	DESCRIPTION	Current	Option 1	Option 2	Option 2a	Option 3	Option 4
			Your Policy Now	Downgrade	Basic Policy	Enhanced Basic Policy	Enhanced RPU	Phase I premium (Current Benefits)
1	PREMIUM FOR EACH OPTION	This is the actual premium for your current policy and for each Option available to you.	\$1,198	\$1,198	\$529	\$529	NO PREMIUM	\$1,198
2	PREMIUM INCREASE OR DECREASE FOR EACH OPTION	For each option, this shows the change from your current premium.	N/A	\$0	-\$669	-\$669	-\$1,198	\$0
				0.0%	-55.8%	-55.8%	-100.0%	0.0%
3	MAXIMUM BENEFIT PERIOD⁴	This is the Maximum Benefit Period (years of care) available under your current policy and each Option.	4.0	4.0	5.0	5.0	2.5	4.0
4	MAXIMUM DAILY BENEFIT⁴	This the Maximum Daily Benefit as of the Plan Effective Date available under your policy and each Option.	\$80	\$80	\$64	\$64	\$64	\$80
5	MAXIMUM POLICY VALUE⁵	This is the maximum amount of coverage provided by your current policy and each Option, adjusted for inflation if applicable.	\$116,800	\$116,800	\$116,800	\$116,800	\$58,400	\$116,800
6	INFLATION	This is the degree of inflation protection provided by your policy and each option.	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
7	POTENTIAL UNCOVERED BENEFITS	This is the amount of your Maximum Policy Value that would not be covered by the applicable state insurance guaranty association in the event SHIP were placed in liquidation.	\$0	\$0	\$0	\$0	\$0	\$0

¹ In the event the Commonwealth Court of Pennsylvania places SHIP into liquidation, your guaranty association coverage would be limited to the statutory limit associated with your state of residence. In this scenario, you may be subject to a premium rate increase at the discretion of the guaranty association and subject to approval by the state in which your policy was issued. The expected premium rate requested by the guaranty association would be:

\$1,198

² If you elect Option 1 or Option 4 you may be subject to Phase II premium rate increases. For purposes of comparison, although it would be adjusted to reflect the effect of Phase 1, if it were calculated as of the Effective Date, the self sustaining premium for your policy would be:

\$1,757

³ Policy Value Indicators reflect policy status as of the Effective Date. All metric values will change subsequent to the effective date. The changes will be significant for active policyholders who become disabled and for disabled policyholders who become active.

⁴ Maximum Benefit Period and Maximum Daily Benefit are shown for the highest level of care covered by the policy. Nursing home is the highest level of care, assisted living facility is the second-highest level of care, and home-health care is the third-highest level of care.

⁵ Maximum Policy Value is the product of the policy's Maximum Benefit Period times its Maximum Daily Benefit, adjusted for inflation. For active policyholders, inflation is accounted for by assuming a claim is incurred on the Effective Date. Actual Maximum Policy Value will vary from policyholder to policyholder and will depend on when a claim is incurred.

The Proposed Rehabilitation Plan (the "Plan") is aimed at reducing or eliminating a very substantial "Funding Gap" or deficit arising from the excess of projected liabilities over the premium and assets projected to be available to fund them, in part by modifying many existing LTC policies while striving to provide policyholders meaningful choices. IF THE REHABILITATION PLAN FAILS TO REDUCE THE FUNDING GAP SUFFICIENTLY, IT IS POSSIBLE THAT SHIP WILL BE PLACED IN LIQUIDATION, POLICYHOLDERS WILL HAVE FEWER OPTIONS, AND SOME MAY LOSE SOME OR ALL OF THEIR COVERAGE IN EXCESS OF GUARANTY ASSOCIATION LIMITS. See discussion beginning at page 92 and especially page 95.

V. PHASE THREE

Following implementation of Phase One and Phase Two, SHIP will continue managing its LTCI in a run-off mode. While some aspects of Phase Three will be developed in the future, if the Company has improved to the point of having assets available, payments will be made to policyholders, agents, and other creditors on account of amounts owed to them. Certain amounts may be owed to policyholders on account of the ***Unfunded Benefit Liability*** created as part of the policy restructuring. See Section VI.H, page 91. By virtue of the restructuring, this Unfunded Benefit Liability (UBL) will be a non-insurance obligation payable only if SHIP has assets available for payments to general creditors in Phase Three. To the extent such assets are available, they will be applied proportionately to the UBL along with other unpaid general creditors liabilities, such as agent commissions and amounts owed to companies previously reinsured by SHIP. The UBL payments to policyholders will actually take the form of extended Maximum Benefit Periods.

It is possible that in Phase Three SHIP will not be able to pay off all remaining liabilities in full. In that event, it is likely that it will then be placed in Liquidation in accordance with Article V. To the extent that at that time there remain unsatisfied insurance policy obligations, the Guaranty Associations may be triggered to protect the remaining policy obligations, subject to applicable statutory conditions and limits. See Section VI.J, page 92.

VI. OTHER MATTERS

A. ABOUT SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA

SHIP commenced business on July 5, 1887, as the Home Beneficial Society. It underwent many transactions and transformations in the ensuing century, culminating in the adoption of the current name in October 2008, when it was transferred by its then owner, Consecro, to the newly formed, nonprofit, *Senior Health Care Oversight Trust* (the “Trust” - see page 90) so it could continue running off its long-term care insurance (“LTCI”) business independently. At the time, SHIP had 152,000 LTC policies in force. As of year-end 2019 that number was down to close to 45,000 and as of this filing it is at around 39,000. It is a Pennsylvania life and health insurance company. Prior to Rehabilitation, SHIP was licensed in 46 states (excluding Connecticut, New York, Rhode Island, and Vermont), the District of Columbia, and the U.S. Virgin Islands. Since SHIP’s creation in 2008, it has utilized an outsourcing model for select functions, specifically: Long Term Care Group, Inc. (“LTCG”) for lower-level claims administration functions; Milliman for rate increase analyses and valuations; Conning, Inc., and New England Asset Management, Inc., for investment services; KPMG for tax services; and external law firms for specific legal issues. Beginning in 2018, the Company engaged Ernst & Young for internal audit services. After SHIP was placed in rehabilitation, the Rehabilitator has retained some and replaced others of these service providers.

Table 7 summarizes the Company's corporate history.

TABLE 7 - CORPORATE HISTORY



B. LONG-TERM CARE INSURANCE

At the time this Second Amended Rehabilitation Plan is filed, the insurance business of SHIP consists entirely of long-term care insurance (LTCI), much of it issued many decades ago, and none issued any later than 2003, when the Company ceased writing new business. Of approximately 646,000 LTCI policies sold by SHIP and its predecessors since the late 1970s, fewer than 40,000 remain in force. More precisely,

1. As of year-end 2018, SHIP had 51,635 LTC policies in force, of which 6,151 policyholders were on claim. As of that date, it also reinsured 2,620 policies of which 401 were on claim. See Section VI.M, page 96. Thus at that time it administered a total of 54,255 policies of which 6,552 were on claim.

2. By year end 2019, SHIP's direct LTCI business was down to 45,518 policies, with 5,776 on claim. Its assumed business was down to 2,267 policies, 376 on claim. At the end of that year, therefore, SHIP was administering 47,785 policies of which 6,152 were on claim.
3. By mid-year (June 30, 2020) these numbers had declined further. The total of direct LTC policies was down to 42,559, of which 5,402 were on claim. Assumed policies numbered 2,114, with 352 on claim. Total of administered LTC policies was therefore 44,673, of which 5,753 were on claim. As noted, by the time of this filing, direct LTC policies number around 39,000.
4. A key characteristic of this remaining "legacy" block of LTCI policies as a group is that the premiums being paid, when added to the Company's assets, are projected to be grossly insufficient to pay the benefits expected to be due under those policies. This anticipated "Funding Gap" led to the Company being placed in Rehabilitation on January 29, 2020, and is the key challenge sought to be addressed by the Plan.
5. SHIP's long-term care insurance policies cover long-term care services, including confinement to nursing facilities and assisted living facilities, as well as home health care and adult day care for individuals who meet specified requirements. These requirements vary among the Company's policies but typically include things like the policyholder requiring care for at least 90 days, and being unable to perform 2 or more Activities of Daily Living (eating, dressing, bathing, transferring, toileting, and continence) without substantial assistance (hands on or standby).
6. The Company's business is comprised of LTCI and health policies written by the Company and assumed reinsurance. The non-LTC health policies written by SHIP and its predecessors were assumed by reinsurance by Conseco when SHIP was spun off in 2008. SHIP, therefore, is not administering those policies, which now number around 45,500. For the LTCI policies written by the Company and its predecessors, average policyholder age is 86 and the average claimant is 89 years old. SHIP's policies are approximately 13% Home Health Care coverage, 17% Facility Care coverage (nursing home and/or assisted living facility), and 70% Comprehensive coverage covering multiple levels of care. The following paragraphs provide a general description of certain terms and features that are included in many of the Company's LTC Policies.
7. Tax Qualified v. Non-Tax Qualified - In order to trigger coverage under a policy, the policyholder generally must satisfy certain needs-based tests that vary depending on whether the policy is Tax Qualified or Non-Tax Qualified. Under Section 213 of the Internal Revenue Code ("IRC"), premiums paid for a Tax Qualified LTC policy are deductible medical expenses. According to Section 7702B of the IRC, a Tax Qualified policy is one that:
 - a. provides insurance coverage only for qualified LTC services;

- b. does not pay or reimburse expenses that are reimbursable under Medicare;
 - c. is guaranteed renewable;
 - d. does not provide for a cash surrender value or other money that can be paid, assigned or pledged as collateral for a loan, or borrowed;
 - e. provides that all refunds of premiums (other than refunds on the death of the insured or on a complete surrender or cancellation of the policy, which cannot exceed the aggregate premiums paid under the policy) and the policyholder dividends, or similar amounts, are applied as a reduction of future premiums or to increase future benefits; and
 - f. satisfies certain consumer protection requirements as well as disclosure and nonforfeitability requirements.
8. “Qualified long-term care services” are defined as necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and other rehabilitative services, and maintenance or personal care services which are required by a chronically ill individual and are provided pursuant to a plan of care prescribed by a licensed health care practitioner. A “chronically ill individual” is defined as one who has been certified within the previous twelve (12) months by a licensed health care provider as:
- a. being unable to perform (without substantial assistance from another individual) at least two (2) Activities of Daily Living (eating, toileting, transferring, bathing, dressing and continence) for a period of at least 90 days due to a loss of functional capacity;
 - b. having a level of disability similar to the level of disability described in the clause above, as determined by the Internal Revenue Service in consultation with the Department of Health and Human Services; or
 - c. requiring substantial supervision to protect such an individual from threats to health and safety due to severe cognitive impairment.
9. A Non-Tax Qualified Policy generally contains eligibility standards, such a Medical Necessity, which is a lower threshold to trigger coverage. For example, some policy forms contain the following conditions for eligibility:
- a. *Your Physician certifies Your care to be Medically Necessary; or*
 - b. *You are unable to perform two (2) or more Activities of Daily Living without assistance or supervision; or*
 - c. *You are afflicted with Cognitive Impairment.*

Approximately 85% of the Company's policies are Non-Tax Qualified policies, and approximately 66% of the in-force policies are eligible to qualify for care through the Medical Necessity provision.

10. **Daily Benefit Amount** - The Company's LTC policies are subject to a Maximum Daily Benefit that was selected by the policyholder when he or she purchased the coverage. The Maximum Daily Benefit available ranged from \$10 to \$300 per day, with many policies subject to annual percentage increases. Some policies, known as "indemnity," pay the full Maximum Daily Benefit, regardless of actual expenses incurred. With the annual percentage increases, in some cases the Maximum Daily Benefit has accumulated to over \$700 and can be envisioned to continue increasing to over \$1,000, far in excess of the cost of care. The Company's average Maximum Daily Benefit for in-force policyholders is \$173.
11. **Inflation Benefit** - Some of the Company's LTC policies were issued with an inflation benefit (referred to as "Inflation Protection"). Inflation Protection may increase a policy's Maximum Daily Benefit by a fixed percentage, often 3% or 5% each year, and inflate the Maximum Lifetime Benefit or Benefit Account Value proportionately. The inflation may be simple (increase by the fixed percentage of the original benefit each year) or compound (increase by the fixed percentage of the current benefit each year). The duration of the inflation benefit may be limited to 20 years, or until a policyholder attains the age of 85, but many policies have Inflation Protection for the life of the policy. Approximately 32% of the in-force policyholders have lifetime 5% compound inflation.
12. **Indemnification** - Indemnity and reimbursement denote the method by which the Maximum Daily Benefit will be paid out. Some policies provide coverage for the actual expenses of care (reimbursement), while others pay the full daily benefit amount regardless of actual expenses incurred (indemnity) much like disability insurance policies. The payment method can vary on comprehensive policies, between Assisted Living Facility Care or Home Health Services. Approximately 63% of in-force policyholders have the indemnity benefit for their main coverage.
13. **Benefit Period** - Most of the Company's LTC policies are subject to a Maximum Benefit Period. The Maximum Benefit Periods range from one year to six years. Some policies, however, have an unlimited benefit period ("lifetime policies") while others are subject to a maximum dollar amount. Approximately 72% of the in-force policyholders have a limited benefit period while approximately 28% of policyholders have lifetime policies.
14. **Elimination Period** - Some of the Company's LTC policies have an Elimination Period, which is a period of time during which the Company is not required to pay benefits to an otherwise eligible policyholder receiving covered care or services. Some policies were issued with a zero-day Elimination Period. Approximately 66% of the in-force policyholders have a zero-day Elimination Period.

15. **Waiver of Premium** - Approximately 99% of the Company's LTC policies provide that a policyholder who receives benefits under his or her policy for a specified period of time (such as 90 days) is no longer required to pay premiums for coverage after that time period as long as the policyholder remains eligible for benefits and/or receives a specified level of care. Once the policyholder's eligibility for benefits ends, the policyholder is required to resume paying premiums. Approximately 14% of policyholders who otherwise would pay premiums are currently eligible for the Waiver of Premium benefit.
16. **Restoration of Benefits** - The Restoration of Benefits ("ROB") provision restores the policy's Benefit Period to the original Maximum Benefit Period after receiving some or all claim benefits if the policyholder does not need or receive care during a specified period of time such as 180 days. In most instances, partial benefits were utilized prior to the restoration period. Some policies may restore an unlimited number of times, while others are restricted in the number of times the policy can be restored. Approximately 76% of the in-force policyholders have a ROB benefit.
17. **Return of Premium** - Approximately 5% of the Company's LTC policies were issued with a Return of Premium ("ROP") benefit. This benefit provides for the return of a percentage of premium paid by the policyholder if the policyholder does not have a claim or has a limited amount of benefits paid under the policy. The ROP typically occurs upon termination or upon ten-year incremental anniversaries. Since 2011, over \$53 million has been returned through the ROP benefit.

C. FINANCIAL CONDITION

The Company has been in a declining financial condition for many years. Its reported surplus is reflected in the following table:

TABLE 8: FINANCIAL CONDITION (IN DOLLARS)

YEAR	ASSETS	LIABILITIES	CAPITAL & SURPLUS/ (DEFICIT)
2009	3,251,994,962	3,058,545,856	193,449,106
2010	3,317,023,144	3,139,706,226	177,314,918
2011	3,161,093,979	3,046,696,672	114,397,307
2012	3,080,745,346	2,975,278,318	105,467,028
2013	2,985,938,782	2,887,736,889	98,201,892
2014	2,906,965,242	2,826,959,318	80,005,924
2015	2,879,794,716	2,824,037,145	55,757,570

2016	2,744,535,287	2,716,512,099	28,023,187
2017	2,688,468,510	2,675,819,343	12,649,166
2018	2,186,058,273	2,652,931,248	(466,814,972)
2019	1,907,181,137	2,823,279,366	(916,098,229)
2020	1,369,908,000	2,592,415,000	(1,222,507,000)

More complete financial information as of December 31, 2019, is included at Appendix B, along with summary updated information through December 31, 2020. It is estimated that SHIP's Funding Gap is more than \$1.2 billion. That is to say, based on Current Premium payments and the current value of SHIP's assets, in the absence of rehabilitation, by the time all of SHIP's policies terminate about twenty to twenty-five years from now, it will have incurred liability for covered benefits costing at least \$1.2 billion more than the money that will be available to pay for those benefits. It is important to note that these are estimates or projections for events that will occur over a long period of time. Any of a multitude of factors can change during that time affecting materially the accuracy of those projections.

There are many reasons that SHIP finds itself in this dilemma, some understood better than others. The Rehabilitator has been conducting and will continue thorough and exhaustive investigations and analyses of the reasons for SHIP's current financial condition. The areas of investigation and analysis will include, but not be limited to, industry wide challenges, common industry practices, volatility in the financial markets, and the conduct of SHIP's management, business partners, consultants and other service providers. The Rehabilitator, in consultation with her advisors and experts, will determine how these forces may have contributed to SHIP's current financial condition. Actions will be taken as appropriate.

Industry wide challenges may have played a role. The LTCI industry or line of insurance business is relatively young, significant numbers of such policies being sold for the first time in the late 1970s and early 1980s. When these insurance products were first designed, there did not exist a robust data base of historical LTCI experience of the type on which actuaries typically rely to calculate what benefits will cost, how the policies will "behave" over time, and what level of premium will be required to make them financially safe. There was insufficient historical data on which to base expectations about benefit costs and required premiums. The industry therefore referred to experience in other lines of insurance, such as life and disability, to make such projections. Soon, the industry came to understand that the characteristics of LTCI policies are materially different in key respects from those in other lines of insurance. For example, many fewer policyholders voluntarily surrender their LTCI policies before expiration than is true of other types of insurance. Similarly, the length of time during which LTCI policyholders will require benefits is materially longer than had been projected. In short, many factors affecting projected liabilities turned out materially different from what had been assumed when the policies were first issued, and when premium rates were set for them.

This problem was compounded by a decision by the industry to structure these policies as level-premium guaranteed-renewable contracts. In summary, this meant that, as long as the policyholders paid their premiums, the policies could not be cancelled despite changes in age, health condition, and other circumstances. Moreover, the premiums could only be increased if they were increased by the same percentage for all policyholders who had the same type of policy, and then only if the state insurance regulator approved the increase. Over time, a large percentage of these policies were found to be substantially underpriced in that the premiums paid for a given group of such policies could be projected to fall far short of what the company would need for the benefits due under the policies for that group. Obtaining the required approval for rate increases from state regulators proved difficult over time, resulting in two key problems. First, for many LTCI companies, the entire block of such policies was projected to create liabilities far in excess of what the companies would be able to pay. In fact, for many companies like SHIP, this became a serious threat of, or contributing cause to, insolvency. Second, because of differences in the responses by different states to requests for authorization to increase premium rates, over time there emerged wide divergence in the premiums policyholders holding similar policies would pay in different states. Some critics characterized this phenomenon as resulting in policyholders in rate-increase-approving states subsidizing those in states that rejected such requests. All of this can be contrasted with typical health insurance policies that generally last only a year or less, and the premiums for which are adjusted at least annually.

Adding to these challenges were material changes in the economic environment in which these policies were required to perform. For example, when early LTCI policies were sold, there did not exist a robust assisted living facility (“ALF”) or continuing care retirement center (“CCRC”) industry. When one became incapable of caring for oneself, the principal choices were internment in a nursing home, widely viewed as undesirable unless absolutely necessary, or (at much lower cost) having family or hired help care for one at home. However, as LTCI policies began becoming more popular and provided a funding source for other alternatives, there emerged a vibrant industry of desirable retirement homes providing varying levels of care, but typically in much more enticing surroundings and with attractive amenities. These ALFs and CCRCs increased the cost of caring for those who qualified for long-term care benefits but preferred not to remain at home to be cared for by their families or hired care-givers. In many other ways, the cost of caring for those who could not fend for themselves also increased beyond what had been projected by some companies and their consultants when early LTCI policies were priced.

Another major development affected a different key source of funding for future benefits. LTCI policies are designed to generate far more premium than needed to pay benefits in their early years, with those amounts to be invested and generate a material investment income that will be added to the premium and be used in later years when benefit costs are expected to exceed premiums being collected at that later time. In short, the notion is that the company will build-up a fund of premium and investment income that will suffice to pay the large claims expected in the future. In addition to premium being inadequately low when first set, and claims costing more than expected, income earned on the invested premium has also turned out to be much less than anticipated. Changes in the capital market and the broader economy, especially the “great recession” of 2008, dramatically suppressed investment returns below expectations. Current economic circumstances

are exacerbating this problem. Many LTCI insurers have amassed billions of dollars in invested premiums. A decline of 1% in yield on each \$1 billion of invested premium amounts to a loss every year of \$10 million in funds to be reinvested and be available for future claims. It is not hard to see how a decline in market yields of even just 3% for five years for a company with \$2 billion in invested assets could be a major event. That would entail a loss of at least \$300 million! This is the nature of lost investment income experienced by SHIP and the rest of the LTCI industry, but on more invested assets for many more years. As a point of reference, the Wall Street Journal Prime Rate was at: 8.25% on March 5, 1975; **17.25%** on March 4, 1980; 10% on January 8, 1990; 9% on March 22, 2000; 5.75% on March 22, 2005; 3.25% on December 16, 2008; 5.50% on December 20, 2018; back down to 3.25% on April 10, 2020, and staying at that level since.

These and other challenges faced by SHIP over the eleven years since it was separated from Consecro have combined to create the Funding Gap described above. The purpose of the Plan is to narrow or eliminate that Funding Gap by a combination of an increase in revenue through rate increases and a reduction in liabilities through benefit modifications.

D. REHABILITATION PROCEEDING

Since the fall of 2008, SHIP has been owned and overseen by the Senior Health Care Oversight Trust (“Trust” - see paragraph VI.E, page 90) and its Trustees. As SHIP’s domiciliary regulator, the Pennsylvania Insurance Department (“PID”) regulates SHIP’s affairs and monitors its financial condition. On May 7, 2015, the PID concluded a financial examination of SHIP for the five-year period ending on December 31, 2013. The results were detailed in the Report of Examination dated as of that date, which concluded that, as of December 31, 2013, SHIP had capital & surplus of \$98,201,892 and made no recommendations.

As surplus continued to decline (see Table 7, at page 86, above), the PID became substantially concerned about SHIP’s financial situation. The Department engaged in an intense regulatory focus aimed in part at encouraging management and the Trustees to review and revise the actuarial and other assumptions on which they were basing their financial projections and reports of SHIP’s financial condition. In 2017 the PID commenced a limited examination of SHIP’s affairs and engaged an independent consulting actuary to assist, especially, in evaluation of the adequacy of the Company’s reserves. This work revealed a number of areas of concern and the PID appointed a Special Representative to work with SHIP management, the Trustees, and consultants for both the Company and the PID, to ascertain SHIP’s financial condition and to determine whether it would be able to fulfill the contractual promises inherent in the LTCI block the Company was running off. As this work progressed it became evident that SHIP was in a more hazardous financial condition even than suggested by the 2017 statutory annual statement filed in March 2018, which reported a decline in surplus to just over \$12.6 million from over \$28 million a year earlier and almost twice that the year before.

SHIP and its consultants, in communication with the PID and its representatives and advisors, re-evaluated their underlying assumptions, and, in early 2019, SHIP completed an annual statement for 2018 that reported a \$467 million deficit. Management was provided an opportunity to develop

a corrective action plan to eliminate this deficit and restore the Company's surplus to acceptable levels but failed to do so. On January 29, 2020, at the request of Pennsylvania Insurance Commissioner Jessica K. Altman, and with the consent of a majority of the Trustees and SHIP's directors, the Commonwealth Court of Pennsylvania entered the Rehabilitation Order placing SHIP in rehabilitation and appointing Commissioner Altman as Rehabilitator. The order directed the Rehabilitator to file a preliminary plan for SHIP's rehabilitation on or before April 22, 2020. Commissioner Altman appointed Patrick H. Cantilo as Special Deputy Rehabilitator (SDR) to comply with the Court's requirement. A Proposed Rehabilitation Plan was filed on that date and this Plan Document is the Second Amended version of the plan required by the Court, the first Amended Rehabilitation Plan having been filed on October 21, 2020.

E. SENIOR HEALTH CARE OVERSIGHT TRUST

As mentioned above, SHIP had been a subsidiary of Conseco, Inc. ("Conseco") until 2008 when it agreed with PID's approval to transfer the Company to a newly created independent nonprofit trust. For that purpose, the Senior Health Care Oversight Trust (the Trust) was formed as a Pennsylvania business trust and the following served as its trustees (the "Trustees") as of the date the Company was placed in Rehabilitation and for at least seven years before that date:

1. Julianne Marie Bowler (Chair), since 2009 the Chief Underwriting Officer, and also the Chief Compliance and Administrative Officer, of Narragansett Bay Insurance Company. Ms. Bowler had served as the Massachusetts Insurance Commissioner from 2002 to 2007;
2. Cecil Dale Bykerk, President of CDBykerk Consulting, LLC, a life and health insurance consulting actuary;
3. Thomas Edward Hampton, Senior Advisor to Dentons US LLP, a Certified Public Accountant and former commissioner of the District of Columbia Department of Insurance, Securities, and Banking;
4. John Martin Morrison, senior Partner at Morrison, Sherwood, Wilson, Deola, PLLP, and former Montana State Auditor and Insurance Commissioner; and
5. Gregory Vincent Serio, Partner and Managing Director of New York lobbying firm Park Strategies, and former New York Superintendent of Insurance.

The transaction transferring SHIP to the Trust was memorialized in an August 1, 2008, Transfer Agreement between Conseco and the Trust. The Trust has been (and continues to be) governed by the board of trustees identified above, who have also served as directors of SHIP and Fuzion, along with certain senior officers of the companies. Their authority to oversee the Company has been effectively suspended by the rehabilitation proceedings.

F. FUZION ANALYTICS

Fuzion Analytics, Inc. (“Fuzion”), is a Delaware corporation formed in 2012 as a subsidiary of the Senior Health Care Oversight Trust ostensibly to provide LTCI data mining, analytical and other services to long-term care insurers, including SHIP. Beginning in 2012, SHIP entered into several agreements with Fuzion under which, over time, it paid Fuzion millions of dollars. In 2014, SHIP conveyed essentially all of its infrastructure to Fuzion in exchange for agreed-upon cash consideration consisting initially of a payment of \$367,806. In due course, Fuzion began providing SHIP all of the services necessary to administer SHIP’s affairs, other than those being performed by other vendors. Since that conveyance, SHIP has had no facilities or employees, relying instead on Fuzion and other vendors to perform all of the functions necessary to run-off SHIP’s LTCI business. On August 20, 2019, the Senior Health Care Oversight Trust conveyed all of its interest in Fuzion to SHIP as a capital contribution, so that Fuzion is now a wholly owned subsidiary of SHIP. In addition to the services provided to SHIP, Fuzion continues to provide Fraud Waste and Abuse and other services to customers in the long-term care industry.

G. LTCG, INC.

In 2008 SHIP entered into a Master Services Agreement with Univita for a broad array of claims and administrative services, excluding complaints. Univita has since become the Long-Term Group, Inc., (“LTCG”) and continues providing these services to SHIP.

H. POLICY RESTRUCTURING

Before the Effective Date and before policyholders have made their elections, the Rehabilitator will determine which of SHIP’s policies are Impaired Policies in that the assets and premiums projected to be available will not suffice to pay the liabilities projected to arise under such policies. For purposes of implementing the Plan and to facilitate identification and implementation of key economic and tax components of the Rehabilitator’s strategy, SHIP’s LTC policy liabilities will be restructured to incorporate the terms of the Plan and permit Policyholder Elections. The restructuring must be approved by the Court. The Rehabilitator expects to file an application with the Court for such approval following approval of the Plan. The Rehabilitator will request that the Court deem SHIP’s liabilities for Impaired Policies to have been restructured as of the Effective Date, and before giving effect to Policyholder Elections or modifications under the Plan. However, this restructuring will not affect the elections made by or available to the policyholders.

The restructuring will be for the purpose of separating the liabilities arising under SHIP’s LTC policies that it is projected to have sufficient assets to fund (the ***Initial Funded Restructured Policy Value*** - “IFRPV”), from those that it is projected to be unable to fund (the Unfunded Benefit Liability - UBL). This restructuring will consist of notionally allocating the liability arising under each such policy (equal to its gross premium reserve - GPR) to its IFRPV and its UBL, with the UBL for each policy being the difference between its original GPR and its IFRPV. Premiums paid as to each policy and Allocated Assets determined under the Plan as described in Section II.E.4.e, page

28, are projected to suffice to enable the Company to fund its IFRPV. As a result, after the Effective Date, SHIP will have assets and expected premiums at least equal to the aggregate funded liabilities (IFRPV) remaining under the Restructured Policies. It is important to note that the Policyholder Elections are not intended to, and will not, eliminate the Unfunded Benefit Liability. To the extent that it cannot be paid, that liability is expected to be discharged in due course by the Commonwealth Court upon the Rehabilitator's application.

The Company will retain non-insurance indebtedness to the policyholders on account of the amount by which the liabilities have been reduced, *i.e.*, the UBL. However, this liability will not be an insurance obligation arising under SHIP's policies and would not constitute a contractual obligation covered by the Guaranty Associations if SHIP were liquidated. Under the Plan, this liability will be converted to non-insurance general creditor indebtedness. It is possible that realization by SHIP of additional assets will enable it to make at least partial payments of the UBL in Phase Three. If made, those payments will take the form of extensions of the benefit periods in the affected policies. In any case, as explained below, the Rehabilitator will request that the portion of SHIP's UBL that it will not be able to fund be discharged by the Commonwealth Court as part of the Plan. A complete Restructuring Statement will be filed with the Court for approval following approval of the Plan.

I. GAUGING PLAN PERFORMANCE

During the pendency of the Plan, the Company's financial condition will be monitored closely with emphasis on changes in the projected deficit. Elections by policyholders to increase premiums and reduce benefits in the aggregate are expected to have a material effect on that projected deficit. Various aspects of the Plan are also expected to have material effects on key trends such as average claim cost, claim incidence, claim duration and policy terminations. Most of these are heavily dependent on policyholder behavior that is difficult to predict with certainty. As time passes following implementation of each phase of the Plan, however, changes in these key trends will become more evident and the effects of the Plan as a whole will be more susceptible of quantification.

J. GUARANTY ASSOCIATIONS

This is a general summary of the state Insurance Guaranty Association system. Readers should review the individual state laws to understand how individual Guaranty Associations operate in each jurisdiction and the protections they afford. The Plan does not contemplate involvement by Guaranty Associations in the Plan's operations. This information is provided solely in the interest of addressing anticipated questions.

All U.S. states and the District of Columbia have legislatively established entities, commonly referred to as "Insurance Guaranty Associations," which protect the policyholders of a licensed insurance company in the event their insurance company fails. These Guaranty Associations generally are required to provide for the continuation of the life and health insurance coverage

provided by the failed insurer, in most cases up to statutory maximum coverage amounts and subject to specified conditions.

Virtually all of SHIP's LTC insurance policies would be covered under the state Guaranty Association system, subject to individual state statutory maxima and conditions, if SHIP were placed into liquidation with a finding that it is insolvent. Policies held by residents of other countries may not be covered by Guaranty Associations.

In most states, Guaranty Association benefits can be "triggered" in one of several ways. Some "triggers" are permissive, authorizing the Guaranty Association to guarantee, assume or reinsure, or cause to be guaranteed, assumed, or reinsured, the covered contractual obligations arising under the insurer's policies or contracts (or to provide loans or other assistance). Other "triggers" are mandatory, requiring the Guaranty Association to take such measures. When triggered, the Guaranty Associations generally provide such protections to the residents of their states, though the contracts may have been issued in other states. In most states, the permissive trigger can be used when an insurer is deemed "impaired" but has not been found insolvent or ordered liquidated. As the term implies permissive triggers are optional with the Guaranty Associations and very rarely used.

Mandatory triggers generally include an insurer not paying claims on time and being placed in liquidation with a finding of insolvency. These provisions vary somewhat among the several states. The Rehabilitator has concluded that SHIP does not now qualify for mandatory triggers largely because there has not been an order of liquidation with a finding of insolvency and it is currently paying claims on time. However, though SHIP is currently paying claims on time as required by the Rehabilitation Order, its financial condition is so dire that it is a virtual certainty that it cannot continue paying claims in full and on time for as long as required by its LTC insurance contracts without remedial measures. In the absence of a rehabilitation plan, the continuation of full benefit payments to current claimants virtually assures that policyholders who go on claim in the future will not be able to receive full, or in some cases any, benefits from SHIP.

Generally, if a policyholder is entitled to receive benefits from the Guaranty Association of his or her state of residence no further inquiry is necessary to determine which Guaranty Association is responsible for his or her policy. However, when that is not the case, it may be necessary to determine whether the Pennsylvania Life and Health Insurance Guaranty Association (PLHIGA) may be required to provide such benefits because SHIP is domiciled in Pennsylvania. It is important to note that the conditions and limits of Guaranty Association protection typically apply to each policyholder, not to each policy. Thus, in a state in which such benefits are limited to \$300,000 (the majority of states), that limit will apply to all of a policyholder's policies issued by the same company combined. Thus, since many SHIP policyholders have more than one SHIP LTC policy, this limit will apply to all of them combined. If one policy is expected to receive benefits up to the applicable cap, all of the benefits of the other policy or policies will potentially be lost. The laws of each specific jurisdiction should be reviewed carefully to determine how these conditions and limits apply in particular cases.

It is important to note also that the amount of statutorily promulgated Guaranty Association coverage limits is not directly comparable to a policy's GPR. GPR is the present value as of the valuation date of expected benefits unpaid, expected expenses unpaid, and unearned or expected premiums, adjusted for future premium increases reasonably expected to be put into effect. It measures the present value of benefits and expenses less the present value of premiums. The Guaranty Association coverage limits are stated nominally (that is the total to be paid over time, no matter how long that time) and not at present value. The GPR equivalent of stated Guaranty Association Limit depends on factors individual to each policyholder, mostly related to the expected timing and amount of benefit and premium payments. Thus, a \$300,000 Guaranty Association limit may equate to a GPR of \$270,000 or some other amount less than \$300,000 for a given policyholder.

Neither the Rehabilitator nor SHIP would be responsible for coverage decisions of the Guaranty Associations. Each Guaranty Association evaluates its own liability and makes its own coverage determinations in accordance with applicable law. Those laws vary to some degree among the states and benefits available in some states may differ from those available in others. For example, in some states the Guaranty Associations do not provide coverage for any portion of a policy or contract to the extent that the rate of interest on which it is based exceeds a specified rate, typically set by reference to Moody's Corporate Bond Yield Average over a specified time. These interest rate limitations often apply retrospectively (to interest earned pre-liquidation) and prospectively (to interest earned after liquidation), though perhaps in different ways. Other states have adopted legislation making such provisions inapplicable to LTCI.

As noted above, Guaranty Association benefits are subject to statutory conditions and limits. For example, PLHIGA is not obligated to provide more than \$300,000 in benefits to a covered individual. In some states that limit can be significantly higher. However, the fact that applicable limits may be higher in another state does not entitle Pennsylvania residents to the higher protection afforded by the Guaranty Association of another state. In addition, the Guaranty Association statutes contain certain residency and other requirements that must be met in order to receive benefits. Some of SHIP's policyholders may have aggregate claims in excess of these limits or which do not qualify for Guaranty Association benefits for other reasons (Uncovered Benefits).

The methods by which Guaranty Associations discharge their statutory responsibilities vary from case to case but normally involve assumption by a Guaranty Association or an insurer of the contractual obligations created by the policies issued by the failed insurer, up to statutorily prescribed limits and subject to statutory conditions. Policyholders are required to continue paying their premiums without interruption in order to preserve their insurance coverage, unless those premiums have been suspended by Premium Waiver provisions in their policies. However, once benefits paid by the Guaranty Association reach the applicable statutory limit (and those benefits are therefore discontinued), typically the policyholder will no longer be required by the Guaranty Association to continue making premium payments.

As noted, SHIP has not been placed in liquidation and Guaranty Association coverage and associated limits are therefore not applicable to SHIP policies. While it is hoped that it will not be necessary to place SHIP in liquidation, and no specific plans exist to do so, past experience provides

guidance about some likely aspects of such an eventuality. Specifically, it is probable that if the Guaranty Associations are “triggered” for a SHIP liquidation they would seek to raise premium rates using a methodology similar to the Plan’s If Knew Premium. Thus, the resulting premium rate increases can be expected to resemble those contemplated by the Plan. To the extent that the Plan does so now, it should reduce or eliminate the need for the Guaranty Associations to do so if that were to occur.

As explained on page 12, the Plan is designed to provide policyholders at least the benefits they would receive from Guaranty Associations in liquidation. Every policyholder will be offered at least one option in Phase One that will provide him or her potential benefits equal to those that would be available from the applicable Guaranty Association in the event of liquidation, but no more than the current policy benefits. Option Two will do that for all policyholders, and for many policyholders other options will do that as well. In that respect, the Plan is expected to place policyholders in no worse a position than they would face in a liquidation of SHIP.

K. LIQUIDATION CLAIMS IN EXCESS OF GUARANTY ASSOCIATION LIMITS

It is estimated that more than 20% of the benefits to which SHIP policyholders are expected to be entitled under current LTC policies would exceed the statutory limits of guaranty association coverage as described in the preceding Section. While the Rehabilitator believes that applicable law would authorize her to use SHIP assets to pay at least part of those “uncovered benefits,” some members of the insurance industry hold the opposite view. This unresolved issue has so far prevented the liquidator of Penn Treaty Network America Insurance Company and American Network Insurance Company from making such payments. These two insurers are also Pennsylvania-domiciled long-term care insurers and the Rehabilitator, who is also the Liquidator in those cases, is concerned that she might be prevented from paying uncovered benefits to SHIP’s policyholders if it also has to be placed in liquidation. Thus, it is possible that placing SHIP in liquidation might result in “truncating” the contractual benefits for which policyholders have been paying premiums to the limits of guaranty association coverage.

L. JURISDICTION OF COMMONWEALTH COURT

In composing this Plan, the Rehabilitator makes the assumption that the Commonwealth Court has exclusive *in rem* jurisdiction over SHIP and all of its assets. The Rehabilitator believes that this principle is both established law and indispensable to the success of a rehabilitation plan of this breadth and complexity. That means that it is the only court with jurisdiction over SHIP’s assets and business. Note by way of distinction that other courts may have *in personam* jurisdiction over SHIP, its policyholders and claimants. The Commonwealth Court has authority to approve a rehabilitation plan for the company. The governing Pennsylvania statute, 40 P.S. § 221.16, expressly authorizes the rehabilitator to “prepare a plan for the reorganization, consolidation, conversion, reinsurance, merger, or other transformation of” SHIP. Without going into detail, that statute gives the rehabilitator broad discretion to develop a plan to correct the conditions that led to the need to

place SHIP in rehabilitation, including changing the Company's policies (and rates) as part of the Plan. So long as all affected parties (including other state insurance departments) are provided an opportunity to object, they will be bound by the Court's approval of the Plan, and its modification of policies and premium rates as part of the Plan.

Some concern has been expressed by certain state regulators about the notion that premium rate modifications under the Plan will not require approval of the states in which the policies were issued. The concern is not surprising given that there have not been many troubled companies for which the issue of rate increases in rehabilitation has arisen. Moreover, insurance rate regulation tends to be an area of intense public and political focus. In some states, Commissioners are constrained by statute in the magnitude of premium rate increases they can authorize for long-term care insurance policies. Regulations have the same effect in other jurisdictions. The Rehabilitator believes strongly that there is fundamental distinction between rate increases for companies in the market place and the extraordinary case of rate increases as part of a court supervised rehabilitation plan for a troubled company. While the matter is without an abundance of clear specific legal precedent, the Rehabilitator believes that the applicable legal authorities support the conclusion that it is properly within the purview of the Rehabilitator and the Commonwealth Court in an Article V rehabilitation proceeding. More importantly, the Plan would not be feasible, and would fail in a key goal, if rate modifications required approval from each of the states in which SHIP policies have been issued. First, that would prevent the plan from accomplishing its key goal of placing policyholders on "a level playing field" by having them pay substantially the same premium for the same coverage, thereby reducing or eliminating the much-criticized historical subsidies. Second, the need to obtain such approvals would insert a lengthy delay in the time-line that would be costly, if not fatal, to the Plan. Nonetheless, the Rehabilitator has added Section VI.V (page 108) as a means of addressing these concerns. That Section strives to reconcile the desire of certain states to make their own rate increases determinations with the fundamental goals of the Plan.

M. REINSURANCE

SHIP has assumed a number of LTC policies through co-insurance or reinsurance and ceded other policies under other reinsurance agreements. This Section describes those arrangements.

1. TRANSAMERICA

On October 11, 1994, JC Penney Insurance Company and JC Penney Life Insurance Company (collectively "JCP") entered into a Reinsurance and Purchase Agreement and Administrative Services Agreement with American Travellers Life Insurance Company ("American Travellers"). The Reinsurance and Purchase Agreement was structured on an Indemnity Reinsurance basis and a trust account was later established pursuant to a Trust Agreement executed on December 31, 2002. American Travellers was purchased by Consec in 1996 and subsequently changed its name to Consec Senior Health Insurance Company and then to Senior Health Insurance Company of Pennsylvania ("SHIP"). JCP changed its name to Stonebridge Life Insurance Company in 2002 and, as a result of corporate transactions, is now Transamerica Life Insurance Company.

2. PRIMERICA

On December 20, 1995 Primerica Life Insurance Company (“Primerica”) and Transport Life Insurance Company (“Transport Life”) entered into a Reinsurance and Administration Agreement whereby Transport Life, on an indemnity basis, accepted 100% of the policy liabilities of Primerica’s individual and group accident and health insurance policies. Transport Life merged with Conseco Senior Health Insurance Company in November 1997 and, with the separation from Conseco, Senior Health Insurance Company of Pennsylvania (“SHIP”) became the successor under the Reinsurance and Administration Agreement. Amendment #2 to the Reinsurance and Administration Agreement, dated November 11, 2008, limits the scope of SHIP’s reinsurance and administration to long-term care policies only.

3. AMERICAN HEALTH AND LIFE

Pursuant to a Reinsurance Agreement dated November 1, 1996, Transport Life entered into a Reinsurance Agreement whereby Transport Life agreed to administer and reinsure, on a coinsurance basis, 100% of the liability of American Health and Life Insurance Company’s long-term care policies. As a result of certain corporate transactions, and later the separation of SHIP from Conseco, SHIP became the successor to Transport Life’s interests under the Reinsurance Agreement and continues to administer the policies.

4. WASHINGTON NATIONAL INSURANCE COMPANY

On June 30, 1998, American Travellers entered into a Coinsurance Agreement with Conseco Life whereby American Travellers ceded 100% of its net liability for certain Connecticut resident state policies to SHIP, including servicing and administration of these policies. On April 1, 2013, CNO assumed, through novation, all of the policies with the exception of certain Connecticut policies which opted out of the assumption. Washington National Insurance Company reinsured those Connecticut policies that opted out.

5. CONSECO LIFE INSURANCE COMPANY

Under an Assignment Agreement effective October 1, 2008 with Conseco Life Insurance Company (“CLIC”), all the assets and liabilities pertaining to SHIP’s non-long-term care business were assigned to, and assumed by, CLIC, which, together with DXC Technology, administers all of the business. SHIP remains contingently liable for the assigned business in the event CLIC fails to perform its obligations under the Assignment Agreement. In recognition of this liability, CLIC is required to and does maintain assets in a trust account of which SHIP is beneficiary. That account is required, and appears, to be adequately funded. The business they manage consists of:

1. 5,781 Traditional Life,
2. 175 Universal Life,
3. 71 Deferred Annuities,
4. 273 Medicare Supplement,

5. 37,682 Specified Disease,
6. 689 Accident Only,
7. 603 Hospital Indemnity,
8. 435 Long term disability, and
9. 38 Other.

6. TEACHER'S PROTECTIVE MUTUAL LIFE INSURANCE COMPANY

Teacher's Protective Mutual Life Insurance Company ("Teachers") and Senior Health Insurance Company of Pennsylvania ("SHIP") entered into an Indemnity and Assumption Reinsurance and Administrative Services Agreement on December 28, 2015, pursuant to which Teachers ceded to SHIP, on an indemnity reinsurance basis, 100% of liabilities and obligations paid or payable by Teacher's. These policies have been novated by SHIP so that they are treated as if they had been issued by SHIP in the first place.

7. TREATMENT OF REINSURANCE ASSUMED

The LTC insurance policies for which SHIP became responsible from Transamerica, Primerica and American Health and Life or their predecessors (the "ceding companies") are what is generally referred to in the industry as "reinsurance assumed." All of these assumed LTCI policies have historically been treated by SHIP for administrative purposes in a manner very similar to those issued directly by SHIP. However, communications with policyholders and regulators properly identified them as policies of the ceding companies.

It is important to note that while these policies have been reinsured by SHIP, they were never "novated" as part of the transaction. Novation occurs when the assuming company substitutes for the ceding company so that all of the policyholders' contractual rights are against the assuming company and the ceding company is relieved of further obligation for the policies at issue. That did not happen in these cases. That means that the policyholders retained, and continue to retain, their contractual rights against the ceding companies (the companies that transferred the policies to SHIP through reinsurance) or their successors. In turn, the ceding companies retain contractual rights against SHIP. However, under the Plan, payments owed by SHIP to the ceding companies on account of these rights are subordinated to amounts owed by SHIP to policyholders under SHIP policies. These assumed policies would not be treated as if they had been issued by SHIP if it were placed in liquidation. In liquidation these policies also would not be subject to the statutory Guaranty Association limits. In the event that SHIP is placed in liquidation, these policies reinsured and administered by SHIP, but not novated, will be administered as the responsibility of the ceding companies.

For purposes of the Plan, it is also important to note that the law governing financially troubled insurers generally requires that liabilities arising under insurance policies issued by the troubled company ("Direct Business") be paid in full before those arising under reinsurance assumed can receive any payment. The companies (or their successors) from which SHIP assumed the

Reinsurance Assumed remain responsible to the policyholders if SHIP fails to fulfill the contractual obligations arising under those policies.

The preliminary plan of rehabilitation filed on April 22, 2020, proposed to treat Direct Business and Reinsurance Assumed in the same way under the Plan. The Rehabilitator believed that this would be most advantageous to the affected policyholders. However, this proposal resulted in a number of objections from insurance regulators around the country, asserting that it departs from established custom and practice and is unsupported by applicable law. In response to these objections, the Rehabilitator changed that provision of the preliminary plan of rehabilitation. The Plan now treats the reinsurance assumed differently from the policies issued directly by SHIP and its predecessors. As a result of this change:

- a. The reinsurance assumed policies will not be modified under the Plan and the policyholders will not be asked (or have the ability) to make elections under the Plan;
- b. SHIP will not be financially responsible for claims and commissions owed under these policies and will not have the right to treat premiums paid by these policyholders as assets of SHIP; and
- c. If SHIP is placed in liquidation, the terms of these policies will remain unchanged and the policyholders will not receive benefits from any life and health insurance Guaranty Association. Instead, in that case, the ceding company (or its successor) will remain fully responsible for these policies and any claims and commissions owed under these policies.

Whether, and to what extent, premium rate increases will be sought for these policies in the future will be decided by the ceding companies, not the Rehabilitator. It is possible that SHIP will enter into agreements to administer some or all of these policies in exchange for appropriate fees.

Consistent with this change in the Plan, on October 1, 2020, Transamerica and SHIP entered into a Recapture Agreement through which Transamerica assumed complete responsibility for the LTC insurance policies its predecessors had ceded to SHIP's predecessors. This Agreement was approved by the Commonwealth Court on December 29, 2020.

N. COMMISSIONS

The payment of commissions owed to Agents under agreements made prior to the inception of rehabilitation proceedings will be suspended under the Plan until policyholders' LTC claims have been paid in full and adequate provision made for reasonably anticipated future claims. Further, the Plan will suspend the accrual of commissions as of the Initial Plan Effective Date. Agents and brokers may assert claims for commissions earned prior to the Initial Plan Effective Date but, under the Plan, those claims will be subordinated to amounts owed to policyholders under SHIP's insurance policies.

The Rehabilitator notes that Agents are not currently providing services at the request of and in support of the Rehabilitator. Since entering rehabilitation, SHIP has evaluated the ongoing role of Agents. It is the belief of the Rehabilitator that most policyholders do not have a close relationship with their Agents, often have not spoken with their Agents since their policies were purchased, and do not contact their Agents for questions about their policies or benefits. Most policyholders contact SHIP directly for policy information or questions, or a financial advisor or trusted professional (lawyer, banker, trustee or family member). The Rehabilitator believes that the payment of commissions should be subordinated to the payment of policyholder obligations consistent with the treatment described in 40 P.S. § 221.44.

O. CERTAIN RETIREE BENEFITS

Transport Life Insurance Company, SHIP's predecessor, had entered into employment agreements with several of its former executives that provided for the post-retirement payment of health care benefits for them and their spouses. Through the series of transactions as a result of which Transport Life became SHIP (see page 97), SHIP became responsible for these payments and has continued to make them without interruption. The Rehabilitator believes that these payments are pre-rehabilitation contractual obligations to general creditors. Like agent commissions, they should be subordinated to the payment of policyholder obligations consistent with the treatment described in 40 P.S. § 221.44. As part of the Plan, these payments will be suspended until all policyholder obligations have been satisfied or reasonable provision has been made for them.

P. OPT OUT

The Company's LTC policies do not provide for any cash or surrender value and policyholders are not entitled to any cash payment upon cancellation either in the ordinary course of business or in liquidation. In short, upon liquidation, policyholders would not receive cash payments.

While the Plan does not propose a separately-identified cash opt-out option, certain features of the Plan would satisfy an opt-out requirement if one were found to be applicable. First, many policyholders will not be required by the Plan to make any changes in their policies. Second, every policyholder will have an option in every scenario to select a Non-forfeiture Option under which no more premium will be due. In fact, elements of the Plan make the NFO option materially more valuable than traditional NFOs. See section II.J, page 34. Finally, every policyholder will have at least one option under which he or she would receive at least as much in benefits as would be provided by his or her Guaranty Association coverage.

Q. STATE DEPOSITS

SHIP has been required to place deposits with various states as a condition of its licensing in those states. These state deposits total approximately \$19.3 million. The Rehabilitator believes

that once the Plan is approved (whether or not modified), she should pursue recovery of those deposits so that the funds can be used to support the Plan.

R. TAX MATTERS

The Plan is not intended to create net adverse tax consequences for policyholders or SHIP, and the Rehabilitator does not believe that it will do so if it is implemented as proposed. However, the tax effects of the Plan depend in part on events, circumstances and the conduct of other parties that are not within the control of, nor can be predicted by, the Rehabilitator.

While a number of federal income tax issues may arise under the Plan, two areas are of particular importance. First, will any modification of LTC policies under the Plan create adverse tax consequences for policyholders? Second, will the inability to fund fully policy obligations or provisions of the Plan create adverse tax consequences for SHIP?

1. POLICY MODIFICATIONS.

It does not appear that the Plan is likely to create adverse tax consequences for policyholders. However, because Policy Modifications and other provisions of the Plan, may raise such issues, it is likely that the Rehabilitator will seek from the Internal Revenue Service of the Department of the Treasury (the “IRS”) a favorable private letter ruling (“PLR”) to the effect that Policy Modifications under the Plan would not produce taxable deemed exchanges or other adverse tax consequences for policyholders.

2. TAX ISSUES FOR SHIP

It is possible that reductions in insurance reserves resulting from Policy Modifications or other elements of the Plan would create significant taxable income. However, the Plan contemplates offsets to taxable income arising from the restructuring of SHIP’s policies, bifurcating the liabilities arising under them as between their Initial Funded Restructured Policy Value (IFRPV) and their Unfunded Benefit Liability (UBL), constituting general creditors obligations and not insurance policy liabilities. The Plan also contemplates the eventual discharge by the Commonwealth Court of the portion of the UBL that cannot be paid, which will minimize this tax exposure. The IFRPV is the portion of a policy’s liability that SHIP is expected to be able to fund. The UBL is the portion of that liability that SHIP is not expected to be able to fund.

SHIP is part of a consolidated group for federal income tax compliance purposes, which also includes its affiliates, the Trust and Fuzion. The group files a consolidated federal income tax return. SHIP and its affiliates currently possess substantial Deferred Tax Assets (“DTAs”) such as net operating loss carry-forwards. These DTAs may serve to offset taxable income generated by operation of the Plan. It is possible that implementation of the Plan may give rise to tax liability, however, because of certain limitations in the Internal Revenue Code on the use of such carry-forwards. The ability of SHIP to realize the benefit of these DTAs may also depend in part on decisions made by other members of the consolidated group. While Fuzion is SHIP’s wholly owned

subsidiary, and under its control, the Trust is governed independently. Current tax law may affect the degree to which other parties may make decisions adverse to SHIP's interest and rehabilitation. Moreover, the discharge of indebtedness under the Plan may also result in reducing or eliminating SHIP's ability to take advantage of these DTAs.

As indicated above, to the extent that the Plan results in the reduction of policy obligations through the modification of policies to make them properly priced or Self-sustaining, it is possible that such reduction would result in federal income tax liability. It is possible that not all of such income may be excludable under an insolvency exception or be offset against net operating loss carry-forwards and other DTAs. It is also possible, as noted, that implementation of the Plan may give rise to tax liability. The Plan is designed, and the Rehabilitator intends to implement it, in a manner that will minimize or eliminate such potential adverse tax consequences. However, there can be no assurances that these measures will be effective.

Nothing in the Plan Document is intended to provide, nor shall be interpreted as providing tax or legal advice. Policyholders and other persons affected by the Plan should consult their own tax, legal, and other advisors regarding the possible tax and other effects of the Plan. The Rehabilitator may seek guidance (such as a private letter ruling) from the U.S. Secretary of the Treasury regarding certain potential tax aspects or consequences of the Plan.

S. PRINCIPLES AND FAIRNESS OF THE PLAN

The Plan is designed to comply with applicable statutory provisions. In addition, by reference to Pennsylvania statutes and judicial opinions governing other insurance rehabilitation and insolvency proceedings in this and other states, the Rehabilitator has adopted the following core principles that should guide implementation of the Plan:

1. To the extent reasonably possible under the circumstances, the Plan should correct the conditions which constituted the grounds for the order to rehabilitate the Company;
2. The paramount goal of the Plan should be protection of policyholders;
3. The Plan should be fair and equitable;
4. The Plan should put policyholders and creditors as a group in a position not materially inferior to what liquidation of SHIP as of the Effective Date would produce; and
5. The Plan should include metrics to gauge progress.

The Rehabilitator believes that the Plan reasonably embodies these principles and that it is fair and equitable to policyholders, creditors and affected parties. It addresses historically discriminatory premium rates through asset allocations in determining Self-sustaining Policies and through the premium rate increase structure governing Policy Modifications. Within the means available, as regards policyholders the Plan is designed to reduce the Funding Gap which principally

led to the inception of the rehabilitation proceeding. It does so through premium rate increases and benefit reductions to reduce or eliminate on a policy-by-policy basis the shortfall between assets and liabilities. The principal goal of the Plan is to protect the interests of policyholders by maximizing preservation of their insurance coverage. It treats similarly situated policyholders in the same way and devotes SHIP's assets to the fulfillment of its purposes in a non-discriminatory and non-arbitrary manner.

T. RISK FACTORS

There are substantial risks and uncertainties associated with the Plan and its implementation. Those described herein are not the only ones that could materially impact SHIP, the Plan, its implementation, and its impact on policyholders, creditors and the public.

1. The actuarial assumptions and projections used to develop the Plan, including investment income, default rates, lapse rates, expenses and claims may be materially different from actual results. Therefore, the benefits and claims that SHIP will be able to pay may be materially higher or lower than the amounts assumed in the Plan.
2. Although the Plan does not contemplate that SHIP will, as a result of the Plan, implement future premium rate increases not described in the Plan, there can be no assurances that such rate increases will not be sought by Guaranty Associations if SHIP is placed in liquidation.
3. Objections may be lodged against the Plan or its implementation which may not be able to be overcome without material changes in the Plan.
4. The Rehabilitator believes that the provisions of the Plan can be implemented with approval of the Commonwealth Court and without the need that insurance regulators in every state approve the Plan, including premium rate increases implemented under the Plan. However, regulators in other states may conclude that their approval is required. The Rehabilitator cannot provide any assurance that approval from other regulators will not ultimately be deemed necessary. Neither can the Rehabilitator provide assurances that if such other state approvals are necessary they can be obtained consistent with the timing and substance of the Plan.
5. Governmental authorities may change the laws and regulations that apply to SHIP, its business and state insurance receiverships in ways that impact policyholders, SHIP, the Plan, or its implementation negatively.
6. Adverse developments in the broader economy may affect adversely the performance of SHIP's invested assets, the costs of its operations or the development of its liabilities. As a result, financial assumptions made in the Plan may differ materially from actual events.
7. Certain changes in the general health of SHIP's insured population (such as developments prolonging the period that such persons remain on claim, the severity of such claims, or the

frequency with which policyholders go on claim) may affect materially the development of SHIP's insurance liabilities. As a result, loss assumptions made in the Plan may differ materially from actual events.

8. The emergence of the Coronavirus disease known as "COVID-19" has created unprecedented and wide-ranging disruptions in virtually every facet of American society. Its economic implications, and the changes that will result in American healthcare and insurance are only now beginning to surface and will take a prolonged time to develop completely and be fully understood. The Rehabilitator cannot predict what effect COVID-19 will have on the Plan and its implementation. The Special Deputy Rehabilitator and rehabilitation team are making efforts to incorporate in the Plan expanded timelines and elements of flexibility that will facilitate responding to these recent and continuing developments.
9. The Plan depends on implementation of a complex restructure of SHIP's insurance business for which there is no close precedent, and which depends in part on legal provisions that may be difficult to implement. Failure to implement these provisions may have a material adverse effect on the success of the Plan.
10. The success of the Plan will depend in part on policyholder elections which are difficult to predict. The actual results of those elections may have a material adverse effect on the Plan.

U. ALTERNATIVES TO THE PLAN

Before determining that the Proposed Rehabilitation Plan is the best option for SHIP's policyholders, the Rehabilitator and the rehabilitation team considered a number of alternatives. Each of these is described briefly below, although a complete explanation of what their terms would include would be too lengthy to be included here and would require further development not justified under the circumstances.

1. SALE OR RECAPITALIZATION

Before SHIP was placed in rehabilitation, its management and the Trustees explored many alternatives to avoid delinquency proceedings. These included sale of the company, reinsurance transactions, recapitalization transactions, and restructuring of the investment portfolio. All of these options were deemed impractical or insufficient. SHIP has a closed block of highly unprofitable LTC insurance business making it very unattractive to buyers and investors. Its financial composition is such that legitimate reinsurance transactions would not offer the prospect of material economic improvement. There is no sufficiently profitable block of insurance within the company to absorb the excess risk of the LTC block. The broad capital markets comprise a low-yield environment that also does not offer a reasonable prospect of material economic improvement from restructuring of SHIP's invested assets. Working with Pennsylvania Insurance Department representatives, management did implement a number of cost saving measures, but the net result is too small to avoid the need for rehabilitation.

2. LIQUIDATION

Before embarking on designing the details of the Proposed Rehabilitation Plan the team evaluated whether policyholders would be better served by placing the Company in liquidation. After extensive analysis and discussion it was determined that policyholders would fare better under the Proposed Rehabilitation Plan. The principal reasons that the Plan was deemed preferable to liquidation were:

- a. It would offer policyholders additional choices to address their individual needs under these difficult circumstances.
- b. It would provide policyholders the ability to preserve their current coverage if they were willing and able to pay the required premium rate increase.
- c. It would eliminate the historical premium rate inequities and subsidies prospectively so that all policyholders would pay comparable premiums for comparable coverages. This is viewed as particularly important since widely different responses to requests for approval of premium rate increases among the states over time have resulted in holders of policies issued in certain states paying substantially higher premiums than holders of similar policies issued in other states. This has created a much-criticized subsidy problem in which the higher premiums paid by the former theoretically have been used in part to pay the claims of the latter.
- d. It would avoid the truncation of policy benefits to the applicable Guaranty Association limit (\$300,000 in most states). This would be particularly important to the policyholders who have more than one SHIP LTC policy since the Guaranty Association limits apply to each insured for all policies combined. See Section VI.K, page 95.
- e. Unlike what would occur under the Plan, premium rate increases sought by Guaranty Associations in liquidation would inure to the benefit of insurers assessed to fund the Guaranty Associations, not for policyholder claims.

3. “GOOD BANK - BAD BANK”

Consideration was also given to a rehabilitation plan along the lines that had been proposed for Penn Treaty Network America Insurance Company and its subsidiary, American Network Insurance Company. Under such a “business division” plan, SHIP’s LTC business would be divided between a “Good Bank” and a “Bad Bank.” Separate legal entities would hold each group of policies, liquidating one with Guaranty Association benefits, and placing the self-sustaining policies, in the other for continued coverage. Many aspects of this plan would be unprecedented and potentially controversial.

It is doubtful that both companies could retain insurance licenses in all the states in which SHIP has been licensed. Many of those licenses have already been suspended or revoked and may be hard to recover in SHIP's current condition. This is problematic because Good Bank needs the licenses to continue the self-sustaining policies in business and Bad Bank may need them in order to remain a "member insurer" so as to retain Guaranty Association protection.

In order to afford policyholders the option to make non-self-sustaining policies self-sustaining and eligible to be in "Good Bank," a complicated elective modification process would have to be implemented. That process would be vulnerable to the same criticism as the Proposed Rehabilitation Plan in that the required modifications would have to be approved by the Rehabilitator and the Rehabilitation Court, not the issuing state.

The Plan would be even more complex than the Proposed Rehabilitation Plan and would likely draw even more objections.

4. PROPOSED REHABILITATION PLAN

The Proposed Rehabilitation Plan is the Rehabilitator's recommended approach for SHIP's rehabilitation. However, there are a number of states that have objected with varying degrees of formality to the aspect of the Proposed Rehabilitation Plan under which the premium rates and benefits of SHIP's policies issued in their states would be modified with the approval of the Commonwealth Court but not of the insurance regulator of the issuing state ("Objecting States"). The Rehabilitator has considered the alternatives described in the following three Sections to address these concerns.

5. ANCILLARY APPROVAL OF MODIFICATIONS

One such alternative would have been to submit benefit and premium rate modifications for approval by each issuing state. The Rehabilitator has concluded that this would even be inferior to liquidation. First, past experience indicates that the process of obtaining approval for rate and benefit modifications would take a prolonged period of time. Second, the same experience indicates that the outcome can be expected to be widely divergent rates for similar policies, perpetuating the premium subsidies, inadequate premium rates, and hodgepodge of reduced-benefit options. In addition, implementation of such an approach would be immensely more complicated than the normal multi-state insurance rehabilitation in which the domiciliary regulator and court manage the entire proceeding.

6. EXCLUDE OBJECTING POLICIES

Another possible approach would have been to avoid rate increases for policies issued in Objecting States ("Objecting Policies"). That would have required that those policyholders not be able to select Option One (Downgrade), Option Two (Basic Policy Endorsements), or Option Four (If Knew Premium rate increases for current benefits). Those three options entail modification of rates or benefits in the existing policies. That would have left only the Non-forfeiture Option

(“NFO”) for these policyholders. Although the NFO eliminates premiums permanently, it reduces benefits substantially, though not as much as the NFO or reduced paid-up policy (“RPU”) currently offered to lapsing policyholders. This very limiting outcome would have been highly undesirable.

As a variation of this alternative, the Objecting States could have been asked to permit SHIP to offer Objecting Policies Option 1 under the Plan as well, allowing them to retain reduced benefits without premium changes. For some policyholders that could have been preferable to the NFO, although for others the NFO might be the better deal. Objecting States might also have allowed SHIP to offer Option Two, which entails more moderate rate increases, and even no rate increases in some cases.

This approach might have allowed the Plan to proceed without making the objectionable modifications to the Objecting Policies while retaining all the Plan benefits for other policyholders. The net effect could have been beneficial for the outcome of the Plan if more policyholders elected to give up their current rich policies which collectively account for the bulk of SHIP’s problem.

However, for the affected policyholders this would have been materially inferior to the *status quo* and the Proposed Rehabilitation Plan because policyholders would have had much more limited options and would not have had the possibility of retaining their current benefits even by paying the required premiums. Accordingly, the Rehabilitator did not favor this approach that effectively would have put the Objecting Policies at a disadvantage when compared to the treatment of other policyholders under the Plan.

7. ISSUE-STATE RATE APPROVALS

The Rehabilitator has concluded that a better alternative is to let the Commissioner (or equivalent officer) in a particular state withdraw all of the policies issued in that state from the rate increase determination provisions of the Plan and instead have that Commissioner make the rate increase determination for those policies independent of the Plan. Under this approach, if a commissioner advises the Rehabilitator to that effect, the rate increases resulting from Options under the Plan will not apply to the policies issued in that state (the “opt-out state”). Instead, the insurance department of the opt-out state will make the rate increase determinations for those policies and the benefits under Plan provisions will be adjusted to correspond to the premium rates approved by the opt-out state. The Rehabilitator proposes this approach as part of the Proposed Rehabilitation Plan. Section VI.V, below at page 108, describes the basic elements of a mechanism for enabling states to make their own rate increases decisions within the context of the Plan. Note that, apart from the rate increase determinations, under this approach the policies issued in the opt-out state will still be administered by the Rehabilitator under the Plan so that the opt-out state will not have to provide that administration.

8. CONCLUSION

On balance, the Rehabilitator believes that the best approach is the Proposed Rehabilitation Plan with a component as suggested in alternative seven, above. Accordingly, the Amended Plan now includes the additional following section.

V. ISSUE-STATE RATE APPROVALS

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

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

1. SUMMARY

If the chief insurance regulator (“Commissioner”) of an issue-state formally advises the Rehabilitator that his or her state elects to “opt-out” of the rate increase component of the Proposed Rehabilitation Plan, the Plan will not apply in the same way to the policies issued in that state (the *Opt-out Policies*). In that case, the Rehabilitator will file in the Opt-out State a premium rate increase request for the Opt-out Policies the Current Premiums of which are below If Knew premiums. **Holders of Opt-out Policies with Current Premiums equal to or greater than If Knew Premium will be unaffected and will retain their current policies without modification.** The holders of the Opt-out Policies with Current Premium below If Knew Premium will not be able to elect from among the Plan options and will instead have the choices described below, determined by how the Opt-out State responds to the Rehabilitator’s premium rate increase request.

THE INTENT OF THIS SECTION IS TO ENABLE STATES THAT OBJECT TO THE REHABILITATOR OR COMMONWEALTH COURT SETTING PREMIUM RATES UNDER THE PLAN WITHOUT THEIR APPROVAL TO REVIEW AND APPROVE (ENTIRELY OR

PARTIALLY) OR DISAPPROVE THE PLAN'S PREMIUM RATES THEMSELVES. HOWEVER, THE EFFECTS OF A STATE "OPTING OUT" UNDER THIS SECTION MAY INCLUDE A REDUCED NUMBER OF MEANINGFUL OPTIONS FOR AFFECTED POLICYHOLDERS AND SOME OF THOSE POLICYHOLDERS PAYING HIGHER PREMIUMS THAN THEY WOULD UNDER THE PLAN. IN ADDITION, SOME POLICYHOLDERS WHO DO NOT MAKE AN ELECTION MAY FACE INVOLUNTARY BENEFIT REDUCTIONS.

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

2. OPT-OUT ELECTIONS

- a. Shortly after approval of the Proposed Rehabilitation Plan, the Rehabilitator will provide every state in which SHIP policies in force have been issued the opportunity to opt out of the rate approval provisions of the Plan. Every state that has not by the specified deadline (the ***Opt-out Deadline***) communicated to the Rehabilitator an election to opt out will be deemed to have opted into the Plan and the rest of this Section will not apply to the policies issued in that state. The Rehabilitator will endeavor to provide states at least thirty (30) days to make the Opt-out Election. States may, but are not required to, affirmatively opt into the Plan. States that do not timely communicate an appropriate Opt-out Election to the Rehabilitator will be deemed to have opted into the Plan.
- b. The communication necessary to Opt Out (the ***Opt-out Election***) must be signed and sworn by the Commissioner, Director, Superintendent or other senior insurance regulatory official of the state. The communication need not take any particular form but must contain the following statement:

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

- c. The original signed and sworn Opt-out Election must be received by the Rehabilitator at the address specified no later than the Opt-out Deadline, but the Opt-out Election will be effective if an electronic form (including a facsimile) of the Opt-out Election is received by the Rehabilitator on or before the Opt-out Deadline and the original

signed and sworn Opt-out Election is received by the Rehabilitator no later than ten days after the Opt-out Deadline. **It is recommended that states commence the evaluation of whether they want to opt out of the Plan as soon as possible so that they will have ample time to finalize and communicate their decision once the Plan is approved. The Rehabilitator will be pleased to answer any question that may assist a state in evaluating this matter. States are NOT required to take any action under this Section before the Plan is approved.**

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

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

- e. Opt-out Elections may only be revoked after the Opt-out Deadline with the Rehabilitator's written consent. Generally, such consent will be provided unless the revocation will have an adverse effect on the Plan or opt-in policyholders.
- f. An Opt-out Election will be effective as to all Opt-out Policies the Current Premium of which is below If Knew Premium, even if the Opt-out State determines to approve some (but not all) of the premium rate increases sought by the Rehabilitator from the Opt-out State. A STATE MAY NOT OPT OUT AS TO ONLY SOME OF SHIP'S POLICIES ISSUED IN THAT STATE.

PHASE ONE

3. PREMIUM RATE INCREASE APPLICATION

- a. Following approval of the Second Amended Rehabilitation Plan, and after receipt of a valid Opt-out Election, the Rehabilitator will file in each Opt-out State a request

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

- b. If the Opt-out State timely approves the requested rate increases in full for all Opt-out Policies, it will be treated as if it had not opted out of the Plan, it will be deemed to be an ***Opt-in State***, and its policyholders will be included in the Plan just as those whose policies were issued in states that did not opt out (Opt-in States). If the Opt-out State does not timely approve the full rate increase sought by the Rehabilitator for all Opt-out Policies, all of the policies (including those on premium waiver) issued in that state the Current Premium (whether or not waived) of which is below If Knew Premium will be deemed Opt-out Policies subject to the following provisions.
- c. If the Opt-out State responds to the rate increase application in the aggregate or by group (such as policy form) rather than seriatim (policy-by-policy), the Rehabilitator will apply the resulting increases on a policy-by-policy basis. Note that, for some policyholders, the state's approved rate might exceed the requested rate increase.
- d. APPROVAL OF THE RATE INCREASES IN THE AGGREGATE RATHER THAN SERIATIM (POLICY-BY-POLICY) COULD RESULT IN SOME POLICYHOLDERS BEING REQUIRED TO PAY A HIGHER PREMIUM RATE THAN REQUESTED BY THE REHABILITATOR AND HIGHER RATES THAN THEY WOULD PAY UNDER THE PLAN.
- e. ALSO, APPROVAL OF THE RATE INCREASES IN THE AGGREGATE RATHER THAN SERIATIM COULD RESULT IN SOME POLICYHOLDERS PAYING A LOWER PREMIUM RATE THAN REQUESTED BY THE REHABILITATOR AND RECEIVING BENEFIT DOWNGRADES UNDER THE DEFAULT OPTION (OPTION A).

- f. PRELIMINARY MODELING BY THE REHABILITATOR SUGGESTS THAT, IF A STATE WERE TO MAKE A RATE DETERMINATION FOR ALL OF THE LTC POLICIES ISSUED IN THAT STATE (INCLUDING THOSE WITH PREMIUM AT OR ABOVE IF KNEW PREMIUM AS TO WHICH THE REHABILITATOR DID NOT SEEK A RATE INCREASE) AS A GROUP, AS MANY AS 65% OF POLICYHOLDERS WILL PAY HIGHER PREMIUM RATES THAN THEY WOULD IF THE RATES WERE DETERMINED SERIATIM.
 - g. IN ADDITION, RATE APPROVAL IN THE AGGREGATE OR BY GROUP, RATHER THAN SERIATIM, MAY RESULT IN A MATERIAL INCREASE IN THE SUBSIDIZATION OF SOME POLICYHOLDERS BY OTHERS.
 - h. OPT-OUT POLICYHOLDERS MAY BE ADVISED BY THE REHABILITATOR THAT THE RESULTING PREMIUM RATES ARE THE RESULT OF DECISIONS MADE BY THE OPT-OUT STATE.
4. TREATMENT OF OPT-OUT POLICIES IN PHASE ONE - PREMIUM PAYING POLICIES
- a. Holders of Opt-out Policies with Current Premium below the If Knew Premium, will be able to choose from among several options described below. These options are designed to preserve as much choice as reasonably possible while giving effect to the Opt-out State's rate decision and avoiding or minimizing subsidies by other policyholders. Holders of Opt-out Policies with Current Premiums equal to or greater than If Knew Premium will be unaffected and will retain their current policies without modification unless the Opt-out State mandated a change in their premium rates. That could occur if such policies were part of a group for which the Opt-out State mandated a premium rate increase for the entire group.
 - b. In Phase One of the Plan, the choices for holders of Opt-out Policies with Current Premium below the If Knew Premium, and which are not subject to a premium waiver (*i.e.*, those paying premiums), will be:

OPTION A:

Pay the required premium (including approved premium rate increases) and keep the current policy. However, every opt-out policy with premiums below the If Knew level (after implementing the rate increase approved by the Opt-out State) will be downgraded to the benefit level supported (on an If Knew Premium basis) by the premium approved by the Opt-out State. The downgrade will be calculated using a method substantially similar to the Plan downgrade mechanism (see Section III.A.1.c, page 42). The Downgrade Process for Option A has fewer steps than the Plan downgrade mechanism for Opt-in policies in that Benefit Reductions Eight (extension of elimination period) and Ten (removal of waiver of premium) do not apply to Opt-out policyholders. The downgrade will be adjusted so that the resulting

Maximum Policy Value (MPV) is no lower than the lesser of the policy's current MPV or the applicable guaranty association limits (the "MPV floor"). This will be accomplished by implementing the downgrade and extending the policy's Maximum Benefit Period (MBP) as necessary so that the resulting MPV satisfies that requirement. In the event that the MPV floor applies, Benefit Reductions Eight (extension of elimination period) and Ten (removal of waiver of premium) do not apply to Opt-out policyholders. Option A will be the default option for Opt-out Policies with Current Premium below If Knew Premium.

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

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

OPTION B:

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

OPTION C:

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

OPTION D:

Keep the current policy benefits and accept a premium increase to the If Knew Premium for the benefits provided by the policy even though such a rate increase has not been approved by the Opt-out State. This is strictly an elective option that will

never apply by default and is intended to provide policyholders the ability to retain the current benefits when they are able and willing to pay the required premium. In other words, this option strives to avoid taking contractual benefits away from policyholders who are willing to pay for them. THIS PROVISION IS INTENDED TO REDUCE POTENTIAL DISADVANTAGES OF OPTING OUT.

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

- a. Every Opt-out Policyholder on premium waiver will retain the waiver as long as required by the policy, but if the Current (waived) Premium is below the If Knew level and the policy's current MPV is greater than the GA limit, the policy's MBP will be reduced to the longer of (1) what can be supported by the Current Premium (had it not been waived) on an If Knew basis, and (2) the MBP required to make the MPV no less than the GA limit. If the current MPV is lower than the GA limit, or if the waived premium is at or above the If Knew level, the MBP will be left unchanged. This is designed to provide substantially no less benefits than what would happen in liquidation while minimizing involuntary subsidies by other policyholders.
- b. Once the waiver expires, such policyholders with waived premium below the If Knew level will be required to resume paying premium at the current rates and retain the reduced MBP (if it has been reduced as explained above).
- c. In Phase One, Opt-out policyholders on premium waiver will not be subject to rate increases and will not be able to choose any other option.

PHASE TWO

6. IMPLEMENTATION OF PHASE TWO FOR OPT-OUT POLICIES

- a. In general, if and when Phase Two of the Plan is implemented for policies issued in Opt-in States, it will also be implemented for Opt-out Policies. The implementation will be similar to that described for Phase One, above but based on Self-sustaining Premiums rather than If Knew Premium. If the Rehabilitator adopts an alternative premium structure for Phase Two it will apply to Opt-out Policies as well. See Section II.E.6, page 28.
- b. In Phase Two, the Rehabilitator will file in the Opt-out State a new premium rate increase request for the Opt-out Policies the Current Premiums of which are below Self-sustaining Premiums and which are not on premium waiver. As in Phase One, the Phase Two rate increase application will be filed on a seriatim basis. The Opt-out State's decision as to the requested rate increases will govern the choices available to the holders of Opt-out Policies in Phase Two.

- c. Because the Opt-out State has already been deemed to have opted out in Phase One, timely approval of the Phase Two requested rate increases in full for all Opt-out Policies will NOT result in the state being treated as if it had not opted out of the Plan. All of the policies issued in that state have been deemed Opt-out Policies in Phase One and remain so in Phase Two.
 - d. If the Opt-out State responds to the Phase Two rate increase application in the aggregate or by group rather than seriatim (policy-by-policy), the Rehabilitator will apply the resulting increases on a policy-by-policy basis. AS IN PHASE ONE, THIS COULD RESULT IN SOME POLICYHOLDERS BEING REQUIRED TO PAY A HIGHER PREMIUM RATE THAN REQUESTED BY THE REHABILITATOR AND HIGHER RATES THAN THEY WOULD PAY UNDER THE PLAN. That would occur if the state's approval exceeded the requested rate increase for one or more policies.
 - e. OPT-OUT POLICYHOLDERS MAY BE ADVISED BY THE REHABILITATOR THAT THE RESULTING PREMIUM RATES ARE THE RESULT OF DECISIONS MADE BY THE OPT-OUT STATE.
 - f. Holders of Opt-out Policies with Current Premiums equal to or greater than Self-sustaining Premiums will be unaffected and will retain their current policies without modification unless the Opt-out State mandated a change in their premium rates. That could occur if such policies were part of a group for which the Opt-out State mandated a premium rate increase for the entire group. The holders of the Opt-out Policies with Current Premium below Self-sustaining Premiums would not be able to elect from among the Plan options and would instead have the choices described above but based on Self-sustaining Premiums, determined according to how the Opt-out State responds to the Rehabilitator's premium rate increase request.
 - g. For purposes of calculating the Self-sustaining Premiums of Opt-out Policies in Phase Two, the Rehabilitator will use a separate pool of assets from those used in the calculation of Self-sustaining Premiums for policies in Opt-in States. Assets will be allocated between the two pools in proportion to accumulated premium paid by the then current policyholders of each group of states.
7. TREATMENT OF OPT-OUT POLICIES IN PHASE TWO - PREMIUM PAYING POLICIES
- a. If and when Phase Two is implemented for policyholders participating in the Plan, the process described above (with the same options) will be repeated for premium-paying Opt-out Policies using Self-sustaining Premiums instead of IfKnew Premium. However, policies that would be fully covered by the applicable guaranty association if SHIP were placed in liquidation, are Self-sustaining, or have elected the NFO or RPU would not be affected in this second phase.

- b. NOTE THAT THERE CAN BE A MATERIAL DIFFERENCE IN PHASE TWO PREMIUMS BETWEEN POLICIES THAT ARE FULLY COVERED AND THOSE THAT ARE NOT, EVEN IF THEY ARE OTHERWISE SIMILAR AND THEIR MPV DIFFERS BY A SMALL AMOUNT.
- 8. TREATMENT OF OPT-OUT POLICIES IN PHASE TWO - POLICIES ON PREMIUM WAIVER
 - a. Much as in Phase One, every Opt-out Policyholder on premium waiver will retain the waiver in Phase Two as long as required by the policy. If the waived premium is below the Self-sustaining Premium level and the policy's current MPV is greater than the GA limit, the policy's MBP will be reduced to the longer of (1) what can be supported by the Current Premium (had it not been waived) on a Self-sustaining Premium basis, and (2) the MBP required to make the MPV no less than the GA limit. If the current MPV is lower than the GA limit, or if the waived premium is at or above the Self-sustaining Premium level, the MBP will be left unchanged.
 - b. Once the waiver expires, such policyholders with waived premium below the Self-sustaining Premium level will be required to resume paying premium at the current rates and retain the reduced MBP (if it has been reduced as explained above).
 - c. As in Phase One, Opt-out Policyholders on premium waiver will not be subject to rate increases in Phase Two and will not be able to choose any other option.
- 9. Other provisions of the Plan not affected by these provisions would remain as applicable to the Opt-out Policies as to other policies. Additional details of the opt-out provisions will be specified depending on further discussions with other regulators and the Orders of the Court.
- 10. This approach is designed to defer to the issue-state for rate approval by making its decision the default option. It would reduce or eliminate the requirement that other policyholders subsidize the Opt-out Policies prospectively and provides Opt-out Policyholders benefits at least equal to, and in many cases exceeding, what they would receive in liquidation. It would offer policyholders benefit downgrade options in lieu of the approved rate increases as well as a reduced paid-up policy option. In addition, to reduce the disadvantage of being excluded from the Plan, these policyholders would also be offered the option of retaining the current coverage if they are able and inclined to pay the required premium.

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

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

- a. Option One for Opt-in policyholders is the same as Option B for Opt-out policyholders.
- b. Opt-in policyholders do not have the equivalent of opt-out Option A - pay the approved rate and be downgraded to what that rate buys on an If Knew basis subject to the GA floor. That is because the “approved rate” for Opt-in policyholders would be the If Knew Premium, which would make Option A the same as Option D. The Opt-in policyholder option most similar to Option A for Opt-in policyholders is Opt-in Option Two, the Basic Policy Endorsement which, like Opt-out Option A, might entail both premium increases and benefit reductions. Note, however, that Option A does not exempt Opt-out policyholders from modifications in Phase Two, while Opt-in policyholders who elect Option Two in Phase One will not face additional rate increases or Benefit Reductions in Phase Two.
- c. Opt-out policyholders do not have the equivalent of Opt-in Option Two, the Basic Policy Endorsements (which is the Default Option for premium-paying Opt-in policyholders) and enhanced Basic Policy Endorsements. The Basic Policy Endorsements consist of specific Policy Modifications intended to provide reasonable benefits and premiums that, if selected in Phase One, will be immune from changes in Phase Two of the Plan. Opt-in policyholders making this election will not face additional modifications in Phase Two of the Plan, except that they may be required to pay full premium rather than Differential Premium if a Premium Waiver becomes inactive.
- d. Both Opt-in policyholders and Opt-out policyholders have an NFO option (Option Three for Opt-in policyholders and Option C for Opt-out policyholders); however, it is likely to be “richer” for Opt-in policyholders. For Opt-out policyholders, this is the only option that ensures that they will not face potential premium rate increases or benefit reductions in Phase Two.
- e. Both groups have the same If Knew premium option – Option Four for Opt-in policyholders and Option D for Opt out policyholders. Note that Option Four in Phase One for Opt-in policyholders is based on Phase One premium (the greater of the current premium and the If Knew premium) while Option D for Opt-out policyholders is based simply on if knew premium. However, they operate the same way because Opt-out policyholders with premium at or above If Knew premium will have no modifications, rate increases, or options. Thus, both Opt-in and Opt-out policyholders already paying at least If Knew premiums will be exempt from mandatory modifications. Although Opt-in policyholders with current premiums at or above If Knew premiums (and who therefore are not required to elect modifications under the Plan) can voluntarily select other options, Opt-out Policyholders with premiums at or above If Knew Premium will not have that option. They will simply retain their current premium and benefits.

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

W. DISCLAIMERS AND SOURCES OF INFORMATION

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

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

THE REHABILITATOR AND SHIP ARE NOT OFFERING LEGAL, BUSINESS, FINANCIAL, TAX OR OTHER ADVICE TO ANY PERSON AND THE PLAN SHOULD NOT BE CONSIDERED TO CONTAIN ANY ADVICE OR INSTRUCTION CONCERNING SUCH MATTERS. THE READER SHOULD CONSULT WITH HIS OR HER LEGAL, BUSINESS, FINANCIAL, TAX AND OTHER ADVISORS AS TO ANY MATTERS CONCERNING THE PLAN.

The Plan document is not required to be prepared in accordance with federal or state securities laws. None of the Securities and Exchange Commission (“SEC”), any state securities commission, or any similar governmental body has approved the Plan Document or has opined on the accuracy or adequacy of the statements contained therein. None of the financial information in the Plan Document was prepared to comply with published guidelines of the SEC, the American Institute of Certified Public Accountants, U.S. Generally Accepted Accounting Principles or prescribed statutory accounting principles, except as specifically described therein.

The Plan Document may not be relied upon for any purpose (including to trade, buy or sell claims or securities) other than to obtain information about the details of the Plan and the related proceeding. Nothing contained herein is intended as or constitutes an admission of any fact or any party’s liability with regard to any claim or litigation, including, but not limited to, any proceeding involving the Rehabilitator, SHIP, or any other party, or any proceeding with respect to the legal effect of the transactions contemplated by the Plan. Nothing contained in the Plan Document constitutes an admission, or can be deemed evidence, of the tax or other legal effects of the Plan on SHIP or on holders of claims against, or equity interests in, SHIP or its affiliates. Statements as to the rationale underlying the treatment of claims and other matters under the Plan are not intended to, and will not, waive, compromise or limit any of the Rehabilitator’s or SHIP’s rights, defenses, or causes of action.

The Plan document contains statements that are, or may be deemed to be, “forward-looking statements” within the meaning of the Private Securities Litigation Reform Act of 1995. Any such forward-looking statements are based upon a variety of estimates and assumptions that, though considered reasonable by the Rehabilitator, may not be realized, and are inherently subject to significant business, economic and other uncertainties and contingencies. Some assumptions inevitably will not materialize and events and circumstances occurring subsequent to the date on which the statements were prepared may be significantly different from those assumed, or may be unanticipated, and thus may affect financial or other results in a material and possibly adverse manner. The statements, therefore, should not be relied upon as a guaranty or other assurance of the actual results that will occur.

To ensure compliance with Internal Revenue Service Circular 230, holders of claims and other interests are hereby notified that: (a) any discussion of United States federal tax issues contained or referred to in the Plan Document is not intended or written to be used, and cannot be used, by holders of claims and other interests for the purpose of avoiding penalties that may be imposed on them under the Internal Revenue Code; (b) such discussion is provided solely in connection with the transactions or matters addressed herein; and (c) holders of claims and other interests should seek advice based on their particular circumstances from an independent tax advisor.

All summaries of the Plan contained herein or in other materials prepared by the Rehabilitator or others, including other filings with the Court, are qualified in their entirety by reference to the Plan as set forth in its entirety herein. Summaries of the Plan herein are not complete and are subject to, and qualified in their entirety by, reference to the full text of the Plan.

VII. GLOSSARY

The following are terms used in, and helpful in understanding, the Plan.

- 1) **“Accumulated Premium”** means, for a policy or group of policies, the total Gross Premiums paid, and premium waived under Waiver of Premium provisions, from inception until the valuation date.
- 2) **“Accumulated Premium Method”** means allocation of assets in proportion to the Accumulated Premium of the relevant policies as is more fully explained in Section II.E.4.e, page 28.
- 3) **“Active Block”** means the LTC insurance policies issued or assumed by the Company that remain in force and are not on claim.
- 4) **“Active Policies”** or **“Active Policyholders”** referred to also as Policies Not On claim and Policyholders Not On claim, means respectively policies or policyholders that have not been terminated due to non-payment of premiums, cancellation, or exhaustion of benefits and also are not listed in the Company’s records as having been approved for benefit payments and are not in the process of being approved for benefit payments as of the Determination Date.
- 5) **“Activities of Daily Living”** or **“ADL”** means eating, bathing, dressing, ambulating, transferring, toileting and continence.
- 6) **“Adult Day Care”** means a program for six or more individuals, of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly, or other disabled adults who can benefit from care in a group setting outside the home. It is generally administered as part of home health care benefits.
- 7) **“Agent”** means any insurance agent, broker or producer that solicited, sold or placed insurance business issued or assumed by the Company or any of its predecessors.
- 8) **“Allocable Assets”** is a notional determination consisting of the total value of the Company’s liquid invested assets, after making provision for costs and expenses of administration, contingencies, accrued but unpaid claim payments, and certain debts of higher priority.
- 9) **“Allocated Assets”** means, for a LTC policy or group of policies, the portion of the Allocable Assets notionally allocated to that policy or group of policies in accordance with the terms of, and solely for the purposes described in, the Plan. All asset allocations are notional and do not give any policyholder a right to any Allocated Assets or any particular sum of money.

- 10) **“Approval Order”** means an Order from the Commonwealth Court approving the Plan.
- 11) **“Article V”** means Article V of the Pennsylvania Insurance Department Act of 1921, P.L. 780, as amended, 40 P.S. § 221.1, et. seq.
- 12) **“Asset/Premium Ratio”** means the ratio of Allocable Assets to the aggregate Accumulated Premiums for all LTC policies.
- 13) **“Basic Policy Endorsements”** means certain endorsements that together constitute the policyholder Option Two under the Plan. They consist of specific Policy Modifications described fully in Section III.A.2.d, page 48, intended to provide reasonable benefits and premiums that will be immune from changes in Phase Two of the Plan. Policyholders making this election will not face additional modifications under the Plan except that they may be required to pay full premium rather than Differential Premium if a Premium Waiver becomes inactive.
- 14) **“Benefit Triggers”** means the conditions that must be satisfied in order to be eligible for benefits under an LTC insurance policy.
- 15) **“Claim Waiver of Premium”** means a provision in a LTC insurance policy under which a policyholder who receives benefits under his or her policy for a specified period of time (such as 90 days) is no longer required to pay premiums for coverage after that time period as long as the policyholder remains eligible for benefits and/or receives a specified level of care.
- 16) **“Commonwealth Court”** means the Commonwealth Court of Pennsylvania, which is the rehabilitation court for SHIP and has exclusive jurisdiction over SHIP’s rehabilitation.
- 17) **“Company”** means SHIP.
- 18) **“Court”** means for purposes of the Plan, and unless otherwise specified, the Commonwealth Court of Pennsylvania.
- 19) **“Covered Benefits”** means the amount of policy benefits provided by SHIP’s insurance policies that, if SHIP were placed in liquidation, would be within the limits, conditions and scope of coverage of the responsible Guaranty Association taking into account the residence and other attributes of the policyholders as determined by the responsible Guaranty Association in accordance with applicable law.
- 20) **“Current Premium”** means the premium paid by or waived for a LTCI policy before the applicable Effective Date under the Plan. This is also equivalent to the Downgrade Target Premium for the Downgrade Process. See Section III.A.1.c, page 42.

- 21) **“Daily Benefit Amount”** or **“DBA”**, also called Maximum Daily Benefit (MDB), means a maximum daily dollar amount available on a covered day of care as specified in the policy.
- 22) **“Default Option”** means the Plan option selected automatically for a policyholder who fails to make a valid election by the required date.
- 23) **“Determination Date”** means a date as of which all the determinations and calculations required to construct the options available to each policyholder will be made by the Rehabilitator, which may vary among policyholders. For Phase One it will be after the Final Approval Date and before the applicable Policyholder Election Date to be selected by the Rehabilitator pursuant to the Plan. Different Determination Dates will be used for Phase One and Phase Two calculations. The Phase Two Determination Date will not be established until the components of Phase Two are finalized.
- 24) **“Differential Premium”** means the applicable premium (If Knew, Phase One, or Self-sustaining) less the Current Premium and is payable under the Plan in lieu of the applicable premium by policyholders on waiver. Under the terms of the Plan, differential premiums cannot be less than zero.
- 25) **“Disabled Life”** means a policyholder who is receiving, or has been approved to receive, policy benefits or a policy under which benefits are being provided, or have been approved, by the Company and is also referred to as a policyholder on claim.
- 26) **“Disabled Life Reserve”** or **“DLR”** means the present value of expected future benefits and expenses calculated for each policyholder listed in the Company’s records as a policyholder on claim.
- 27) **“Downgrade Process”** means the process for reducing the benefits of a policy pursuant to Option One so that the policyholder may retain the Current Premium but reduce the benefits provided by that policy to those that premium can fund on an If Knew basis in Phase One and a Self-sustaining Basis in Phase Two. It is described in detail at Section III.A.1.c, page 42.
- 28) **“Downgrade Target Premium”** means the premium paid by, or waived for, a long-term care policy before the applicable Effective Date under the Plan. This is also equivalent to the Current Premium. See Section III.A.1.b, page 42.
- 29) **“Dual Waiver of Premium”** or **“Dual Waiver”** (DWOP), sometimes called Spousal Waiver of Premium, means a provision in a LTC insurance policy under which the premium of a spouse is also waived when the policyholder’s premium is waived upon going on claim.
- 30) **“Effective Date”** means the date as of which the provisions of the Plan, including Policyholder Elections and modification of LTC policies, will become effective following the approval of the Plan. For most policyholders the Effective Date will be the Initial Plan Effective Date. For policyholders who undergo specified changes in status during the

Policyholder Transition Period as described in Section II.L.3.c, page 38 the Effective Date will be the Supplemental Plan Effective Date.

- 31) **“Elimination Period”** or **“EP”** means the time period during which a policyholder’s circumstances qualify for Long-term Care insurance benefits but for which no such benefits are yet payable by the Company. The Elimination Period is similar to a deductible or waiting period. The length of the elimination period varies by policy. The majority of the Company’s policies include elimination periods of zero days, 30 days, 60 days, 90 days, and 110 days, although the Company has some policies with elimination periods up to 365 days.
- 32) **“Extension of Benefits”** provision means a provision in the policy permitting claim payments to continue for a policy on claim that lapses due to non-payment of premium.
- 33) **“Final Approval Date”** means the date upon which the Approval Order becomes final and non-appealable or upon which an appellate Order affirming the Approval Order has itself become final and no longer appealable.
- 34) **“Fully Covered”** means that the Maximum Policy Value projected for a particular policy is no greater than the limits of Guaranty Association coverage that would apply to that policy if SHIP were placed in liquidation. A Fully Covered policy has no Uncovered Benefits.
- 35) **“Funding Gap”** means the gap between: (a) the sum of: (1) the amount of SHIP’s assets, (2) projected future premiums, and (3) projected earnings on investments, and (b) the sum of: (1) SHIP’s future policy benefits, (2) related expense payment obligations, and (3) other expenses.
- 36) **“Fuzion”** means Fuzion Analytics, Inc., a subsidiary of SHIP that, among other things, provides management and administrative services to SHIP.
- 37) **“Gross Premium”** means the periodic payments that are required to keep the policy in force. In the absence of rehabilitation, the rates used to establish the Gross Premium are typically filed with, and subject to approval of, insurance regulators. Gross Premium includes provisions for expenses and profit margins.
- 38) **“Gross Premium Reserve”** or **“GPR”** means the present value as of the valuation date of expected benefits unpaid, expected expenses unpaid, and unearned or expected premiums, adjusted for future premium increases reasonably expected to be put into effect. Expected expenses include commissions and premium taxes (if applicable). GPR is the reserve amount that results from performing a GPV. For a Self-sustaining Policy GPR is no more than the assets allocated to that policy under the Plan for calculation purposes only.
- 39) **“Gross Premium Valuation”** or **“GPV”** is the determination of the present value of expected future benefits and related expenses less the present value of expected future premiums at current and anticipated rates where “expected” consists of best estimate

assumptions including a provision for moderately adverse deviation. The gross premium valuation process is used in determining the GPR.

- 40) **“Guaranty Association”** means the life, health and accident insurance Guaranty Association or equivalent entity in a particular state responsible for providing benefits to the policyholders of an insolvent long-term care insurer in liquidation.
- 41) **“HIPAA”** means the Health Insurance Portability and Accountability Act of 1996, which among other things establishes data privacy and security safeguards for patient health information and which also provides that premiums paid for “Tax Qualified policies” as defined in the Act, may be deductible from federal income tax.
- 42) **“If Knew Differential Premium”** means the If Knew Premium less the Current Premium. It is the Differential Premium when the applicable premium is the If Knew Premium. Under the terms of the Plan differential premiums cannot be less than zero.
- 43) **“If Knew Premium”** means the premium that if charged from inception would have produced the greater of the initial target loss ratio or the minimum loss ratio applicable to the policy form. For the sake of simplicity, the Plan assumes a 60% target loss ratio. Thus, the If Knew Premium rate is the rate that, if charged from policy issue, would produce a 60% lifetime loss ratio. It is sometimes described as the premium the insurer would have charged from inception had it known then what it knows now.
- 44) **“Impaired Policy”** means an LTCI policy: (1) for which on Phase One the Current Premium is less than the If Knew Premium, and/or (2) that in Phase Two is Non-self-sustaining.
- 45) **“Inflation Protection”** means riders purchased by policyholders or policy features that provide for defined increases in benefits at regular intervals in order to protect against the effects of inflation on the cost of care.
- 46) **“Initial Funded Restructured Policy Value”** or **“IFRPV”** means a policy value equal to the portion of the liabilities arising under the policy that SHIP can reasonably be expected to meet based on future premiums and Allocated Assets. For a policy that is not an Impaired Policy, the IFRPV will be equal to the full amount of the liabilities currently expected to arise under the policy.
- 47) **“Initial Plan Effective Date”** is the Effective Date for all policyholders other than those to whom the Supplemental Plan Effective Date applies. It will not be the same specific day for all policyholders. For each policyholder, the Initial Plan Effective Date will be the policy’s *Monthiversary Date* occurring during the *Initial Plan Effective Month*. See definitions, pages 125 and 126. The Initial Plan Effective Month will be the same for all policyholders for whom the Effective Date is the Initial Plan Effective Date, that is, those who have not undergone certain specified changes in status during the Policyholder Transition Period as described in Section II.L.3.c, page 38.

- 48) **“Initial Plan Effective Month”** means the calendar month immediately following the Plan Preparation Period. The Initial Plan Effective Month will be the same for all policyholders for whom the Effective Date is the Initial Plan Effective Date, that is, those who have not undergone certain specified changes in status during the Policyholder Transition Period as described in Section II.L.3.c, page 38.
- 49) **“Lifetime Waiver of Premium” or “LWP”** means a provision in a LTC insurance policy under which the premium payments are permanently suspended upon the death of a covered spouse after a qualifying period (typically five, seven, or ten years).
- 50) **“Limited Benefit Period”** means any Maximum Benefit Period that is subject to a stated limit by the terms of the policy. It refers to a policy that is not a lifetime or unlimited benefit policy.
- 51) **“Liquidation Benefits”** means the benefits a policyholder would reasonably be expected to receive if SHIP were liquidated under the provisions of Article V, taking into account the Company’s history, the orders of the Court, the risks and uncertainties of the liquidation process, and the effect of Guaranty Association coverage.
- 52) **“Long-term Care” or “LTC”** insurance means defined benefit accident and health insurance policies covering long-term care services, including confinement to nursing facilities and assisted living facilities, as well as home health care and adult day care.
- 53) **“LTCI”** means long-term care insurance.
- 54) **“Maximum Benefit Amount”** means the dollar maximum in benefits available under a LTC policy.
- 55) **“Maximum Benefit Period” or “MBP”** means the maximum time (typically stated as number of years or days, either lapsed time or of provided service) during which benefits will be available under a LTC policy. Benefits are usually defined in the contract to be a maximum amount payable per day or per month, for a maximum number of years. However, in some policies, if the claimant uses less than the maximum amount permissible in a given period, the unused excess typically serves to lengthen the Maximum Benefit Period under what is known as the “pool of money” clause. Benefits commence after satisfaction of an Elimination Period (EP) and continue until the recovery or death of the claimant or until the pool of money has been exhausted. In these cases the Maximum Benefit Period is sometimes expressed as a dollar amount, the Maximum Benefit Amount. Under other policies (sometimes called “days of care” policies) reducing the daily benefit amount utilized does not extend the benefit period. For these policies the Maximum Benefit Period is expressed as the number of days, months or years during which coverage remains available under the policies. In either case, modifications by the policyholder under the Plan may have the effect of reducing the Maximum Benefit Period.

- 56) **“Maximum Daily Benefit”** or **“MDB”** also called Daily Benefit Amount (DBA), means a maximum daily dollar amount available on a covered day of care as specified in the policy.
- 57) **“Maximum Policy Value”** or **“MPV”** means the product of a policy’s Maximum Benefit Period times its Maximum Daily Benefit determined as of a specified date, adjusted for inflation protection. For Plan purposes, MPV will be calculated as if the policyholder went on claim on the Plan Effective Date.
- 58) **“Monthiversary Date”** means the day of the month upon which premium is due under a particular policy or would be due except for a Premium Waiver provision.
- 59) **“NAIC”** means the National Association of Insurance Commissioners.
- 60) **“Net Premium”** means the part of the Gross Premium that is intended to cover the cost of future claims, as opposed to future operating expenses and profit margin. The Net Premium is typically set at issue.
- 61) **“Non-core Policy Benefits”** means certain benefits provided by some SHIP LTC policies other than nursing home, facility, home health (which often includes hospice) or adult day care. They are enumerated in section II.H, page 33.
- 62) **“Non-forfeiture Option”** or **“NFO”** traditionally means an option to exchange an existing LTC policy for a reduced paid up contract on which no future premiums need be paid by the policyholder but under which benefits are limited to premiums previously paid less benefits previously received. NFO benefits are enhanced substantially under the Plan.
- 63) **“Non-Self-Sustaining Policy”** means a LTC policy the Projected Benefit Amount (PBA) of which exceeds its Projected Credit Amount (PCA). It is a policy for which Current Premium rates are inadequate given assets available to be allocated to it and its projected liability for benefits and expenses.
- 64) **“Non-Tax-Qualified”** or **“NTQ”** benefit triggers means LTC insurance policy provisions under which the conditions that must be satisfied to be eligible for benefits do not conform to the legal standards for Tax Qualified policies. Policies containing such provisions were formerly called “traditional” Long-term Care Insurance policies. They often include a benefit “trigger” called a “medical necessity” trigger under which the insurer is obligated to pay if the policyholder’s own doctor, or that doctor in conjunction with someone from the insurance company, determines that the policyholder needs covered care for any medical reason. The United States Department of the Treasury has not fully clarified the tax status of premiums paid for and benefits received under a NTQ Long-term Care Insurance policy as precisely as the status of benefits received under a tax qualified policy. Therefore, the federal taxation of benefits under a NTQ policy is not certain. **The Rehabilitator makes no representation and does not offer any opinion regarding tax matters.**

- 65) **“Partnership-Qualified”** (PQ), means LTC policies that are intended to satisfy the requirements under the Deficit Reduction Act of 2006 entitling the policyholder to a dollar of asset disregard or spend-down credit with respect to Medicaid eligibility for every dollar of benefit received under the LTC policy.
- 66) **“On claim”** refers to a policyholder who is receiving, or has been approved to receive, policy benefits or a policy under which benefits are being provided by the Company.
- 67) **“Paid-Up Policy”** means an in-force policy that is paid in full and no longer requires premium payments under its terms.
- 68) **“Phase One Differential Premium”** means the Phase One Premium less the Current Premium. It is the Differential Premium when the applicable premium is the Phase One Premium. Under the terms of the Plan, the Phase One Differential Premium cannot be less than zero.
- 69) **“Phase One Premium”** means the premium calculated for a specified policy (or group of policies) on the If Knew basis, but not less than the Current Premium.
- 70) **“Phase Two Policyholder Election Package”** means the Policyholder Election Package sent to certain policyholders to inform them of options available in Phase Two of the Plan and to enable them to elect from among those options.
- 71) **“PID”** means the Pennsylvania Insurance Department.
- 72) **“Plan”** means this Rehabilitation Plan.
- 73) **“Plan Document”** means this document describing the Plan.
- 74) **“Plan Limits”** means the minimum and maximum modifications permitted by the Plan for a policy’s Maximum Benefit Period (MBP) and Maximum Daily Benefit (MDB). Except as noted in Section III.A.1.c.(4), page 43, a policy’s MBP cannot be reduced by the Plan below the lower of (a) the current MBP or (b) four years, and cannot be increased by the Plan above the greater of (a) the current MBP or (b) six years. A policy’s MDB cannot be reduced by the Plan below the lesser of 80% of current level and \$300 for Nursing Home Care; the lesser of (a) 80% of current level or (b) \$225 for Facility Care; and the lesser of (a) 80% of current level or (b) \$150 for Home Health Care. The MDB cannot be increased by the Plan above the greater of (a) the current MDB or (b) \$600 for Nursing Home Care, \$450 for Facility Care and \$300 for Home Health Care.
- 75) **“Plan Option”** means any of the options available to policyholders under the Plan, which are described on page 23.

- 76) **“Plan Premium”** means the premium that a policyholder must pay under the terms of the Plan. Depending on the policyholder’s circumstances, it could be the Phase One Premium, If Knew Premium, Self-Sustaining Premium, Phase One Differential Premium, If Knew Differential Premium, or Self-sustaining Differential Premium.
- 77) **“Plan Preparation Period”** means the time between the Final Approval Date and the Effective Date of the Plan, during which preparatory steps necessary to implement the Plan will be completed. It includes the period during which policyholders will make elections under the Plan.
- 78) **“Policies Not On claim”** or **“Policyholders Not On claim,”** also called Active Policies or Policyholders, means policies or policyholders that have not been terminated due to non-payment of premiums, cancellation, or exhaustion of benefits and also are not listed in the Company’s records as having been approved for benefit payments or in the process of being approved for benefit payments as of the Determination Date.
- 79) **“Policy Modifications”** means Premium Rate Increases or Benefit reductions selected by a policyholder, or made applicable, in accordance with the terms of the Plan.
- 80) **“Policyholder Election”** means the election by a policyholder to modify the premiums or benefits of a policy under the Plan.
- 81) **“Policyholder Election Date”** means the date by which the Rehabilitator must receive properly completed Policyholder Election Forms in order to give them effect.
- 82) **“Policyholder Election Form”** means the form on which a policyholder specifies whether, and if so how, he or she elects to modify his or her LTC policy in accordance with the terms of the Plan.
- 83) **“Policyholder Election Package”** means the materials, including the Policyholder Election Form, to be sent to policyholders by the Rehabilitator so that they may make the elections available under the Plan.
- 84) **“Policyholders”** means holders of insurance policies and certificate holders under group insurance policies.
- 85) **“Policyholder Transition Period”** means the period between the Plan Determination Date and the Initial Plan Effective Date during which policyholders may experience changes in circumstances (such as going on claim) as the result of which they may have to make new elections under the Plan.
- 86) **“Possible Benefit Reductions”** means the list of possible benefit reductions applicable to premium paying active policyholders who select a Downgrade option as described fully beginning on page 45.

- 87) **“Premium Waiver”** means a policy provision that allows a policyholder to discontinue paying premiums and maintain the policy in force during a period of covered care or under circumstances specified in the policy.
- 88) **“Projected Benefit Amount” or “PBA”** means the present value as of the valuation date of unpaid expected benefits and unpaid expected policy expenses. For purposes of this determination, “expected” consists of best estimate assumptions including a provision for moderately adverse deviation.
- 89) **“Projected Credit Amount” or “PCA”** means, for a LTC insurance policy, the sum of (a) the present value as of the valuation date of expected premiums, adjusted for future premium increases reasonably expected to be put into effect and (b) the assets allocated to that policy using the Accumulated Premium Method. For purposes of this determination, “expected” consists of best estimate assumptions including a provision for moderately adverse deviation.
- 90) **“Reduced Paid-up Policy” or “RPU”** means a policy offering reduced long-term care benefits but for which no more premium has to be paid and which will not lapse before the death of the policyholder. The Non-forfeiture Option offered under the Plan is a RPU.
- 91) **“Rehabilitation Plan”** means this Plan for the rehabilitation of SHIP’s Long-term Care insurance business.
- 92) **“Rehabilitator”** means Jessica K. Altman, Insurance Commissioner of the Commonwealth of Pennsylvania, and her successors in office, in the capacity of Statutory Rehabilitator of the Company. Pursuant to her statutory authority to do so, the Rehabilitator has delegated broad responsibility to the Special Deputy Rehabilitator and in the Plan documents references to the Rehabilitator should be interpreted as including the SDR unless specified otherwise.
- 93) **“Restoration of Benefits”** means a LTC insurance policy feature under which the benefit period for a policyholder who has received benefits will be restored to the original Maximum Benefit Period after receiving some or all claim benefits if the policyholder does not need or receive care during a specified period of time (such as 180 days).
- 94) **“Restructured Policy”** means a policy that has been restructured as described in Section VI.H, page 91, to allocate the liabilities arising under the policy between its IFRPV and its UBL.
- 95) **“Return of Premium”** means a LTC insurance policy feature which provides for the return of a percentage of premium paid by the policyholder (such as 80%) if the policyholder does not make a claim (or has a limited expected amount of benefits paid) during a given period of time in which the policy was in force (such as ten years).
- 96) **“Self-sustaining”** means a policy for which its Projected Credit Amount (PCA) equals or exceeds its Projected Benefit Amount (PBA). It is a policy for which Current Premium rates

are adequate given assets available to be allocated to it and its projected liability for benefits and claims expenses.

- 97) **“Self-sustaining Differential Premium”** means the Self-sustaining Premium less the Current Premium. It is the Differential Premium when the applicable premium is the Self-sustaining Premium. Under the terms of the Plan, differential premiums cannot be less than zero.
- 98) **“Self-sustaining Premium”** means the premium calculated by determining the amount of premium required to eliminate a policy’s Shortfall Amount.
- 99) **“Senior Health Care Oversight Trust”** means the Pennsylvania business trust governed by an independent Board of Trustees comprised of former insurance regulators and an independent actuary, who also served as members of the board of directors of SHIP, created in 2008 to be the sole owner of SHIP.
- 100) **“SHIP”** means the Senior Health Insurance Company of Pennsylvania, the subject of this Rehabilitation Plan.
- 101) **“Shortfall Amount”** for a LTC policy means the difference between its Projected Benefit Amount and its Projected Credit Amount where the difference is more than zero. The Shortfall Amount can also be expressed as a policy’s GPR less its Allocated Assets. If the difference is zero or less there is no shortfall and the policy is Self-sustaining.
- 102) **“Special Deputy Rehabilitator”** or **“SDR”** means Patrick H. Cantilo or his successors, appointed by the Rehabilitator to serve as the Special Deputy Rehabilitator for SHIP.
- 103) **“Statutory Reserve”** means the insurance reserve required by Pennsylvania insurance laws to be included in an insurer’s financial statement on account of its insurance business in force.
- 104) **“Supplemental Plan Effective Date”** is the Effective Date for policyholders who undergo certain changes in status during the Policyholder Transition Period as described in Section II.L.3.c, page 38. It will occur on the policy’s Monthiversary Date during the month specified by the Rehabilitator following the Policyholder Transition Period.
- 105) **“Tax Qualified”** or **“TQ”** benefit triggers means the conditions that must be satisfied to be eligible for benefits under a LTC insurance policy that is designed to conform to certain standards in federal law and may offer certain federal tax advantages. TQ policies were created as a result of HIPAA, which included provisions for favorable tax treatment of qualified Long Term Care Insurance contracts. To comply with those standards, TQ policies are required to cover services for a chronically ill individual, and do not have a “medical necessity” benefit trigger. A TQ benefit trigger requires that a person 1) be expected to require care for at least 90 days, and be unable to perform 2 or more Activities of Daily

Living (eating, dressing, bathing, transferring, toileting, and continence) without substantial assistance (hands on or standby); or 2) for at least 90 days, need substantial assistance due to a severe cognitive impairment. In either case a licensed healthcare professional must certify a plan of care. Premiums paid for a TQ policy may be deductible from taxable income, and benefits from a TQ policy may not be subject to federal income tax. See the discussion in Section VI.B.7, page 83. **The Rehabilitator makes no representation and does not offer any opinion regarding tax matters.**

- 106) **“TQ Triggers”** means the requirements that must be met under a Tax Qualified LTC policy in order to receive benefits.
- 107) **“Transitional Events”** means the events described on page 38 as a result of which a policyholder must make an election after the Initial Policyholder Election Date and before the Supplemental Plan Effective Date.
- 108) **“Trust”** means the Senior Health Care Oversight Trust, as defined above.
- 109) **“Uncovered Benefits”** means the portion of the LTC policy benefits to which policyholders are contractually entitled on the Effective Date that exceed Guaranty Association statutory limits or otherwise are not covered by Guaranty Associations as determined by the responsible Guaranty Association in accordance with applicable law.
- 110) **“Unfunded Benefit Liability”** or **“UBL”** means the portion of a policy’s Unmodified Policy Value that exceeds its IFRPV.
- 111) **“Waiver of Premium”** see Claim Waiver of Premium, Dual Waiver of Premium, and Lifetime Waiver of Premium.

VIII. APPENDIX A - CHANGES FROM OCTOBER 21, 2020 AMENDED PLAN

1. Clarifying language changes and updates have been made in various Plan provisions.
2. The selection of a default option for policies on premium waiver has been simplified by removing consideration of possible future premium upon recovery. See Section I.A.4, page 13.
3. The discussion of the COVID-19 pandemic has been expanded. See Section I.C, page 16.
4. A new section has been added describing the order of distributions under the Plan. See Section I.G, page 21.
5. A disclosure has been added that a policyholder immune from required elections in Phase One (due to premium at or above If Knew Premium) may nonetheless have a non-self-sustaining policy and be required to elect policy modifications in Phase Two. See Section II.C.4, page 25.
6. The possibility of an alternative premium structure in Phase Two is described. See Sections II.E.6 and IV.A.6, pages 28 and 59, respectively.
7. The Policyholder Transition Period has been changed to commence on the Plan Determination Date rather than the Policyholder Election Date. See Table 3, beginning at page 35, Section II.L.3, page 37, and the definition on page 128.
8. The determination of MPV has been clarified. See Section II.N.7, page 40.
9. The possibility of material changes in Phase Two has been emphasized. See page 58.
10. Clarification has been added that UBL payments in Phase Three will take the form of MBP extensions. See Section V, page 81.
11. A reference to the issue-state rate approval alternative has been added to the discussion of the Commonwealth Court's jurisdiction. See page 96.
12. Clarifying language has been added regarding the ceding companies' claims against SHIP. See Section VI.M.7, page 98.
13. The reinsurance Section has been edited to reflect the recapture agreement with Transamerica. See page 99.
14. Clarifying language has been added to the Section about agents' commissions. See page 99.

15. A new Section has been added regarding the suspension to Transport Life retiree benefits. See page 100.
16. A more robust issue-state rate approval Section has been substituted. See Section VI.V, page 108.
17. Notice has been added that the decisions of Opt-out States may affect policyholders residing in other states whose policies had been issued in the Opt-out States. See page 109.
18. The definition of Determination Date has been clarified to note that different dates will be used for Phase One and Phase Two. See page 122.
19. A definition has been added for Downgrade Target Premium. See page 122.
20. The definition of “Fully Covered” has been clarified. See page 123.

APPENDIX B
SELECTED FINANCIAL INFORMATION



SENIOR HEALTH INSURANCE COMPANY
OF PENNSYLVANIA
IN REHABILITATION

THE ATTACHED PAGES ARE SELECTED EXCERPTS FROM THE COMPANY'S UNFILED 2019 STATUTORY FINANCIAL STATEMENT AND INTERNAL 2020 FINANCIAL INFORMATION. NO REPRESENTATION, EXPRESS OR IMPLIED, IS MADE AS TO THEIR ACCURACY OR COMPLETENESS.

THIS INFORMATION IS PROVIDED SOLELY FOR INFORMATION AND CONTAINS STATEMENTS THAT ARE, OR MAY BE DEEMED TO BE, "FORWARD-LOOKING STATEMENTS" WITHIN THE MEANING OF THE PRIVATE SECURITIES LITIGATION REFORM ACT OF 1995. ANY SUCH FORWARD-LOOKING STATEMENTS ARE BASED UPON A VARIETY OF ESTIMATES AND ASSUMPTIONS THAT, THOUGH CONSIDERED REASONABLE BY THE REHABILITATOR, MAY NOT BE REALIZED, AND ARE INHERENTLY SUBJECT TO SIGNIFICANT BUSINESS, ECONOMIC AND OTHER UNCERTAINTIES AND CONTINGENCIES.

SOME ASSUMPTIONS INEVITABLY WILL NOT MATERIALIZE AND EVENTS AND CIRCUMSTANCES OCCURRING SUBSEQUENT TO THE DATE ON WHICH THE INFORMATION WAS PREPARED MAY BE SIGNIFICANTLY DIFFERENT FROM THOSE ASSUMED, OR MAY BE UNANTICIPATED, AND THUS MAY AFFECT FINANCIAL OR OTHER RESULTS IN A MATERIAL AND POSSIBLY ADVERSE MANNER. THE INFORMATION, THEREFORE, SHOULD NOT BE RELIED UPON AS A GUARANTY OR OTHER ASSURANCE OF THE ACTUAL RESULTS THAT WILL OCCUR.

ASSETS

	Current Year			Prior Year
	1	2	3	4
	Assets	Nonadmitted Assets	Net Admitted Assets (Cols. 1 - 2)	Net Admitted Assets
1. Bonds (Schedule D).....	1,721,888,236		1,721,888,236	2,006,961,967
2. Stocks (Schedule D):				
2.1 Preferred stocks.....	86,271,292		86,271,292	109,432,792
2.2 Common stocks.....	3,578,386		3,578,386	1,813,578
3. Mortgage loans on real estate (Schedule B):				
3.1 First liens.....	12,681,751		12,681,751	17,540,853
3.2 Other than first liens.....			0	
4. Real estate (Schedule A):				
4.1 Properties occupied by the company (less \$.....0 encumbrances).....			0	
4.2 Properties held for the production of income (less \$.....0 encumbrances).....			0	
4.3 Properties held for sale (less \$.....0 encumbrances).....			0	
5. Cash (\$.....(6,955,915), Schedule E-Part 1), cash equivalents (\$.....53,638,393, Schedule E-Part 2) and short-term investments (\$.....0, Schedule DA).....	46,682,478		46,682,478	20,755,355
6. Contract loans (including \$.....0 premium notes).....			0	
7. Derivatives (Schedule DB).....			0	
8. Other invested assets (Schedule BA).....	25,617,716	9,916,628	15,701,088	11,834,651
9. Receivables for securities.....	135,570		135,570	10,149
10. Securities lending reinvested collateral assets (Schedule DL).....			0	
11. Aggregate write-ins for invested assets.....	0	0	0	0
12. Subtotals, cash and invested assets (Lines 1 to 11).....	1,896,855,429	9,916,628	1,886,938,801	2,168,349,345
13. Title plants less \$.....0 charged off (for Title insurers only).....			0	
14. Investment income due and accrued.....	12,081,945		12,081,945	15,264,664
15. Premiums and considerations:				
15.1 Uncollected premiums and agents' balances in the course of collection.....	929,722	1,699	928,023	1,071,261
15.2 Deferred premiums, agents' balances and installments booked but deferred and not yet due (including \$.....0 earned but unbilled premiums).....			0	
15.3 Accrued retrospective premiums (\$.....0) and contracts subject to redetermination (\$.....0).....			0	
16. Reinsurance:				
16.1 Amounts recoverable from reinsurers.....	22,002		22,002	13,421
16.2 Funds held by or deposited with reinsured companies.....			0	
16.3 Other amounts receivable under reinsurance contracts.....	(48)		(48)	
17. Amounts receivable relating to uninsured plans.....			0	
18.1 Current federal and foreign income tax recoverable and interest thereon.....	2,364,433		2,364,433	(138,737)
18.2 Net deferred tax asset.....			0	
19. Guaranty funds receivable or on deposit.....	1,208,738		1,208,738	1,448,680
20. Electronic data processing equipment and software.....			0	
21. Furniture and equipment, including health care delivery assets (\$.....0).....			0	
22. Net adjustment in assets and liabilities due to foreign exchange rates.....			0	
23. Receivables from parent, subsidiaries and affiliates.....	49,541		49,541	49,639
24. Health care (\$.....0) and other amounts receivable.....	30,700	30,700	0	
25. Aggregate write-ins for other-than-invested assets.....	3,587,702	0	3,587,702	0
26. Total assets excluding Separate Accounts, Segregated Accounts and Protected Cell Accounts (Lines 12 to 25).....	1,917,130,164	9,949,027	1,907,181,137	2,186,058,273
27. From Separate Accounts, Segregated Accounts and Protected Cell Accounts.....			0	
28. TOTAL (Lines 26 and 27).....	1,917,130,164	9,949,027	1,907,181,137	2,186,058,273

DETAILS OF WRITE-INS

1101.			0	
1102.			0	
1103.			0	
1198. Summary of remaining write-ins for Line 11 from overflow page.....	0	0	0	0
1199. Totals (Lines 1101 through 1103 plus 1198) (Line 11 above).....	0	0	0	0
2501. Reimbursement from Insurance Carrier.....	3,587,702		3,587,702	
2502.			0	
2503.			0	
2598. Summary of remaining write-ins for Line 25 from overflow page.....	0	0	0	0
2599. Totals (Lines 2501 through 2503 plus 2598) (Line 25 above).....	3,587,702	0	3,587,702	0

		1	2
		Current Year	Prior Year
1.	Aggregate reserve for life contracts \$.....0 (Exhibit 5, Line 9999999) less \$.....0 included in Line 6.3 (including \$.....0 Modco Reserve).....		
2.	Aggregate reserve for accident and health contracts (including \$.....0 Modco Reserve).....	2,766,443,751	2,608,580,649
3.	Liability for deposit-type contracts (Exhibit 7, Line 14, Col. 1) (including \$.....0 Modco Reserve).....		
4.	Contract claims:		
4.1	Life (Exhibit 8, Part 1, Line 4.4, Col. 1 less sum of Cols. 9, 10 and 11).....		
4.2	Accident and health (Exhibit 8, Part 1, Line 4.4, sum of Cols. 9, 10 and 11).....	37,734,617	35,658,375
5.	Policyholders' dividends/refunds to members \$.....0 and coupons \$.....0 due and unpaid (Exhibit 4, Line 10).....		
6.	Provision for policyholders' dividends, refunds to members and coupons payable in following calendar year - estimated amounts:		
6.1	Policyholders' dividends and refunds to members apportioned for payment (including \$.....0 Modco).....		
6.2	Policyholders' dividends and refunds to members not yet apportioned (including \$.....0 Modco).....		
6.3	Coupons and similar benefits (including \$.....0 Modco).....		
7.	Amount provisionally held for deferred dividend policies not included in Line 6.....		
8.	Premiums and annuity considerations for life and accident and health contracts received in advance less \$.....0 discount; including \$.....1,462,254 accident and health premiums (Exhibit 1, Part 1, Col. 1, sum of Lines 4 and 14).....	1,462,254	1,655,643
9.	Contract liabilities not included elsewhere:		
9.1	Surrender values on canceled contracts.....		
9.2	Provision for experience rating refunds, including the liability of \$.....0 accident and health experience rating refunds of which \$.....0 is for medical loss ratio rebate per the Public Health Service Act.....		
9.3	Other amounts payable on reinsurance, including \$.....16,032 assumed and \$.....1,910 ceded.....	17,942	35,585
9.4	Interest Maintenance Reserve (IMR, Line 6).....	4,746,341	1,564,865
10.	Commissions to agents due or accrued - life and annuity contracts \$.....0, accident and health \$.....0 and deposit-type contract funds \$.....0.....	580,812	699,855
11.	Commissions and expense allowances payable on reinsurance assumed.....		
12.	General expenses due or accrued (Exhibit 2, Line 12, Col. 7).....	6,629,583	3,792,089
13.	Transfers to Separate Accounts due or accrued (net) (including \$.....0 accrued for expense allowances recognized in reserves, net of reinsured allowances).....		
14.	Taxes, licenses and fees due or accrued, excluding federal income taxes (Exhibit 3, Line 9, Col. 6).....	414,345	603,523
15.1	Current federal and foreign income taxes, including \$.....0 on realized capital gains (losses).....		(2,573,298)
15.2	Net deferred tax liability.....		
16.	Unearned investment income.....		
17.	Amounts withheld or retained by reporting entity as agent or trustee.....		
18.	Amounts held for agents' account, including \$.....0 agents' credit balances.....		
19.	Remittances and items not allocated.....	329,763	336,270
20.	Net adjustment in assets and liabilities due to foreign exchange rates.....		
21.	Liability for benefits for employees and agents if not included above.....		
22.	Borrowed money \$.....0 and interest thereon \$.....0.....		
23.	Dividends to stockholders declared and unpaid.....		
24.	Miscellaneous liabilities:		
24.01	Asset valuation reserve (AVR Line 16, Col. 7).....	206,126	58,003
24.02	Reinsurance in unauthorized and certified (\$.....0) companies.....		
24.03	Funds held under reinsurance treaties with unauthorized and certified (\$.....0) reinsurers.....		
24.04	Payable to parent, subsidiaries and affiliates.....		
24.05	Drafts outstanding.....		
24.06	Liability for amounts held under uninsured plans.....		
24.07	Funds held under coinsurance.....		
24.08	Derivatives.....		
24.09	Payable for securities.....	1,975,610	
24.10	Payable for securities lending.....		
24.11	Capital notes \$.....0 and interest thereon \$.....0.....		
25.	Aggregate write-ins for liabilities.....	2,738,221	2,519,689
26.	Total liabilities excluding Separate Accounts business (Lines 1 to 25).....	2,823,279,366	2,652,931,248
27.	From Separate Accounts Statement.....		
28.	Total liabilities (Line 26 and 27).....	2,823,279,366	2,652,931,248
29.	Common capital stock.....	2,500,005	2,500,005
30.	Preferred capital stock.....	5,000,000	5,000,000
31.	Aggregate write-ins for other-than-special surplus funds.....	0	0
32.	Surplus notes.....	50,000,000	50,000,000
33.	Gross paid in and contributed surplus (Page 3, Line 33, Col. 2 plus Page 4, Line 51.1, Col. 1).....	1,198,824,011	1,196,326,042
34.	Aggregate write-ins for special surplus funds.....	0	0
35.	Unassigned funds (surplus).....	(2,172,422,245)	(1,720,699,022)
36.	Less treasury stock, at cost:		
36.1	0.000 shares common (value included in Line 29 \$.....0).....		
36.2	0.000 shares preferred (value included in Line 30 \$.....0).....		
37.	Surplus (Total Lines 31 + 32 + 33 + 34 + 35 - 36) (including \$.....0 in Separate Accounts Statement).....	(923,598,234)	(474,372,980)
38.	Totals of Lines 29, 30 and 37 (Page 4, Line 55).....	(916,098,229)	(466,872,975)
39.	Totals of Lines 28 and 38 (Page 2, Line 28, Col. 3).....	1,907,181,137	2,186,058,273

DETAILS OF WRITE-INS			
2501.	Unclaimed funds.....	2,738,221	2,519,689
2502.	.....		
2503.	.....		
2598.	Summary of remaining write-ins for Line 25 from overflow page.....	0	0
2599.	Totals (Lines 2501 through 2503 plus 2598) (Line 25 above).....	2,738,221	2,519,689
3101.	.....		
3102.	.....		
3103.	.....		
3198.	Summary of remaining write-ins for Line 31 from overflow page.....	0	0
3199.	Totals (Lines 3101 through 3103 plus 3198) (Line 31 above).....	0	0
3401.	.....		
3402.	.....		
3403.	.....		
3498.	Summary of remaining write-ins for Line 34 from overflow page.....	0	0
3499.	Totals (Lines 3401 through 3403 plus 3498) (Line 34 above).....	0	0

	1 Current Year	2 Prior Year
1. Premiums and annuity considerations for life and accident and health contracts (Exhibit 1, Part 1, Line 20.4, Col. 1, less Col. 11)	78,564,611	1,237,392,658
2. Considerations for supplementary contracts with life contingencies		
3. Net investment income (Exhibit of Net Investment Income, Line 17)	69,898,620	81,934,412
4. Amortization of Interest Maintenance Reserve (IMR) (Line 5)	497,421	192,717,772
5. Separate Accounts net gain from operations excluding unrealized gains or losses		
6. Commissions and expense allowances on reinsurance ceded (Exhibit 1, Part 2, Line 26.1, Col. 1)	244	945,401
7. Reserve adjustments on reinsurance ceded		
8. Miscellaneous Income:		
8.1 Income from fees associated with investment management, administration and contract guarantees from Separate Accounts		
8.2 Charges and fees for deposit-type contracts		
8.3 Aggregate write-ins for miscellaneous income	0	0
9. Totals (Lines 1 to 8.3)	148,960,896	1,512,990,242
10. Death benefits		
11. Matured endowments (excluding guaranteed annual pure endowments)		
12. Annuity benefits (Exhibit 8, Part 2, Line 6.4, Cols. 4 + 8)		
13. Disability benefits and benefits under accident and health contracts	371,758,091	390,323,186
14. Coupons, guaranteed annual pure endowments and similar benefits		
15. Surrender benefits and withdrawals for life contracts		
16. Group conversions		
17. Interest and adjustments on contract or deposit-type contract funds		
18. Payments on supplementary contracts with life contingencies		
19. Increase in aggregate reserves for life and accident and health contracts	157,863,106	1,391,115,603
20. Totals (Lines 10 to 19)	529,621,197	1,781,438,788
21. Commissions on premiums, annuity considerations and deposit-type contract funds (direct business only) (Exhibit 1, Part 2, Line 31, Col. 1)	5,172,110	6,133,056
22. Commissions and expense allowances on reinsurance assumed (Exhibit 1, Part 2, Line 26.2, Col. 1)	482,173	569,135
23. General insurance expenses and fraternal expenses (Exhibit 2, Line 10, Columns 1, 2, 3, 4 and 6)	29,395,680	34,197,614
24. Insurance taxes, licenses and fees, excluding federal income taxes (Exhibit 3, Line 7, Cols. 1 + 2 + 3 + 5)	3,889,989	2,640,964
25. Increase in loading on deferred and uncollected premiums		
26. Net transfers to or (from) Separate Accounts net of reinsurance		
27. Aggregate write-ins for deductions	0	12,570,929
28. Totals (Lines 20 to 27)	568,561,149	1,837,550,486
29. Net gain from operations before dividends to policyholders, refunds to members and federal income taxes (Line 9 minus Line 28)	(419,600,253)	(324,560,244)
30. Dividends to policyholders and refunds to members		
31. Net gain from operations after dividends to policyholders, refunds to members and before federal income taxes (Line 29 minus Line 30)	(419,600,253)	(324,560,244)
32. Federal and foreign income taxes incurred (excluding tax on capital gains)	(1,632,614)	(463,908)
33. Net gain from operations after dividends to policyholders, refunds to members and federal income taxes and before realized capital gains or (losses) (Line 31 minus Line 32)	(417,967,639)	(324,096,336)
34. Net realized capital gains (losses) (excluding gains (losses) transferred to the IMR) less capital gains tax of \$....2,815,978 (excluding taxes of \$....(977,935) transferred to the IMR)	(44,066,405)	(175,822,458)
35. Net income (Line 33 plus Line 34)	(462,034,044)	(499,918,794)
CAPITAL AND SURPLUS ACCOUNT		
36. Capital and surplus, December 31, prior year (Page 3, Line 38, Col. 2)	(466,872,971)	12,649,170
37. Net income (Line 35)	(462,034,044)	(499,918,794)
38. Change in net unrealized capital gains (losses) less capital gains tax of \$.....0	842,233	131,852
39. Change in net unrealized foreign exchange capital gain (loss)		
40. Change in net deferred income tax		
41. Change in nonadmitted assets	9,616,707	(19,510,668)
42. Change in liability for reinsurance in unauthorized and certified companies		11,626,473
43. Change in reserve on account of change in valuation basis (increase) or decrease		
44. Change in asset valuation reserve	(148,123)	28,148,996
45. Change in treasury stock, (Page 3, Lines 36.1 and 36.2 Col. 2 minus Col. 1)		
46. Surplus (contributed to) withdrawn from Separate Accounts during period		
47. Other changes in surplus in Separate Accounts Statement		
48. Change in surplus notes		
49. Cumulative effect of changes in accounting principles		
50. Capital changes:		
50.1 Paid in		
50.2 Transferred from surplus (Stock Dividend)		
50.3 Transferred to surplus		
51. Surplus adjustment:		
51.1 Paid in	2,497,969	0
51.2 Transferred to capital (Stock Dividend)		
51.3 Transferred from capital		
51.4 Change in surplus as a result of reinsurance		
52. Dividends to stockholders		
53. Aggregate write-ins for gains and losses in surplus	0	0
54. Net change in capital and surplus for the year (Lines 37 through 53)	(449,225,258)	(479,522,141)
55. Capital and surplus, December 31, current year (Lines 36 + 54) (Page 3, Line 38)	(916,098,229)	(466,872,971)
DETAILS OF WRITE-INS		
08.301.		
08.302.		
08.303.		
08.398. Summary of remaining write-ins for Line 8.3 from overflow page	0	0
08.399. Totals (Lines 08.301 through 08.303 plus 08.398) (Line 8.3 above)	0	0
2701. Termination of Roebling Reinsurance Agreement		12,570,929
2702.		
2703.		
2798. Summary of remaining write-ins for Line 27 from overflow page	0	0
2799. Totals (Lines 2701 through 2703 plus 2798) (Line 27 above)	0	12,570,929
5301.		
5302.		
5303.		
5398. Summary of remaining write-ins for Line 53 from overflow page	0	0
5399. Totals (Lines 5301 through 5303 plus 5398) (Line 53 above)	0	0

CASH FLOW

		1	2
		Current Year	Prior Year
CASH FROM OPERATIONS			
1.	Premiums collected net of reinsurance.....	62,752,519	73,765,461
2.	Net investment income.....	75,782,728	91,432,001
3.	Miscellaneous income.....	244	1,057
4.	Total (Lines 1 through 3).....	138,535,491	165,198,519
5.	Benefit and loss related payments.....	353,928,567	351,102,177
6.	Net transfers to Separate Accounts, Segregated Accounts and Protected Cell Accounts.....		
7.	Commissions, expenses paid and aggregate write-ins for deductions.....	36,182,999	42,838,983
8.	Dividends paid to policyholders.....		
9.	Federal and foreign income taxes paid (recovered) net of \$.....0 tax on capital gains (losses).....	135,301	(671,176)
10.	Total (Lines 5 through 9).....	390,246,866	393,269,984
11.	Net cash from operations (Line 4 minus Line 10).....	(251,711,376)	(228,071,464)
CASH FROM INVESTMENTS			
12.	Proceeds from investments sold, matured or repaid:		
12.1	Bonds.....	432,428,356	452,604,302
12.2	Stocks.....	1,474,442	15,714,528
12.3	Mortgage loans.....	4,859,102	14,266,387
12.4	Real estate.....		
12.5	Other invested assets.....	5,040,743	283,790
12.6	Net gains or (losses) on cash, cash equivalents and short-term investments.....		(1,834)
12.7	Miscellaneous proceeds.....	1,975,610	728,906
12.8	Total investment proceeds (Lines 12.1 to 12.7).....	445,778,253	483,596,079
13.	Cost of investments acquired (long-term only):		
13.1	Bonds.....	158,454,700	651,406,627
13.2	Stocks.....	67,901	77,189,849
13.3	Mortgage loans.....		
13.4	Real estate.....		
13.5	Other invested assets.....	5,900,000	
13.6	Miscellaneous applications.....	125,421	0
13.7	Total investments acquired (Lines 13.1 to 13.6).....	164,548,022	728,596,476
14.	Net increase (decrease) in contract loans and premium notes.....		
15.	Net cash from investments (Line 12.8 minus Lines 13.7 minus Line 14).....	281,230,231	(245,000,397)
CASH FROM FINANCING AND MISCELLANEOUS SOURCES			
16.	Cash provided (applied):		
16.1	Surplus notes, capital notes.....		
16.2	Capital and paid in surplus, less treasury stock.....		0
16.3	Borrowed funds.....		
16.4	Net deposits on deposit-type contracts and other insurance liabilities.....		
16.5	Dividends to stockholders.....		
16.6	Other cash provided (applied).....	(3,591,732)	(2,264,237)
17.	Net cash from financing and miscellaneous sources (Lines 16.1 to 16.4 minus Line 16.5 plus Line 16.6).....	(3,591,732)	(2,264,237)
RECONCILIATION OF CASH, CASH EQUIVALENTS AND SHORT-TERM INVESTMENTS			
18.	Net change in cash, cash equivalents and short-term investments (Line 11, plus Lines 15 and 17).....	25,927,123	(475,336,098)
19.	Cash, cash equivalents and short-term investments:		
19.1	Beginning of year.....	20,755,358	496,091,456
19.2	End of year (Line 18 plus Line 19.1).....	46,682,481	20,755,358

Note: Supplemental disclosures of cash flow information for non-cash transactions:

20.0001		

EXHIBIT 6 - AGGREGATE RESERVES FOR ACCIDENT AND HEALTH CONTRACTS - ACCIDENT AND HEALTH (a)

	1	Comprehensive		4	5	6	7	8	9	10	11	12	13
		2	3										
	Total	Individual	Group	Medicare Supplement	Vision Only	Dental Only	Federal Employees Health Benefits Plan	Title XVIII Medicare	Title XIX Medicaid	Credit A&H	Disability Income	Long-Term Care	Other Health
ACTIVE LIFE RESERVE													
1. Unearned premium reserves.....	12,003,829											12,003,829	
2. Additional contract reserves (b).....	1,223,633,993											1,223,633,993	
3. Additional actuarial reserves - Asset/Liability analysis.....	636,536,764											636,536,764	
4. Reserve for future contingent benefits.....	0												
5. Reserve for rate credits.....	0												
6. Aggregate write-ins for reserves.....	0	0	0	0	0	0	0	0	0	0	0	0	0
7. Totals (Gross).....	1,872,174,585	0	0	0	0	0	0	0	0	0	0	1,872,174,585	0
8. Reinsurance ceded.....	806,876											806,876	
9. Totals (Net).....	1,871,367,710	0	0	0	0	0	0	0	0	0	0	1,871,367,710	0
CLAIM RESERVE													
10. Present value of amounts not yet due on claims.....	895,879,794											895,879,794	
11. Additional actuarial reserves - Asset/Liability analysis.....	0												
12. Reserve for future contingent benefits.....	0												
13. Aggregate write-ins for reserves.....	0	0	0	0	0	0	0	0	0	0	0	0	0
14. Totals (Gross).....	895,879,794	0	0	0	0	0	0	0	0	0	0	895,879,794	0
15. Reinsurance ceded.....	803,753											803,753	
16. Totals (Net).....	895,076,042	0	0	0	0	0	0	0	0	0	0	895,076,042	0
17. TOTALS (Net).....	2,766,443,751	0	0	0	0	0	0	0	0	0	0	2,766,443,751	0
18. TABULAR FUND INTEREST.....	94,796,751											94,796,751	

DETAILS OF WRITE-INS

0601.	0												
0602.	0												
0603.	0												
0698. Summary of remaining write-ins for Line 6 from overflow page.....	0	0	0	0	0	0	0	0	0	0	0	0	0
0699. Totals (Lines 0601 through 0603 plus 0698) (Line 6 above).....	0	0	0	0	0	0	0	0	0	0	0	0	0
1301.	0												
1302.	0												
1303.	0												
1398. Summary of remaining write-ins for Line 13 from overflow page.....	0	0	0	0	0	0	0	0	0	0	0	0	0
1399. Totals (Lines 1301 through 1303 + 1398) (Line 13 above).....	0	0	0	0	0	0	0	0	0	0	0	0	0

(a) Indicate if blocks of business in run-off that comprise less than 5% of premiums and less than 5% of reserve and loans liability are aggregated with material blocks of business and which columns are affected.

(b) Attach statement as to valuation standard used in calculating this reserve, specifying reserve bases, interest rates and methods.

EXHIBIT 8 - CLAIMS FOR LIFE AND ACCIDENT AND HEALTH CONTRACTS

PART 1 - Liability End of Current Year

	1 Total	2 Industrial Life	Ordinary			6 Credit Life (Group and Individual)	Group		Accident and Health		
			3 Life Insurance	4 Individual Annuities	5 Supplementary Contracts		7 Life Insurance	8 Annuities	9 Group	10 Credit (Group and Individual)	11 Other
1. Due and unpaid:											
1.1 Direct.....	0										
1.2 Reinsurance assumed.....	0										
1.3 Reinsurance ceded.....	0										
1.4 Net.....	0	0	0	0	0	0	0	0	0	0	0
2. In course of settlement:											
2.1 Resisted:											
2.11 Direct.....	0										
2.12 Reinsurance assumed.....	0										
2.13 Reinsurance ceded.....	0										
2.14 Net.....	0	0	(b) 0	(b) 0	0	(b) 0	(b) 0	0	0	0	0
2.2 Other:											
2.21 Direct.....	31,934,537								470,450		31,464,087
2.22 Reinsurance assumed.....	2,601,162								373,231		2,227,931
2.23 Reinsurance ceded.....	28,754										28,754
2.24 Net.....	34,506,945	0	(b) 0	(b) 0	0	(b) 0	(b) 0	0	(b) 843,682	(b) 0	(b) 33,663,264
3. Incurred but unreported:											
3.1 Direct.....	2,875,720								72,350		2,803,370
3.2 Reinsurance assumed.....	352,675								49,835		302,840
3.3 Reinsurance ceded.....	723										723
3.4 Net.....	3,227,672	0	(b) 0	(b) 0	0	(b) 0	(b) 0	0	(b) 122,185	(b) 0	(b) 3,105,486
4. Totals:											
4.1 Direct.....	34,810,257	0	0	0	0	0	0	0	542,801	0	34,267,457
4.2 Reinsurance assumed.....	2,953,837	0	0	0	0	0	0	0	423,066	0	2,530,771
4.3 Reinsurance ceded.....	29,477	0	0	0	0	0	0	0	0	0	29,477
4.4 Net.....	37,734,617	(a) 0	(a) 0	0	0	0	(a) 0	0	965,867	0	36,768,750

(a) Including matured endowments (but not guaranteed annual pure endowments) unpaid amounting to \$.....0 in Column 2, \$.....0 in Column 3 and \$.....0 in Column 7.

(b) Include only portion of disability and accident and health claim liabilities applicable to assumed "accrued" benefits. Reserves (including reinsurance assumed and net of reinsurance ceded) for unaccrued benefits for Ordinary Life Insurance \$.....0, Individual Annuities \$.....0, Credit Life (Group and Individual) \$.....0, and Group Life \$.....0, are included in Page 3, Line 1, (See Exhibit 5, Section on Disability Disabled Lives); and for Group Accident and Health \$.....19,896,545, Credit (Group and Individual) Accident and Health \$.....0 and Other Accident and Health \$.....875,179,497 are included in Page 3, Line 2, (See Exhibit 6, Claim Reserve).

EXHIBIT 8 - CLAIMS FOR LIFE AND ACCIDENT AND HEALTH CONTRACTS

PART 2 - Incurred During the Year

	1	2	Ordinary			6	Group		Accident and Health		
			3	4	5		7	8	9	10	11
	Total	Industrial Life (a)	Life Insurance (b)	Individual Annuities	Supplementary Contracts	Credit Life (Group and Individual)	Life Insurance (c)	Annuities	Group	Credit (Group and Individual)	Other
1. Settlements during the year:											
1.1 Direct.....	343,343,970								4,931,883		338,412,086
1.2 Reinsurance assumed.....	26,475,718								4,222,270		22,253,448
1.3 Reinsurance ceded.....	129,258								-		129,258
1.4 Net.....	(d) 369,690,430	0	0	0	0	0	0	0	9,154,153	0	360,536,277
2. Liability December 31, current year from Part 1:											
2.1 Direct.....	34,810,257	0	0	0	0	0	0	0	542,801	0	34,267,457
2.2 Reinsurance assumed.....	2,953,837	0	0	0	0	0	0	0	423,066	0	2,530,771
2.3 Reinsurance ceded.....	29,477	0	0	0	0	0	0	0	0	0	29,477
2.4 Net.....	37,734,617	0	0	0	0	0	0	0	965,867	0	36,768,750
3. Amounts recoverable from reinsurers Dec. 31, current year.....	22,002										22,002
4. Liability December 31, prior year:											
4.1 Direct.....	32,821,419								486,861		32,334,558
4.2 Reinsurance assumed.....	2,881,635								488,252		2,393,383
4.3 Reinsurance ceded.....	44,679										44,679
4.4 Net.....	35,658,375	0	0	0	0	0	0	0	975,112	0	34,683,262
5. Amounts recoverable from reinsurers Dec. 31, prior year.....	13,421										13,421
6. Incurred benefits:											
6.1 Direct.....	345,332,808	0	0	0	0	0	0	0	4,987,823	0	340,344,985
6.2 Reinsurance assumed.....	26,547,920	0	0	0	0	0	0	0	4,157,084	0	22,390,836
6.3 Reinsurance ceded.....	122,637	0	0	0	0	0	0	0	0	0	122,637
6.4 Net.....	371,758,091	0	0	0	0	0	0	0	9,144,908	0	362,613,183

(a) Including matured endowments (but not guaranteed annual pure endowments) amounting to \$.....0 in Line 1.1, \$.....0 in Line 1.4, \$.....0 in Line 6.1 and \$.....0 in Line 6.4.
(b) Including matured endowments (but not guaranteed annual pure endowments) amounting to \$.....0 in Line 1.1, \$.....0 in Line 1.4, \$.....0 in Line 6.1 and \$.....0 in Line 6.4.
(c) Including matured endowments (but not guaranteed annual pure endowments) amounting to \$.....0 in Line 1.1, \$.....0 in Line 1.4, \$.....0 in Line 6.1 and \$.....0 in Line 6.4.
(d) Includes \$.....(15,834,951) premiums waived under total and permanent disability benefits.

	1 Current Year Total Nonadmitted Assets	2 Prior Year Total Nonadmitted Assets	3 Change in Total Nonadmitted Assets (Col. 2 - Col. 1)
1. Bonds (Schedule D).....			0
2. Stocks (Schedule D):			
2.1 Preferred stocks.....			0
2.2 Common stocks.....			0
3. Mortgage loans on real estate (Schedule B):			
3.1 First liens.....			0
3.2 Other than first liens.....			0
4. Real estate (Schedule A):			
4.1 Properties occupied by the company.....			0
4.2 Properties held for the production of income.....			0
4.3 Properties held for sale.....			0
5. Cash (Schedule E-Part 1), cash equivalents (Schedule E-Part 2) and short-term investments (Schedule DA).....			0
6. Contract loans.....			0
7. Derivatives (Schedule DB).....			0
8. Other invested assets (Schedule BA).....	9,916,628	19,513,439	9,596,811
9. Receivables for securities.....			0
10. Securities lending reinvested collateral assets (Schedule DL).....			0
11. Aggregate write-ins for invested assets.....	0	0	0
12. Subtotals, cash and invested assets (Lines 1 to 11).....	9,916,628	19,513,439	9,596,811
13. Title plants (for Title insurers only).....			0
14. Investment income due and accrued.....			0
15. Premiums and considerations:			
15.1 Uncollected premiums and agents' balances in the course of collection.....	1,699	19,216	17,517
15.2 Deferred premiums, agents' balances and installments booked but deferred and not yet due.....			0
15.3 Accrued retrospective premiums and contracts subject to redetermination.....			0
16. Reinsurance:			
16.1 Amounts recoverable from reinsurers.....			0
16.2 Funds held by or deposited with reinsured companies.....			0
16.3 Other amounts receivable under reinsurance contracts.....			0
17. Amounts receivable relating to uninsured plans.....			0
18.1 Current federal and foreign income tax recoverable and interest thereon.....			0
18.2 Net deferred tax asset.....			0
19. Guaranty funds receivable or on deposit.....			0
20. Electronic data processing equipment and software.....			0
21. Furniture and equipment, including health care delivery assets.....			0
22. Net adjustment in assets and liabilities due to foreign exchange rates.....			0
23. Receivables from parent, subsidiaries and affiliates.....			0
24. Health care and other amounts receivable.....	30,700	33,079	2,379
25. Aggregate write-ins for other-than-invested assets.....	0	0	0
26. Total assets excluding Separate Accounts, Segregated Accounts and Protected Cell Accounts (Lines 12 through 25).....	9,949,027	19,565,734	9,616,707
27. From Separate Accounts, Segregated Accounts and Protected Cell Accounts.....			0
28. TOTALS (Lines 26 and 27).....	9,949,027	19,565,734	9,616,707

DETAILS OF WRITE-INS			
1101.			0
1102.			0
1103.			0
1198. Summary of remaining write-ins for Line 11 from overflow page.....	0	0	0
1199. Totals (Lines 1101 through 1103 plus 1198) (Line 11 above).....	0	0	0
2501.			0
2502.			0
2503.			0
2598. Summary of remaining write-ins for Line 25 from overflow page.....	0	0	0
2599. Totals (Lines 2501 through 2503 plus 2598) (Line 25 above).....	0	0	0

NOTES TO FINANCIAL STATEMENTS

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19	Direct Premium Written/Produced by Managing General Agents/Third Party Administrators	19.15
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24	Retrospectively Rated Contracts & Contracts Subject to Redetermination	19.19
25	Change in Incurred Losses and Loss Adjustment Expenses	19.20
26	Intercompany Pooling Arrangements	19.20
27	Structured Settlements	19.20
28	Health Care Receivables	19.20
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30	Premium Deficiency Reserves	19.20
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33	Premium and Annuity Considerations Deferred and Uncollected	19.20
34	Separate Accounts	19.20
35	Loss/Claim Adjustment Expenses	19.20

NOTES TO FINANCIAL STATEMENTS

1. Summary of Significant Accounting Policies

A. Accounting Practices

The financial statements of Senior Health Insurance Company of Pennsylvania ("Company") are presented on the basis of accounting practices prescribed or permitted by the Pennsylvania Commissioner of Insurance ("Commissioner").

The Commissioner recognizes only statutory accounting practices prescribed or permitted by the Commonwealth of Pennsylvania for reporting the financial condition and results of operations of an insurance company and determining its solvency under Pennsylvania Insurance Law. The *Accounting Practices and Procedures* manual ("NAIC SAP") has been adopted as a component of prescribed or permitted practices by the Commonwealth of Pennsylvania. However, Pennsylvania may adopt certain prescribed accounting practices that differ from NAIC SAP. In addition, the Commissioner has the right to permit other specific practices that deviate from prescribed practices. The Company received a permitted practice for a one-time release of the Interest Maintenance Reserve ("IMR") prescribed by NAIC Statement of Statutory Accounting Principles (SSAP) No. 7 – Asset Valuation and Interest Maintenance Reserve effective January 1, 2018. The effect of this permitted practice was a release of the amortized IMR of \$192,502,234 which increased the Company's 2018 reported Net Income and negative Surplus balances by \$72,502,234. As a result of the IMR release, the Company established a premium deficiency reserve of \$120,000,000. The effect of the permitted practice in 2019 was an increase in net income and negative surplus balances of \$116,228,684. A reconciliation of the Company's net income and capital & surplus is shown below.

	SSAP #	F/S Page	F/S Line #	2019	2018
NET INCOME					
(1) Senior Health Insurance Company of Pennsylvania state basis	XXX	XXX	XXX	\$ (465,369,419)	\$ (499,918,794)
(2) State Prescribed Practices that are an increase/decrease from NAIC SAP					
(3) State Permitted Practices that are an increase/decrease from NAIC SAP: Amortization of Interest Maintenance Reserve	7	4	4	161,958,913	176,638,177
Increase in Aggregate Reserves for Life and Accident and Health Company	54R	4	19	(45,730,229)	(68,622,724)
(4) NAIC SAP (1 – 2 – 3 = 4)	XXX	XXX	XXX	\$ (581,598,103)	\$ (607,934,247)
SURPLUS					
(5) Senior Health Insurance Company of Pennsylvania state basis	XXX	XXX	XXX	\$ (919,285,952)	\$ (466,872,975)
(6) State Prescribed Practices that increase/decrease from NAIC SAP					
(7) State Permitted Practices that increase/decrease from NAIC SAP: Amortization of Interest Maintenance Reserve	7	4	37	161,958,913	176,638,177
Increase in Aggregate Reserves for Life and Accident and Health Company	54R	4	37	(45,730,229)	(68,622,724)
(8) NAIC SAP (5 – 6 – 7 = 8)	XXX	XXX	XXX	\$ (1,035,514,636)	\$ (574,888,428)

B. Use of Estimates in the Preparation of the Financial Statements

The preparation of financial statements in conformity with Statutory Accounting Principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities. It also requires disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the period. Actual results could differ from those estimates.

C. Accounting Policy

Health premiums are earned ratably over the terms of the related insurance and reinsurance contracts or policies.

In addition, the Company uses the following accounting policies:

- (1) Short-term investments are stated at amortized cost.
- (2) Bonds are stated at amortized cost using the scientific interest method, except those rated NAIC class 6, which are stated at the lower of amortized cost or fair value.
- (3) Common stocks are stated at market value.
- (4) Preferred stocks are stated at amortized cost, except those rated NAIC class 4 or lower quality, which are carried at the lower of cost or fair value.
- (5) Mortgage loans on real estate are stated at the aggregate unpaid balance, excluding accrued interest.
- (6) Loan-Backed securities are stated at amortized cost using the interest method including anticipated prepayments at the date of purchase; significant changes in estimated cash flows from the original purchase assumptions are accounted for using the retrospective method. These assumptions are generally consistent with the current interest rate and economic environment.
- (7) The Company reports Fuzion Analytics, Inc., a non-insurance company, at audited GAAP equity.
- (8) Ownership interests in joint ventures are classified as other invested assets on the balance sheet. The Company carries these interests based on its proportionate share of the underlying audited GAAP equity of the investee, adjusted for any distributions received.

NOTES TO FINANCIAL STATEMENTS

1.

Summary of Significant Accounting Policies, continued
- (9)

The Company has no investments in derivatives.
- (10)

The Company anticipates investment income as a factor in the premium deficiency calculation, in accordance with SSAP No. 54R—Individual and Group Accident and Health Contracts.
- (11)

Unpaid losses and loss adjustment expenses include amounts determined from individual case estimates and loss reports and amounts, based on experience, for losses incurred but not reported. Such liabilities are necessarily based on assumptions and estimates. The ultimate liability may be greater or less than the amount reported. The methods for making such estimates and for establishing the resulting liabilities are continually reviewed. Any adjustments to these liabilities are reflected in the period determined.
- (12)

The Company has not modified its capitalization policy from the prior period.
- (13)

The Company receives no pharmaceutical rebates.
- D.

The Company has suffered recurring losses from operations and has a net capital and surplus deficit. The Company is actively working with the Pennsylvania Insurance Department to develop a corrective action plan.
2.

Accounting Changes and Corrections of Errors
- A.

There are no material changes in accounting principles or corrections of errors.
3.

Business Combinations and Goodwill
- A.

During 2019, the Company did not purchase any interest in another company.
- B.

During 2019, the Company did not merge with any other insurance company.
- C.

During 2019, the Company did not participate in an assumption reinsurance agreement.
- D.

During 2019, the Company did not recognize an impairment loss on the transactions described above.
4.

Discontinued Operations
- During 2019, the Company did not discontinue any operations.

NOTES TO FINANCIAL STATEMENTS

5. Investments

A. Mortgage Loans, including Mezzanine Real Estate Loans

- (1) The Company originated no new loans in 2019.
- (2) The maximum percentage of any one loan to the value of the security at the time of the loan, exclusive of insured, guaranteed or purchase money mortgages, was 65.00%.

	<u>Current Year</u>	<u>Prior Year</u>
(3) Taxes, assessments and any amounts advanced and not included in the mortgage loan total:	\$ -	\$ -

(4) Age Analysis of Mortgage Loans:

a. Current Year	<u>Insured</u>	<u>Commercial All Other</u>	<u>Total</u>
1. Recorded Investment			
a) Current	\$ -	\$ 12,681,751	\$ 12,681,751
b) 30-59 Days Past Due	-	-	-
c) 60-89 Days Past Due	-	-	-
d) 90-179 Days Past Due	-	-	-
e) 180+ Days Past Due	-	-	-
2. Accruing Interest 90-179 Days Past Due			
a) Recorded Investment	-	-	-
b) Interest Accrued	-	-	-
3. Accruing Interest 180+ Days Past Due			
a) Recorded Investment	-	-	-
b) Interest Accrued	-	-	-
4. Interest Reduced			
a) Recorded Investment	-	-	-
b) Number of Loans	-	-	-
c) Percent Reduced	-	-	-
b. Prior Year			
1. Recorded Investment			
(a) Current	\$ -	\$ 17,540,853	\$ 17,540,853
(b) 30-59 Days Past Due	-	-	-
(c) 60-89 Days Past Due	-	-	-
(d) 90-179 Days Past Due	-	-	-
(e) 180+ Days Past Due	-	-	-
2. Accruing Interest 90-179 Days Past Due			
a) Recorded Investment	-	-	-
b) Interest Accrued	-	-	-
3. Accruing Interest 180+ Days Past Due			
a) Recorded Investment	-	-	-
b) Interest Accrued	-	-	-
4. Interest Reduced			
a) Recorded Investment	-	-	-
b) Number of Loans	-	-	-
c) Percent Reduced	-	-	-

(5) Investment in Impaired Loans With or Without Allowance for Credit Losses:

a. Current Year	<u>Insured</u>	<u>Commercial All Other</u>	<u>Total</u>
1. With Allowance for Credit Losses	\$ -	\$ -	\$ -
2. No Allowance for Credit Losses	-	-	-
b. Prior Year			
1. With Allowance for Credit Losses	-	-	-
2. No Allowance for Credit Losses	-	-	-

(6) Investment in Impaired Loans – Average Recorded Investment, Interest Income Recognized, Recorded Investment on Nonaccrual Status and Amt of Interest Income Recognized Using a Cash-Basis Method

a. Current Year	<u>Insured</u>	<u>Commercial All Other</u>	<u>Total</u>
1. Average Recorded Investment	\$ -	\$ -	\$ -
2. Interest Income Recognized	-	-	-
3. Recorded Investments on Nonaccrual Status	-	-	-
4. Amt of Int Inc recognized Using Cash Basis	-	-	-
b. Prior Year			
1. Average Recorded Investment	-	-	-
2. Interest Income Recognized	-	-	-
3. Recorded Investments on Nonaccrual Status	-	-	-
4. Amt of Int Inc recognized Using Cash Basis	-	-	-

(7) Allowance for Credit Losses:	<u>Current Year</u>	<u>Prior Year</u>
a. Balance at beginning of period	\$ -	\$ -
b. Additions charged to operations	-	-
c. Direct write-downs charged against the allowances	-	-
d. Recoveries of amounts previously charged off	-	-
e. Balance at end of period	-	-

- (8) The Company has no mortgage loans derecognized because of foreclosure.
- (9) Interest income on impaired loans is reported as collected when cash is received

NOTES TO FINANCIAL STATEMENTS

5. Investments, continued

B. Debt Restructuring

The Company has no investments involving troubled debt restructurings.

C. Reverse Mortgages

The Company has no investment in reverse mortgages.

D. Loan-Backed Securities

- (1) The Company uses a proprietary model for loss assumptions and widely accepted models for prepayment assumptions in valuing mortgage-backed and asset-backed securities with inputs from major third-party data providers. It combines the effects of interest rates, volatility, and pre-payment speeds based on various scenario simulations (Monte Carlo) with credit loss analysis and resulting effective analytics (spreads, duration, convexity) and cash-flows on a monthly basis. Credit sensitive cash flows are calculated using a proprietary model which estimates future loan defaults in terms of timing and severity. Model assumptions are specific to asset class and collateral types and are regularly evaluated and adjusted where appropriate.
- (2) The Company has no loan-backed securities with a recognized other-than-temporary impairment due to the intent to sell or the inability or lack of intent to retain the investment in the security for a period of time sufficient to recover the amortized cost basis.
- (3) The Company has no loan-backed securities with a recognized other-than-temporary impairments for which the present value of cash flows expected to be collected is less than amortized cost as of December 31, 2019.
- (4) Impaired loan-backed securities for which an other-than-temporary impairment has not been recognized in earnings as a realized loss are as follows:

	Amortized		Fair		Unrealized
	Cost		Value		Loss
					Position
In a continuous loss position less than 12 months	\$ 44,288,723	\$	44,126,191	\$	(162,532)
In a continuous loss position 12 months or longer	15,051,325		14,926,301		(125,024)
Total	\$ 59,340,048	\$	59,052,492	\$	(287,556)

- (5) There are several factors that are considered in determining whether an “other-than-temporary” impairment exists, including but not limited to debt burden, credit ratings, sector, liquidity, financial flexibility, company management, expected earnings and cash flow stream, and economic prospects associated with the investment.

E. Dollar Repurchase Agreements and/or Securities Lending Transactions

The Company has no dollar repurchase agreements and/or securities lending transactions at December 31, 2019.

F. Repurchase Agreements Transactions Accounted for as Secured Borrowing

The Company has no repurchase agreements transactions accounted for as a secured borrowing at December 31, 2019.

G. Reverse Repurchase Agreements Transactions Accounted for as Secured Borrowing

The Company has no reverse repurchase agreements transactions accounted for as a secured borrowing at December 31, 2019.

H. Repurchase Agreements Transactions Accounted for as a Sale

The Company has no repurchase agreements transactions accounted for as a sale at December 31, 2019.

I. Reverse Repurchase Agreements Transactions Accounted for as a Sale

The Company has no reverse repurchase agreements transactions accounted for as a sale at December 31, 2019.

J. Real Estate

The Company has no investment in real estate at December 31, 2019.

K. Low Income Housing Tax Credits (“LIHTC”)

The Company holds no LIHTC property investments at December 31, 2019.

NOTES TO FINANCIAL STATEMENTS

5. Investments, continued

L. Restricted Assets

1) Restricted Assets (including Pledged)

Restricted Asset Category	Gross (Admitted & Nonadmitted) Restricted							Current Year			
	Current Year									Percentage	
	1	2	3	4	5	6	7	8	9	10	11
	Total General Account (G/A)	G/A Supporting S/A Activity (a)	Total Separate Account (S/A) Restricted Assets	S/A Assets Supporting G/A Activity (b)	Total (1 plus 3)	Total From Prior Year	Increase/ (Decrease) (5 minus 6)	Total Nonadmitted Restricted	Total Admitted Restricted (5 minus 8)	Gross (Admitted & Nonadmitted) Restricted to Total Assets (c)	Admitted Restricted to Total Admitted Assets (d)
a. Subject to contractual obligation for which liability is not shown											
b. Collateral held under security lending arrangements											
c. Subject to repurchase agreements											
d. Subject to reverse repurchase agreements											
e. Subject to dollar repurchase agreements											
f. Subject to dollar reverse repurchase agreements											
g. Placed under option contracts											
h. Letter stock or securities restricted as to sale – excluding FHLB capital stock											
i. FHLB capital stock					513,300		67,900		513,300	0.027	27
j. On deposit with states	18,726,442				18,726,442	19,834,582	(1,108,140)		18,726,442	0.979	0.979
k. On deposit with other regulatory bodies											
l. Pledged as collateral to FHLB (including assets backing funding agreements)											
m. Pledged as collateral not captured in other categories											
n. Other restricted assets											
o. Total Restricted Assets	\$ 19,239,742	\$	\$	\$	\$ 19,239,742	\$ 20,279,982	\$(1,040,240)		\$ 19,239,742	1.006	.006

NOTES TO FINANCIAL STATEMENTS

5. Investments, continued

2. Detail of Assets Pledged as Collateral Not Captured in Other Categories (Contracts that Share Similar Characteristics, Such as Reinsurance and Derivatives, Are Reported in the Aggregate)

Description of Assets	Gross (Admitted & Nonadmitted) Restricted						8	Percentage	
	Current Year					6		7	9
	1	2	3	4	5				
	Total General Account (G/A)	G/A Supporting S/A Activity (a)	Total Separate Account (S/A) Restricted Assets	S/A Assets Supporting G/A Activity (b)	Total (1 plus 3)	Total From Prior Year	Increase/ (Decrease) (5 minus 6)	Total Current Year Admitted Restricted	Gross (Admitted & Nonadmitted) Restricted to Total Assets
	\$	\$	\$	\$	\$	\$	\$		
Total (c)	\$	\$	\$	\$	\$	\$	\$		

3. Detail of Other restricted Assets (Contracts that Share Similar Characteristics, Such as Reinsurance and Derivatives, Are Reported in the Aggregate)

Description of Assets	Gross (Admitted & Nonadmitted) Restricted							8	Percentage	
	Current Year					6	7		9	10
	1	2	3	4	5					
	Total General Account (G/A)	G/A Supporting S/A Activity (a)	Total Separate Account (S/A) Restricted Assets	S/A Assets Supporting G/A Activity (b)	Total (1 plus 3)	Total From Prior Year	Increase/ (Decrease) (5 minus 6)	Total Current Year Admitted Restricted	Gross (Admitted & Nonadmitted) Restricted to Total Assets	Admitted Restricted to Total Admitted Assets
	\$	\$	\$	\$	\$	\$	\$			
Total (c)	\$	\$	\$	\$	\$	\$	\$			

4. The Company has no collateral received and reflected as assets within the financial statements.

M. Working Capital Finance Investments

The Company has no working capital finance investments.

N. Offsetting and Netting of Assets and Liabilities

The Company has no derivatives, repurchase and reverse repurchases, securities borrowing and securities lending assets and liabilities that are offset per SSAP No. 64—Offsetting and Netting of Assets and Liabilities.

O. 5GI Securities

The Company had no 5GI securities at December 31, 2019 or 2018.

Investment	Number of 5GI Securities		Aggregate BACV		Aggregate Fair Value	
	Current Year	Prior Year	Current Year	Prior Year	Current Year	Prior Year
Bonds – Actual Cost			\$	\$	\$	\$
Bonds – Fair Value						
Preferred Stock–Actual Cost						
Preferred Stock – Fair Value						
Total			\$	\$	\$	\$

P. Short Sales

The Company had no short sales during 2019.

Q. Prepayment Penalty and Acceleration Fees

The Company had 30 CUSIPs that were called prior to their maturity date in 2019. The securities received proceeds of \$21,082,846 and a book/ adjusted carrying value of \$20,383,245 resulting in a net realized gain of \$699,601.

	General Account
Number of CUSIPs	30
Aggregate Amount of Insurance Income	\$692,010

NOTES TO FINANCIAL STATEMENTS

6. Joint Ventures, Partnerships and Limited Liability Companies

- M. The Company has no investment in joint ventures, partnerships or limited liability companies that exceeds 10% of its admitted assets.
- N. In 2018, the Company recognized other-than-temporary impairments of \$43,264,419 on bond securities, common stock, joint venture, partnerships and limited liability companies within its portfolio. These assets are illiquid private placement investments that are in bankruptcy or work out status for which the fair value was determined based on a liquidation analysis. All the assets in the table below have been nonadmitted as of December 31, 2019.

CUSIP	Description	Actual Cost	Fair Value	Book/Adjusted Carrying Value	Current Year's OTTI Recognized
99Y800BE6	Agera Holdings LLC Equity Interest	\$ 2,978,104	\$ 0	\$ 0	\$ 2,978,104
00119@AA4	Agera	7,500,000	0	0	7,500,000
00119@114	Agera	17,500,000	0	0	17,500,000
99Y801WR2	Agera Parent LLC	2,500,000	0	0	2,500,000
99Y802HM8	Agera Parent LLC	470,000	0	0	470,000
99Y802ZP1	Agera Parent LLC	5,661,500	0	0	5,661,500
76016VAB9	RentPath LLC	2,213,829	0	0	2,213,829
99Y795QL6	Platinum Partners Value Arbitrage	500,000	0	0	500,000
99Y800JH1	Platinum Partners Master Fund	399,548	0	0	399,548
99Y801VN2	Platinum Partners Master Fund	51,000	0	0	51,000
99Y797TA3	Montsant Partners LLC	1,621,035	0	0	1,621,035
99Y798K13	Montsant Partners LLC	378,965	0	0	378,965
99Y802IJ4	Kingdom Energy Resources LLC	930,000	930,000	930,000	489,748
99Y802FD0	Equipment Finance SPE V LLC	7,010,089	7,010,089	7,010,089	1,000,000
608753109	Molycorp Inc	690	0	0	690
TOTAL		\$ 49,714,760	\$ 7,940,089	\$ 7,940,089	\$ 43,264,419

7. Investment Income

The Company did not exclude any due and accrued income from investment income in 2019.

8. Derivative Instruments

The Company did not utilize derivatives in 2018 or 2019.

NOTES TO FINANCIAL STATEMENTS

9. Income Taxes

A. The Company adopted SSAP 101, a replacement of SSAP No. 10R, effective 1/1/2013. Balances and related disclosures are presented pursuant to SSAP 101.

1. Components of Net Deferred Tax Asset

		2019			2018			Change		
		Ordinary	Capital	Total	Ordinary	Capital	Total	Ordinary	Capital	Total
a.	Gross deferred tax assets	283,857,446		328,751,544	200,637,758		246,804,351	83,219,688	(1,272,496)	81,947,192
			44,894,098			46,166,594				
b.	Statutory valuation allowance adjustment	278,854,808	44,894,098	323,748,907	192,106,517	46,166,594	238,273,110	86,748,291	(1,272,496)	85,475,795
c.	Adjusted gross deferred tax assets	5,002,637	0	5,002,637	8,531,241	0	8,531,241	(3,528,603)	0	(3,528,603)
d.	Deferred tax assets non-admitted	0	0	0	0	0	0	0	0	0
e.	Net deferred tax asset	5,002,637	0	5,002,637	8,531,241	0	8,531,241	(3,528,603)	0	(3,528,603)
f.	Deferred tax liabilities	5,002,637	0	5,002,637	8,531,241	0	8,531,241	(3,528,603)	0	(3,528,603)
g.	Net admitted deferred tax asset/(liability)	0	0	0	0	0	0	0	0	0

2. Admission Calculation Components

		2019			2018			Change		
		Ordinary	Capital	Total	Ordinary	Capital	Total	Ordinary	Capital	Total
a.	Federal income taxes paid in prior years recoverable through loss carrybacks	0	0	0	0	0	0	0	0	0
b.	Adjusted gross deferred tax assets expected to be realized	0	0	0	0	0	0	0	0	0
c.	Adjusted gross deferred tax assets offset by gross deferred tax liabilities	0	0	0	0	0	0	0	0	0
g.	Deferred tax assets admitted as the result of SSAP No 101	0	0	0	0	0	0	0	0	0

3.		2019	2018
(a)	Ratio Percentage Used to Determine Recovery Period and Threshold Limitation Amount	(1,533%)	(909%)
(b)	Amount of Adjusted Capital and Surplus Used to Determine Recovery Period and Threshold Limitation	\$ (915,731,212)	\$ (466,814,972)

4. Tax planning strategies did not have an effect on the Company's net admitted deferred tax assets for 2019 or 2018.

B. There are no temporary differences for which deferred tax liabilities are not recognized

NOTES TO FINANCIAL STATEMENTS

9. Income Taxes, continued

C. Current income taxes incurred consist of the following major components:

	2019		2018		Change
1. Current Income Tax					
(a) Federal	\$	(1,632,614)	\$	(463,908)	\$ (1,168,706)
(b) Foreign					
(c) Subtotal	\$	(1,632,614)	\$	(463,908)	\$ (1,168,706)
(d) Federal income tax on net capital gains		-		-	
(e) Utilization of capital loss carryforwards		-		-	
(f) Other		-		-	
(99) Subtotal	\$	(1,632,614)	\$	(463,908)	\$ (1,168,706)
2. Deferred Tax Assets:					
(a) Ordinary					
(1) Discounting of unpaid losses	\$	-	\$	-	\$ -
(2) Unearned premium reserve		-		-	-
(3) Policyholder reserves		165,654,143		112,796,962	52,857,181
(4) Investments		-		-	-
(5) Deferred acquisition costs		9,654,853		11,110,674	(1,455,821)
(6) Policyholder dividends accrual		-		-	-
(7) Fixed assets		-		-	-
(8) Compensation and benefits accrual		-		-	-
(9) Pension accrual		-		-	-
(10) Nonadmitted Assets		2,089,296		4,108,804	(2,019,508)
(11) Net operating loss carry-forward		106,397,361		72,533,393	33,863,967
(12) Tax credit carry-forward		-		-	-
(13) Other (including items <5% of total ordinary tax assets)		61,793		87,925	(26,132)
(99) Subtotal	\$	283,857,446	\$	200,637,758	\$ 83,219,688
(b) Statutory valuation allowance adjustment		(278,854,808)		(192,106,517)	(86,748,282)
(c) Non-admitted		-		-	-
(d) Admitted ordinary deferred tax assets	\$	5,002,637	\$	8,531,241	\$ (3,528,604)
(e) Capital:					
(1) Investments		44,759,823		36,718,851	8,040,972
(2) Net capital loss carry-forward		0		6,723,864	(6,723,864)
(3) Partnerships		134,276		2,723,879	(2,589,603)
(4) Other (including items <5% of total capital tax assets)		-		-	-
(99) Subtotal	\$	44,894,098	\$	46,166,594	\$ (1,272,495)
(f) Statutory valuation allowance adjustment		(44,894,098)		(46,166,594)	1,272,495
(g) Non-admitted		-		-	-
(h) Admitted capital deferred tax assets	\$	-	\$	-	\$ -
(i) Admitted deferred tax assets	\$	5,002,637	\$	8,531,241	\$ (3,528,604)
3. Deferred Tax Liabilities:					
(a) Ordinary:					
(1) Reserves – Transition Adjustment TCJA	\$	4,783,378	\$	7,305,785	\$ (2,522,408)
(2) Accrued dividends		24,375		1,000,491	(976,116)
(3) Deferred and uncollected premium		194,885		224,965	(30,080)
(4) Policyholder reserves		-		-	-
(5) Other (including items <5% of total ordinary tax liabilities)		-		-	-
(99) Subtotal	\$	5,002,637	\$	8,531,241	\$ (3,528,604)
(b) Capital:					
(1) Investments	\$	-	\$	-	\$ -
(2) Real estate		-		-	-
(3) Other (including items <5% of total capital tax liabilities)		-		-	-
(99) Subtotal	\$	-	\$	-	\$ -
(c) Deferred tax liabilities	\$	5,002,637	\$	8,531,241	\$ (3,528,604)
4. Net Deferred tax assets/liabilities:	\$	-	\$	-	\$ -

NOTES TO FINANCIAL STATEMENTS

9. Income Taxes, continued

The valuation allowance adjustments to gross deferred tax assets as of December 31, 2019 and 2018 were \$323,748,907 and \$238,273,110 respectively. The net change in the total valuation allowance adjustments for the year(s) ended December 31, 2019 was \$85,475,796. The AMT Credits will be fully refunded in future periods, due to the Tax Cuts and Jobs Act ("TJCA") that eliminated the corporate AMT for 2018 and future years. As the Company is going to receive a refund for its AMT credits by 2021, the amount is presented in income tax receivable.

D. Among the more significant book to tax adjustments were the following:

The Company's income tax incurred and change in deferred income tax differs from the amount obtained by applying the federal statutory rate of 35% to income before taxes as follows:

	Current Year	Prior Year
(1) Current Income Taxes Incurred	\$ (1,632,614)	\$ (463,908)
(2) Change In Deferred Income Tax (Without Tax on Unrealized Gains and Losses)	-	-
Tax on Capital Gain	1,838,060	
(3) Total Income Tax Reported	\$ 205,446	\$ (463,908)
(4) Income Before Taxes	\$(465,163,973) 21%	\$(496,806,89) 21%
(5) Expected Income Tax Expense (Benefit) at Statutory Rate	(97,684,434)	(104,329,448)
(6) Increase (Decrease) In Actual Tax Reported Resulting From:		
b. Amortization of IMR	668,110	(40,844,617)
c. Section 382 Adjustment	-	-
d. Deferred Tax Benefit on Nonadmitted Assets	2,019,508	696
e. Return to provision	205,446	(9,760,491)
f. Impact of tax reform rate change	-	53,355,419
g. AMT Credit Sequestration	85,475,796	149,480
h. Change in Valuation Allowance	9,521,020	(80,732,174)
i. Other		(652,144)
(7) Total Income Tax Reported	\$ 205,446	\$ (463,908)

E. Operating Loss Carryforwards and Income Taxes Available for Recoupment

- (1) As of December 31, 2019, the Company has a \$256,523,608 operating loss carryforward which will begin to expire in 2031, an \$250,130,490 operating loss carryforward with an indefinite carryforward period and a \$2,060,618 AMT tax credit carryforward, which will be fully refunded by 2021. The Company also has a \$32,018,399 capital loss carryforward, which will begin to expire in 2023.
- (2) The amount of Federal income taxes incurred that are available for recoupment in the event of future net losses are \$0 as the TCJA eliminated loss carrybacks for life insurance companies.
- (3) The aggregate amount of deposits admitted under Section 6603 of the Internal Revenue Code are \$0.

F. Consolidated Federal Income Tax Return

- (1) The Company files a consolidated return with the following entities:

Senior Health Oversight Trust
Fuzion Analytics, Inc.
- (2) The Company is included in a consolidated federal income tax return with its parent company, Senior Health Care Oversight Trust and subsidiary, Fuzion Analytics, Inc. The Company has a written tax sharing agreement, approved by the Pennsylvania Insurance Department, which sets forth the manner in which the total combined federal tax income is allocated to each entity which is a party to the consolidation.

G. The Company does not believe that it is reasonably possible that the liability related to any federal or foreign tax loss contingency will significantly increase within the next 12 months.

NOTES TO FINANCIAL STATEMENTS

10. Information Concerning Parent, Subsidiaries, Affiliates and Other Related Parties

- A. Effective August 20, 2019, Senior Health Oversight Trust (“Oversight Trust”) contributed all of its issued and outstanding stock in its wholly-owned subsidiary, Fuzion Analytics, Inc. (“Fuzion”), to the capital of the Company, resulting in Fuzion becoming a wholly-owned subsidiary of the Company. The Company’s affiliated investment, Fuzion, has a current equity position of \$2,975,269 for December 31, 2019, but is in draft form and could potentially increase by approximately \$1.1 million after the filing of the Company’s Annual Statement.
- B. See Notes 10 F. and 10 I. below.
- C. As of December 31, 2019, the Company recognizes an equity valuation for Fuzion of \$2,975,269.
- D. At December 31, 2019, the Company reported a net receivable from Fuzion of \$49,541.

At December 31, 2019, the Company reported no receivable or payable from/to Oversight Trust.

Intercompany payables and receivables are settled on a monthly basis.
- E. There are no guarantees or undertakings concerning parent, subsidiaries, affiliates or other related parties.
- F. On March 1, 2014, the employees and operating assets of the Company were transferred to Fuzion in connection with the execution of a management services agreement under which Fuzion is responsible for the management of the Company’s closed block of long-term care insurance business. First year fees under this agreement were fixed based on expenses the Company would have been expected to incur in the absence of the agreement. In the second and subsequent years of the agreement, fees decline based on the attrition of the Company’s runoff block of long-term care business, subject to minimum and maximum annual decreases. The Company paid Fuzion \$12,778,644 and \$15,477,760 for services under this agreement in 2019 and 2018, respectively.
- G. See note 10A and 10F. above.
- H. See note 10A and 10F. above.
- I. The Company has no investments in SCA entities that exceeds 10 percent of admitted assets.
- J. The Company did not recognize any impairment write down for its investments in SCA entities during the statement period
- K. The Company has no investments in foreign insurance subsidiaries.
- L. The Company has an investment in downstream noninsurance holding companies, Fuzion Analytics, Inc.
- M.

Balance Sheet Value of All SCA Entities

SCA Entity	Percentage of SCA Ownership	Gross Amount	Admitted Amount	Nonadmitted Amount
a. SSAP No. 97 8a Entities				
b. SSAP No. 97 8b(ii) Entities Fuzion Analytics, Inc	100%	\$ 2,975,269	\$ 2,975,269	\$ -
Total SSAP No 97 8b(ii) Entities		\$ 2,975,269	\$ 2,975,269	\$ -
c. SSAP No. 97 8b(iii) Entities				
d. SSAP No. 97 8b(iv) Entities				
e. Total SSAP No. 97 8b Entities		\$ 2,975,269	\$ 2,975,269	\$ -
f. Aggregate Total (a + e)		\$ 2,975,269	\$ 2,975,269	\$ -

- N. The Company has no investments in Insurance SCA entities.
- O. The Company has no share of losses in SCA entities that exceeds its investment.

11. Debt

- A. The Company has no debt.
- B. In 2015, the Company became a member of the Federal Home Loan Bank (FHLB) of Pittsburgh. To date, the Company has no borrowings with the FHLB.

NOTES TO FINANCIAL STATEMENTS

12. Retirement Plans, Deferred Compensation, Postemployment Benefits and Compensated Absences and Other Postretirement Benefit Plans

A. Defined Benefit Plan

The Company has no defined benefit plan.

B. Not applicable

C. Not applicable

D. Not applicable

E. Not applicable

F. Multiemployer Plans

The Company does not participate in a multiemployer plan.

G. Consolidated/Holding Company Plans

The Company does not participate in consolidated/holding company plans.

H. Postemployment Benefits and Compensated Absences

The Company does not offer post-employment benefits but, pursuant to a contract entered into by Conseco Life, provided health insurance coverage in 2019 for three retirees. This cost of this coverage has not been accrued because these benefits are life-contingent, non-accumulating and cannot be reasonably estimated.

I. Impact of Medicare Modernization Act on Postretirement Benefits

The FASB issued FASB Staff Position (“FSP”) FAS 106-2, “Accounting and Disclosure Requirements Related to the Medicare Prescription Drug, Improvement and Modernization Act of 2003” (“FSP FAS 106-2”) in May 2004. FSP FAS 106-2 provides guidance on accounting for the effects of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (the “Modernization Act”). The Modernization Act provides, among other things, a federal subsidy to plan sponsors who maintain postretirement health care plans that provide prescription drug benefits and meet certain equivalency criteria. FSP FAS 106-2 superseded FSP SAS 106-1, “Accounting and Disclosure Requirements Related to the Medicare Prescription Drug, Improvement and Modernization Act of 2003”. The adoption of FSP FAS 106-2 did not have any impact on the Company’s financial statements.

13. Capital and Surplus, Shareholders’ Dividend Restrictions and Quasi-Reorganizations

- (1) The Company's capital consists of 200,000 common shares authorized and 166,667 issued and outstanding with a par value of \$15 per share.
- (2) The Company has 20,000 preferred shares authorized and 5,000 issued and outstanding, with a stated value of \$1,000 per share.
- (3) The Company may not pay any dividends without the prior written approval of the Pennsylvania Insurance Department.
- (4) The Company paid no dividends to shareholders during 2019.
- (5) See Note No.13 (3) above.
- (6) The Company’s parent, the Oversight Trust, is governed by an independent Board of Trustees comprised of former insurance regulators and financial experts. The Oversight Trust’s purpose is to support the solvency of the Company and the interests of its policyholders. The Company and the Oversight Trust are subject to the oversight of the Pennsylvania Insurance Department in accordance with an order issued by the Pennsylvania Insurance Department on November 12, 2008.
- (7) During 2019, the Company had no advances to surplus.
- (8) During 2019, the Company held no stock for special purposes.
- (9) During 2019, the Company had no special surplus funds.
- (10) As of December 31, 2019, the portion of unassigned funds (surplus) represented or increased by cumulative net unrealized gains was \$828,998.
- (11) The Company issued a surplus note (“Note”) on February 19, 2015 to Beechwood Re Investments, LLC for cash. Payment of principal and interest on the Note is not guaranteed and such payment is subordinated to claims of all policyholders, creditors, and other liabilities of the Company. Interest and principal payments on the Note require prior approval of the Commissioner.

Date Issued	Interest Rate	Par Value	Carrying Value	Interest And Principal Paid Current Year	Total Interest and/or Principal Paid	Unapproved Interest and/or Principal	Date of Maturity
2/19/2015	6.0%	\$50,000,000	\$50,000,000	-	-	\$11,550,000	04/01/2020

- (12,13) The Company has not restated surplus due to a quasi-reorganization.

NOTES TO FINANCIAL STATEMENTS

14. Liabilities, Contingencies and Assessments

A. Contingent Commitments

- (1) The Company has not made any guarantees or undertakings for the benefit of an affiliate that would result in a material contingent exposure of the Company’s or any affiliated insurer’s assets to liability.
- (2) The Company does not have any credit facility commitments at December 31, 2019.
- (3) The Company has two credit facilities with Alliance Bernstein Private Credit Investors Middle Market Direct Lending Fund, L.P. The Company currently has investments of \$22,500,000 and remaining commitments of \$2,250,000 as of December 31, 2019. The Company no longer participates in new investments after December 31, 2018, however, the existing credit facilities may continue to have capital commitments according to the terms of the applicable loan documents. Alliance Bernstein anticipates full repayment of the debt obligations under the existing facilities over the next two years.

B. Assessments

- (1) The Company has recorded a liability of \$52,739 for guaranty fund assessments on several insolvencies as of December 31, 2019. This amount represents estimated obligations to state guaranty funds to provide for covered claims and other insurance obligations of insolvent insurers, net of the estimated offset to future premium taxes. The period over which the assessments are anticipated to be funded varies by insolvency and is difficult to predict.

The Company’s estimate of probable recoveries of prior payments through premium tax credits is \$967,227 and is recorded as an asset. The period over which the credits are realized varies by state but typically ranges from five to ten years.

- (2) Assessments:

Assets recognized from paid and accrued premium tax offsets and policy surcharges, prior year end	\$ 1,448,680
Increases:	
Premium tax offsets recognized from current year assessments paid	\$ 79,112
Decreases:	
Premium tax offsets applied	\$ 201,761
Change in accrued assessment liability	\$ 117,292
Assets recognized from paid and accrued premium tax offsets and policy surcharges, current year end	\$ 1,208,738

- (3) Guaranty Fund Liabilities and Assets Related to Assessments from Insolvencies of Entities that Write Long-Term Care
- a. Discount Rate Applied: Not Applicable
- b. The Undiscounted and Discounted Amount of the Guaranty Fund Assessment and Related Assets by Insolvency are presented in the following table:

Name of the Insolvency	Guaranty Fund Assessment		Related Assets	
	Undiscounted	Discounted	Undiscounted	Discounted
Penn Treaty Network American Insurance Co	\$ 1,156,420	\$ -	\$ 890,073	\$ -
American Network Insurance Co	65,885	-	53,631	-
Senior American Insurance Co	6,830	-	6,584	-
Total	\$ 1,229,136	\$ -	\$ 950,288	\$ -

- c. Number of Jurisdictions, Ranges of Years Used to Discount and Weighted Average Number of Years of the Discounting Time Period for Payables and Recoverables by Insolvency: Not Applicable

C. Gain Contingencies

The Company has not reported all benefits from an Investment Management Services agreement that had a guaranteed return of 5.85% on all assets due to the counterparties inability to fulfill their obligation to pay the interest. However, management continues to proceed in collecting the interest owed to the Company.

D. Claims Related Extra Contractual Obligation (“ECO”) and Bad Faith Losses Stemming From Lawsuits

The Company has no ECO and Bad Faith Losses Stemming from Lawsuits.

E. Joint and Several Liabilities

The Company has no joint and several liability arrangements.

NOTES TO FINANCIAL STATEMENTS

14. Liabilities, Contingencies and Assessments, continued

F. All Other Contingencies

- (1) Various lawsuits against the Company arise in the course of the Company's business. On December 19, 2018, the Receiver for Platinum Partners Credit Opportunities Funds filed an action against the Company, its affiliate Fuzion Analytics, Inc., Beechwood entities and others in the United States District Court for the Southern District of New York captioned *Melanie L. Cyganowski, as Equity Receiver for Platinum Partners Credit Opportunities Master Fund LP, et al. v. Beechwood RE Ltd., et al* ("PPCO Receiver Action"). The Company believes that this claim is not estimable at this time and has been tendered to the Company's insurance carrier. The Company is vigorously defending this matter. SHIP's motion for Summary Judgement was filed on February 14, 2020, which remains pending. In a related action, Company filed third party claims and crossclaims against a number of Beechwood and Platinum individuals and entities on April 19, 2019. Company has reached a settlement in principle for those third party claims and crossclaims. Notwithstanding the foregoing, an unfavorable resolution in the larger PPCO Receiver Action could have an adverse impact on the Company's financial position. The Company has a recorded value of \$3.3 million for the PPCO asset, which could change as a result of the pending litigation.
- (2) On June 24, 2019 the Company was served with a complaint filed on June 7, 2019 by the Joint Official Liquidators of Platinum Partners Value Arbitrage Fund against the Company in Delaware State Court captioned Principal Growth Strategies, LLC, a Delaware limited liability company; Platinum Partners Value Arbitrage Fund L.P. (in Official Liquidation), a Cayman Islands exempted limited partnership; and Martin Trott & Christopher Smith, Joint Official Liquidators of Platinum Partners Value Arbitrage Fund, L.P. (in official liquidation) v. AGH Parent LLC; Senior Health Insurance Company of Pennsylvania, et al. (the "PPVA Action"). Plaintiffs allege that several transactions involving Agera Energy resulted plaintiff Principal Growth Strategies losing its interests in Agera Energy in exchange for worthless Platinum Funds. Plaintiffs allege the Agera-related transactions were conceived by Beechwood and Platinum Partners insiders to benefit alleged Beechwood preferred investor clients, including the Company. The lawsuit has been removed to Delaware federal court, but a motion to remand is pending. The Company believes that this claim is not estimable at this time and it has been tendered to the Company's insurance carrier. The Company plans to vigorously defend this matter. Nevertheless, an unfavorable resolution could have an adverse impact on the Company's financial position.
- (2) On April 10, 2019, David Levy filed a complaint against the Company in the United States District Court for the Southern District of New York captioned David Levy v. Senior Health Insurance Company of Pennsylvania ("Levy advancement action") seeking indemnification and advancement for his legal fees incurred in connection with various third-party actions filed against him, including the above-referenced PPCO Action and PPVA Action, pursuant to provisions in the Investment Management Agreements entered into between the Company and Beechwood entities. Contemporaneously with filing the complaint, Levy also filed a Motion for a Preliminary Injunction seeking the immediate advancement of legal fees incurred by him in connection with the third-party actions. On May 13, 2019, in the preliminary injunction, the court found that Levy is entitled to advancement of third-party claims, but limited fees to only those incurred in defending allegations of conduct by Levy in his role as investment adviser to the Company while an officer of Beechwood. On July 9, 2019, Levy was convicted of fraud and conspiracy to commit fraud in connection with the same scheme for which the court ordered the Company to advance litigation expenses. Following the jury's verdict, the Company moved for and was granted summary judgment in the Levy advancement action on the basis that Levy's criminal conduct eliminated any entitlement to indemnification or advancement. In light of the criminal conviction, on August 7, 2019, the Company filed its notice of appeal of the Preliminary Injunction ruling regarding advancement and posted a bond with the registry of the court in the amount of \$765,630. In late September 2019, the judge in Levy's criminal trial granted Levy a post-trial acquittal, which the government has appealed. In light of the appeal of the criminal action, on January 22, 2020, the parties filed a Joint Motion to Stay the Appeal of the Preliminary Injunction Pending Outcome of Pending Criminal Appeal. On February 20, 2020, the court granted the Company's voluntary dismissal and request to withdraw the \$765,360 from the registry of the Court, plus interest, less any administrative fees. This settlement has not been reflected in the December 31, 2019 financial statement and will be recorded in 2020.
- (3) On May 16, 2019, several Beechwood entities and individuals filed an action for advancement and indemnification for third-party expenses, along with a motion for summary judgment on the advancement claim in the United States District Court of the Southern District of New York captioned BAM et al. v. Senior Health Insurance Company. Similar to the Levy action, the court granted the Beechwood Parties' motion for summary judgment for third-party expenses, which the Company appealed. The parties have reached a settlement in principle which makes the appeal moot. By Order dated February 22, the court ordered that the Company's deposit of \$519,252.81, plus interest, less any administrative fees, be returned. This settlement has not been reflected in the December 31, 2019 financial statement and will be recorded in 2020.
- (4) Under an assignment agreement effective October 1, 2008 with Conseco Life Insurance Company ("Conseco Life"), all the assets and liabilities pertaining to the Company's non-long-term care business were assigned and assumed by Conseco Life. The Company remains contingently liable for the assigned business in the event Conseco Life fails to perform its obligations under the assignment agreement. In recognition of this liability, Conseco Life is required to maintain assets in a trust account of which the Company is beneficiary, with an aggregate fair market value equal to the estimated reserves of the assigned business. Assets are deposited or withdrawn from the trust on a quarterly basis as needed to maintain the aggregate market value of the trust assets. As of December 31, 2019, the required trust amount was \$152,701,732. The market value of trust assets was \$154,131,222.

15. Leases

A. Lessee Leasing Arrangements

- (1) The Company has no lessee leasing arrangements.
- (2) The Company has no initial or remaining noncancelable lessee terms in excess of one year.
- (3) The Company has no sale-leaseback transactions.

B. Lessor Leasing Arrangements

- (1) The Company has no operating leases as a significant part of its business activity.

NOTES TO FINANCIAL STATEMENTS

(2) The Company has no leveraged leases.

16. Information About Financial Instruments with Off-Balance Sheet Risk and Financial Instruments with Concentrations of Credit Risk

The Company does not have any financial instruments with off-balance sheet risk.

17. Sale, Transfer and Servicing of Financial Assets and Extinguishments of Liabilities

- A. During 2019, the Company had no transfers of receivables reported as sales.
- B. Transfer and Servicing of Financial Assets
 - (1) During 2019, the Company had no transfers or servicing of financial assets.
 - (2) During 2019, the Company had no transfers or servicing of financial assets and liabilities.
 - (3) During 2019, the Company had no transfers or servicing of financial assets and liabilities.
 - (4) During 2019, the Company had no asset-backed financing arrangements and similar transfers accounted for as sales.
 - (5) During 2019, the Company had no transfers of financial assets accounted for as secured borrowing.
 - (6) During 2019, the Company had no transfers of receivables with recourse.
 - (7) During 2019, the Company had no securities subject to repurchase and reverse repurchase agreements.
- C. Wash Sales

During 2019, the Company had no securities with NAIC designation 3 or below which were sold and reacquired within 30 days of the sale date.

18. Gain or Loss to the Reporting Entity from Uninsured Plans and the Portion of Partially Insured Plans

- A. The Company does not serve as administrator of any ASO plans.
- B. The Company does not serve as administrator of any ASC plans.
- C. The Company has no Medicare or similarly structured cost-based reimbursement contracts.

19. Direct Premium Written/Produced by Managing General Agents/Third Party Administrators

The Company does not have any direct premiums written by managing general agents or third-party administrators.

NOTES TO FINANCIAL STATEMENTS

20. Fair Value Measurement

A. The Company’s valuation techniques and the inputs used to develop the fair value measurements are as follows:

- Pricing Level 1 – Valuations are based on unadjusted quoted prices in active markets for identical assets that our pricing sources have the ability to access. Since the valuations are based on quoted prices that are readily and regularly available in an active market, valuation of these securities does not entail a significant amount or degree of judgment.
- Pricing Level 2 – Valuations based upon quoted prices for similar assets in active markets, quoted prices for identical or similar assets in inactive markets, or valuations based on models where the significant inputs are observable (e.g. interest rates, yield curves, prepayment speeds, default rates, loss severities), or can be corroborated by observable market data.
- Pricing Level 3 – Valuations that are derived from techniques in which one or more of the significant inputs are unobservable, including broker quotes which are non-binding.

(1) Fair Value Measurement as of December 31, 2019.

<u>Description for each class of asset or liability</u>	<u>Level 1</u>	<u>Level 2</u>	<u>Level 3</u>	<u>Net Asset Value (NAV)</u>	<u>Total</u>
a. Assets carried at fair value					
Bonds					
Industrial & Misc.	\$ -	\$ -	\$ -	\$ -	\$ -
Total Bonds	\$ -	\$ -	\$ -	\$ -	\$ -
Common Stock					
Industrial & Misc. Other	\$ -	\$ 513,300	\$ -	\$ -	\$ 513,300
Industrial & Misc. Publicly Traded	\$ -	\$ -	\$ 89,817	\$ -	\$ 89,817
Parent, Subs, & Affiliates	\$ -	\$ -	\$ 2,975,269	\$ -	\$ 2,975,269
Total Common Stock	\$ -	\$ 513,300	\$ 3,065,086	\$ -	\$ 3,578,386
Money Market Funds					
Exempt Money Market Funds	\$ 41,843,393	\$ -	\$ -	\$ -	\$ 41,843,393
Other Money Market Funds	11,795,000	-	-	-	11,795,000
Total Money Market Funds	\$ 53,638,393	\$ -	\$ -	\$ -	\$ 53,638,393
Total Assets carried at fair value	\$ 53,638,393	\$ 513,300	\$ 3,065,086	\$ -	\$ 57,216,779

(2) Following is a reconciliation of the opening balances to the closing balances for fair value measurements categorized within Level 3 of the fair value hierarchy.

<u>Description</u>	<u>Beginning Balance at 01/01/2019</u>	<u>Transfers into Level 3</u>	<u>Transfers out of Level 3</u>	<u>Total gains and (losses) included in Net Income</u>	<u>Total gains and (losses) included in Surplus</u>	<u>Purchases</u>	<u>Issuances</u>	<u>Sales</u>	<u>Settlements</u>	<u>Ending Balance at 12/31/2019</u>
Assets										
Bonds	\$ -	-	-	-	-	-	-	-	-	-
Common Stock	106,627	-	-	(690)	461,179	2,497,970	-	-	-	3,065,086
Total	\$106,627	-	-	\$(690)	\$461,179	\$2,497,970	-	-	-	\$3,065,086

- (3) Pricing level changes are infrequent and occur when the Company’s widely accepted pricing service provider is not able to determine a price on observable inputs, in which case the Company uses broker quotes which may use unobservable inputs.
- (4) See Note 20 A.
- (5) The Company had no derivative activity in 2019 or 2018.

B. The Company reports only on a statutory basis, hence there are no other fair value disclosures.

NOTES TO FINANCIAL STATEMENTS

20. Fair Value Measurement, continued

C. Aggregate fair value for all financial instruments.

Type of Financial Instrument	Aggregate Fair Value	Admitted Assets	(Level 1)	(Level 2)	(Level 3)	Net Asset Value (NAV)
Bonds	1,803,159,678	1,721,888,231	2,299,806	1,756,233,799	44,626,073	
Common Stock	3,578,386	3,578,386	-	513,300	3,065,086	-
Perpetual Preferred Stock	86,859,728	86,271,292	-	14,716,228	72,143,500	-
Mortgage Loans	13,530,338	12,681,751	-	-	13,530,338	-
Cash Equivalents	53,638,393	53,638,393	53,638,393	-	-	-
Surplus Notes	1,712,669	1,645,981	-	1,712,669	-	-
Other Invested Assets	20,188,946	10,719,726	-	-	20,188,946	-

- D. Not applicable
- E. At December 31, 2019, the Company did not hold any investments using the NAV practical expedient pursuant to SSAP No. 100R – Fair Value.

21. Other Items

A. Unusual or Infrequent Items

During 2019 and 2018, there were no unusual or infrequent items.

B. Troubled Debt Restructuring

The Company had no troubled debt restructuring.

C. Other Disclosures

- (1) Assets with statement values totaling \$18,726,442 and \$19,834,582 at December 31, 2019 and 2018, respectively, were on deposit with government authorities or trustees as required by law.
- (2) The Pennsylvania Department of Insurance has approved a permitted practice to a one-time release of the Interest Maintenance Reserve ("IMR") of \$192,502,234 million effective January 1, 2018. This permitted practice also created a premium deficiency reserve of \$120,000,000 million which ultimately increased surplus a net \$72,576,741 million between the two transactions.
- (3) On September 28, 2018, the Bruckner Investment Trust Class A and Class B Notes were terminated in exchange for the transfer to the Company of Sutton Capital Trust securities and a cash payment. The termination of the Bruckner Class A and B Notes resulted in a net loss to the Company of \$9,916,628.
- (4) In order to meet the Equity Limited Partnership threshold according to the Pennsylvania Investment statute, the Company nonadmitted \$9,916,628 of its holdings in Alliance Bernstein Private Credit Investors Middle Market Direct Lending Fund, L.P. The Company holds this investment at \$19,435,088 based upon the October 31, 2019 statements at fair market value (FMV). The December 31, 2019 financial statements received late February reflect a FMV of \$17,706,269 and the change in value of \$1.7 million will be recorded in 2020.
- (5) On July 24, 2018, Senior Health Insurance Company of Pennsylvania ("SHIP") filed a Complaint in the United States District Court for the Southern District of New York entitled Senior Health Insurance Company of Pennsylvania v. Beechwood Re Ltd., B Asset Manager, L.P., Beechwood Bermuda International, Ltd., Beechwood Re Investments, LLC a/k/a Beechwood Re Investors, LLC, Illumin Capital Management, LP, Moshe M. Feuer a/k/a Mark Feuer, Scott A. Taylor, David I. Levy, Dhruv Narain, and John Does 1-20, Case No. 1:18-cv-6658 (JSR) seeking damages for breach of three Investment Management Agreements, fraud, gross negligence, unjust enrichment, and conspiracy (the "SHIP Action"). SHIP filed amended complaints in the SHIP Action on December 14, 2018 and December 28, 2018. The action is currently stayed as to defendant David Levy due to a pending criminal matter. Fact and expert discovery in the SHIP Action as to the remaining parties is now complete. The final pretrial conference is set for April 2, 2020.

NOTES TO FINANCIAL STATEMENTS

21. Other Items, continued

(6) On July 31, 2019 the Company filed litigation in the United States District Court for the Southern District of New York captioned Senior Health Insurance Company of Pennsylvania v. Lincoln International LLC, Lincoln Advisors LLC. The Company filed a Second Amended Complaint on October 31, 2019 seeking damages for aiding and abetting fraud, aiding and abetting breach of fiduciary duty, conspiracy and contribution and indemnity and unjust enrichment/constructive trust. On February 14, 2020, Defendants moved for Summary Judgement. Company's opposition to Defendants Motion for Summary Judgement is due March 6, 2020.

- D. The Company had no business interruption insurance recoveries.
- E. The Company had no state transferable or non-transferable tax credits at December 31, 2019.
- F. Subprime Mortgage Related Risk Exposure

- (1) The company has exposure to subprime lending in the fixed maturity (bond) investment portfolio, which contains securities collateralized by mortgages that have characteristics of subprime lending such as low FICO score, adjustable rate mortgages and alternative documentation mortgages. These investments are in the form of asset-backed securities and collateralized mortgage obligations which are collateralized by subprime mortgages. The Company reviews its mortgage-backed investments for other than temporary impairments and records losses to the extent it believes it is probable that not all payments due under these investments will be collected subject to the Company's ability and intent to hold these investments to a point of recovery. The risk to subprime mortgage investments is mitigated through portfolio diversification.
- (2) The Company had no direct investments in subprime mortgage loans at December 31, 2019.
- (3) At December 31, 2019, the Company had subprime mortgage related risk exposure through mortgage-backed securities as presented below:

Direct Exposure Through Other Investments:

	Actual Cost	Book/Adjusted Carrying Value (excluding interest)	Fair Value	OTTI Losses Recognized
Residential mortgage-backed securities	\$ 868,704	\$ 854,534	\$ 886,263	\$ -

- (4) The Company does not write Mortgage Guaranty or Financial Guaranty insurance.

- G. The Company has no retained assets for 2019 and 2018.
- H. Insurance-Linked Securities (ILS) Contracts

The Company has no insurance-linked securities (ILS) contracts.

22. Events Subsequent

(A) On February 27, 2019, as required under 40 P.S. §443 (a), SHIP filed its Risk-Based Capital ("RBC") report reflecting total adjusted capital of -\$466,814,972, placing the Company below the "mandatory control level." As a result, on July 30, 2019, a majority of the Oversight Trust Trustees voted to give consent to rehabilitation of the Company and to waive the hearing contemplated by 40 P.S. §221.15. On that same date, a majority of the directors of the Company voted to give consent to rehabilitation of the Company and to waive the hearing contemplated by 40 P.S. §221.15. On January 23, 2020, the Insurance Commissioner of the Commonwealth of Pennsylvania filed an Application in the Commonwealth Court of Pennsylvania seeking to place the Company in rehabilitation pursuant to 40 P.S. §221.1 to §221.63 on the ground that rehabilitation was consented to by the Trustees of the Oversight Trust Trustees and directors of the Company. By Order dated January 29, 2020, the Commonwealth Court of Pennsylvania granted the Application and the Company was placed into rehabilitation.

NOTES TO FINANCIAL STATEMENTS

23. Reinsurance

A. Ceded Reinsurance Report
Section 1 - General Interrogatories

1.

Are any of the reinsurers, listed in Schedule S as non-affiliated, owned in excess of 10% or controlled, either directly or indirectly, by the Company or by any representative, officer, trustee, or director of the Company?
Yes () No (☒) If yes, give full details.
2.

Have any policies issued by the Company been reinsured with a company chartered in a country other than the United States (excluding U.S. Branches of such companies) that is owned in excess of 10% or controlled directly or indirectly by an insured, a beneficiary, a creditor or an insured or any other person not primarily engaged in the insurance business?
Yes () No (☒) If yes, give full details.

Section 2 - Ceded Reinsurance Report - Part A

1.

Does the Company have any reinsurance agreements in effect under which the reinsurer may unilaterally cancel any reinsurance for reasons other than for nonpayment of premium or other similar credits?
Yes () No (☒)

a.

If yes, what is the estimated amount of the aggregate reduction in surplus of a unilateral cancellation by the reinsurer as of the date of this statement, for those agreements in which cancellation results in a net obligation of the Company to the reinsurer, and for which such obligation is not presently accrued? Where necessary, the Company may consider the current or anticipated experience of the business reinsured in making this estimate.

b.

What is the total amount of reinsurance credits taken, whether as an asset or as a reduction of liability, for these agreements in this statement?
2.

Does the Company have any reinsurance agreements in effect such that the amount of losses paid or accrued through the statement date may result in a payment to the reinsurer of amounts that, in aggregate and allowing for offset of mutual credits from other reinsurance agreements with the same reinsurer, exceed the total direct premium collected under the reinsured policies?
Yes () No (☒)
If yes, give full details.

Section 3 - Ceded Reinsurance Report - Part B

1.

What is the estimated amount of the aggregate reduction in surplus, (for agreements other than those under which the reinsurer may unilaterally cancel for reasons other than for nonpayment of premium or other similar credits that are reflected in Section 2 above) of termination of ALL reinsurance agreements, by either party, as of the date of the statement? Where necessary, the Company may consider the current or anticipated experience of the business reinsured in making the estimate. \$0
2.

Have any new agreements been executed, or existing agreements amended, since January 1 of the year of this statement, to include policies or contracts that were in force or which had existing reserves established by the Company as of the effective date of the agreement?
Yes (☐) No (☒)

If yes, what is the amount of reinsurance credits, whether an asset or a reduction of liability, taken for such new agreements or amendments? \$ 0

B. Uncollectible Reinsurance

Effective January 1, 2018, the Roebling reinsurance treaty was terminated, resulting in a write-off of \$11,626,473, all of which was unauthorized in 2017.

C. Commutation of Ceded Reinsurance

During 2019, the Company did not report any income or expenses as a result of commutation of reinsurance.

D. Reporting Entity Ceding to Certified Reinsurer Whose Rating was Downgraded or Status Subject to Revocation

The Company has had no certified reinsurers ratings downgraded or status subject to revocation.

E. The Company has no reinsurance of variable annuity contracts with an affiliated captive reinsurer.

F. The Company has no reinsurance agreements with an affiliated captive reinsurer.

G. The Company does not utilize captives to assume reserves.

24. Retrospectively Rated Contracts & Contracts Subject to Redetermination

The Company has no retrospectively rated contracts or contracts subject to redetermination.

NOTES TO FINANCIAL STATEMENTS

25. Change in Incurred Losses and Loss Adjustment Expenses

Gross of Reinsurance
Reserves as of December 31, 2018 were \$959,644,499. As of December 31, 2019, gross payments of \$317,253,364, discounted to December 31, 2018, have been made for incurred losses and estimated waiver of premium to insured events of prior years. Reserves remaining for prior years are now \$634,244,696, discounted to December 31, 2018, as a result of re-estimation of unpaid claims and claim adjustment expenses on the long- term care line of insurance. Thus, there has been an \$8,146,439 favorable prior year development on an annual basis from December 31, 2018 to December 31, 2019. As additional information becomes known on individual claims experience, the original estimates are adjusted accordingly. None of the Company's accident and health contracts are subject to retrospective rating or experience refunds.

26. Intercompany Pooling Arrangements

The Company is not part of an affiliated intercompany pooling arrangement.

27. Structured Settlements

The Company has not reduced reserves through the purchase of an annuity as part of a structured settlement.

28. Health Care Receivables

The Company has no pharmaceutical rebate receivables or risk sharing receivables.

29. Participating Policies

The Company has no participating policies.

30. Premium Deficiency Reserves

Premium deficiency reserves were necessary.

1) Liability carried for premium deficiency reserves	\$ 636,536,749
2) Date of most recent evaluation of this liability	12/31/2019
3) Was anticipated investment income utilized in the calculation?	Yes [x] No []

31. Reserves for Life Contracts and Deposit-type Contracts

The Company had no life contracts or annuity contracts in force as of December 31, 2019.

32. Analysis of Annuity Actuarial Reserves and Deposit Liabilities by Withdrawal Characteristics

The Company had no annuity contracts in force and had no deposit-type liabilities as of December 31, 2019.

33. Premium and Annuity Considerations Deferred and Uncollected

The Company had no life contracts or annuity contracts in force as of December 31, 2019.

34. Separate Accounts

The Company had no separate accounts at December 31, 2019.

35. Loss/Claim Adjustment Expenses

The balance in the liability for unpaid accident and health claim adjustment expenses as of December 31, 2019 and 2018 was \$20,947,086 and \$21,543,776, respectively. The Company incurred \$10,305,677 on a net basis and paid \$11,090,455 of net claim adjustment expenses in the current year, of which \$1,260,431 of the paid amount was attributable to insured or covered events of prior years. The Company did not increase or decrease the provision for insured events of prior years. The Company does not take into account any anticipated salvage and subrogation in its determination of the liability for unpaid claims/losses.

GENERAL INTERROGATORIES

PART 1 - COMMON INTERROGATORIES

GENERAL

1.1

Is the reporting entity a member of an Insurance Holding Company System consisting of two or more affiliated persons, one or more of which is an insurer?
If yes, complete Schedule Y, Parts 1, 1A and 2.

Yes ☒ No ☐

1.2

If yes, did the reporting entity register and file with its domiciliary State Insurance Commissioner, Director or Superintendent or with such regulatory official of the state of domicile of the principal insurer in the Holding Company System, a registration statement providing disclosure substantially similar to the standards adopted by the National Association of Insurance Commissioners (NAIC) in its Model Insurance Holding Company System Regulatory Act and model regulations pertaining thereto, or is the reporting entity subject to standards and disclosure requirements substantially similar to those required by such Act and regulations?

Yes ☒ No ☐ N/A ☐

1.3

State regulating? PENNSYLVANIA

1.4

Is the reporting entity publicly traded or a member of publicly traded group?

Yes ☐ No ☒

1.5

If the response to 1.4 is yes, provide the CIK (Central Index Key) code issued by the SEC for the entity/group.

2.1

Has any change been made during the year of this statement in the charter, by-laws, articles of incorporation, or deed of settlement of the reporting entity?

Yes ☐ No ☒

2.2

If yes, date of change:

3.1

State as of what date the latest financial examination of the reporting entity was made or is being made.

12/31/2018

3.2

State the as of date that the latest financial examination report became available from either the state of domicile or the reporting entity.
This date should be the date of the examined balance sheet and not the date the report was completed or released.

12/31/2018

3.3

State as of what date the latest financial examination report became available to other states or the public from either the state of domicile or the reporting entity. This is the release date or completion date of the examination report and not the date of the examination (balance sheet date).

12/31/2018

3.4

By what department or departments?
PENNSYLVANIA

3.5

Have all financial statement adjustments within the latest financial examination report been accounted for in a subsequent financial statement filed with departments?

Yes ☐ No ☐ N/A ☒

3.6

Have all of the recommendations within the latest financial examination report been complied with?

Yes ☒ No ☐ N/A ☐

4.1

During the period covered by this statement, did any agent, broker, sales representative, non-affiliated sales/service organization or any combination thereof under common control (other than salaried employees of the reporting entity) receive credit or commissions for or control a substantial part (more than 20 percent of any major line of business measured on direct premiums) of:

4.11

sales of new business?

Yes ☐ No ☒

4.12

renewals?

Yes ☐ No ☒

4.2

During the period covered by this statement, did any sales/service organization owned in whole or in part by the reporting entity or an affiliate, receive credit or commissions for or control a substantial part (more than 20 percent of any major line of business measured on direct premiums) of:

4.21

sales of new business?

Yes ☐ No ☒

4.22

renewals?

Yes ☐ No ☒

5.1

Has the reporting entity been a party to a merger or consolidation during the period covered by this statement?
If the answer is YES, complete and file the merger history data file with the NAIC.

Yes ☐ No ☒

5.2

If yes, provide the name of entity, NAIC company code, and state of domicile (use two letter state abbreviation) for any entity that has ceased to exist as a result of the merger or consolidation.

1	2	3
Name of Entity	NAIC Company Code	State of Domicile

6.1

Has the reporting entity had any Certificates of Authority, licenses or registrations (including corporate registration, if applicable) suspended or revoked by any governmental entity during the reporting period?

Yes ☒ No ☐

6.2

If yes, give full information:
Subsequent to the 2018 Annual Statement filing, certificates of authority in the following states have been suspended: Alaska, Arizona, Idaho, Iowa, Kentuck, Oregon, Virginia, Washington, West Virginia, and Wyoming

7.1

Does any foreign (non-United States) person or entity directly or indirectly control 10% or more of the reporting entity?

Yes ☐ No ☒

7.2

If yes,

7.21

State the percentage of foreign control

7.22

State the nationality(s) of the foreign person(s) or entity(s); or if the entity is a mutual or reciprocal, the nationality of its manager or attorney-in-fact and identify the type of entity(s) (e.g., individual, corporation, government, manager or attorney-in-fact).

1	2
Nationality	Type of Entity

8.1

Is the company a subsidiary of a bank holding company regulated with the Federal Reserve Board?

Yes ☐ No ☒

8.2

If response to 8.1 is yes, please identify the name of the bank holding company.

8.3

Is the company affiliated with one or more banks, thrifts or securities firms?

Yes ☐ No ☒

8.4

If the response to 8.3 is yes, please provide below the names and locations (city and state of the main office) of any affiliates regulated by a federal financial regulatory services agency [i.e. the Federal Reserve Board (FRB), the Office of the Comptroller of the Currency (OCC), the Federal Deposit Insurance Corporation (FDIC) and the Securities Exchange Commission (SEC)] and identify the affiliate's primary federal regulator.

1	2	3	4	5	6
Affiliate Name	Location (City, State)	FRB	OCC	FDIC	SEC

9.

What is the name and address of the independent certified public accountant or accounting firm retained to conduct the annual audit?
Eide Bailly, LLP, 800 Nicollet Mall, Ste. 1300, Minneapolis, MN 55402-7033

10.1

Has the insurer been granted any exemptions to the prohibited non-audit services provided by the certified independent public accountant requirements as allowed in Section 7H of the Annual Financial Reporting Model Regulation (Model Audit Rule), or substantially similar state law or regulation?

Yes ☐ No ☒

10.2

If the response to 10.1 is yes, provide information related to this exemption:

10.3

Has the insurer been granted any exemptions related to other requirements of the Annual Financial Reporting Model Regulation as allowed for in Section 18A of the Model Regulation, or substantially similar state law or regulation?

Yes ☐ No ☒

10.4

If the response to 10.3 is yes, provide information related to this exemption:

GENERAL INTERROGATORIES

PART 1 - COMMON INTERROGATORIES

10.5

Has the reporting entity established an Audit Committee in compliance with the domiciliary state insurance laws?

Yes [X] No [] N/A []

10.6

If the response to 10.5 is no or n/a, please explain:

11.

What is the name, address and affiliation (officer/employee of the reporting entity or actuary/consultant associated with an actuarial consulting firm) of the individual providing the statement of actuarial opinion/certification?
Allen J Schmitz, F.S.A, M.A.A.A. Actuary/Consultant with Milliman, Inc., 15800 West Bluemound Road Suite 100, Brookfield, WI 53005

12.1

Does the reporting entity own any securities of a real estate holding company or otherwise hold real estate indirectly?

Yes [] No [X]

12.11

Name of real estate holding company

12.12

Number of parcels involved

0

12.13

Total book/adjusted carrying value

\$

0

12.2

If yes, provide explanation

13.

FOR UNITED STATES BRANCHES OF ALIEN REPORTING ENTITIES ONLY:

13.1

What changes have been made during the year in the United States manager or the United States trustees of the reporting entity?

13.2

Does this statement contain all business transacted for the reporting entity through its United States Branch on risks wherever located?

Yes [] No []

13.3

Have there been any changes made to any of the trust indentures during the year?

Yes [] No []

13.4

If answer to (13.3) is yes, has the domiciliary or entry state approved the changes?

Yes [] No [] N/A []

14.1

Are the senior officers (principal executive officer, principal financial officer, principal accounting officer or controller, or persons performing similar functions) of the reporting entity subject to a code of ethics, which includes the following standards?

Yes [X] No []

(a)

Honest and ethical conduct, including the ethical handling of actual or apparent conflicts of interest between personal and professional relationships;

(b)

Full, fair, accurate, timely and understandable disclosure in the periodic reports required to be filed by the reporting entity;

(c)

Compliance with applicable governmental laws, rules and regulations;

(d)

The prompt internal reporting of violations to an appropriate person or persons identified in the code; and

(e)

Accountability for adherence to the code.

14.11

If the response to 14.1 is no, please explain:

14.2

Has the code of ethics for senior managers been amended?

Yes [] No [X]

14.21

If the response to 14.2 is yes, provide information related to amendment(s).

14.3

Have any provisions of the code of ethics been waived for any of the specified officers?

Yes [] No [X]

14.31

If the response to 14.3 is yes, provide the nature of any waiver(s).

15.1

Is the reporting entity the beneficiary of a Letter of Credit that is unrelated to reinsurance where the issuing or confirming bank is not on the SVO Bank List?

Yes [] No [X]

15.2

If the response to 15.1 is yes, indicate the American Bankers Association (ABA) Routing Number and the name of the issuing or confirming bank of the Letter of Credit and describe the circumstances in which the Letter of Credit is triggered.

1	2	3	4
American Bankers Association (ABA) Routing Number	Issuing or Confirming Bank Name	Circumstances That Can Trigger the Letter of Credit	Amount
			\$

16.

Is the purchase or sale of all investments of the reporting entity passed upon either by the Board of Directors or a subordinator committee thereof?

Yes [X] No []

17.

Does the reporting entity keep a complete permanent record of the proceedings of its Board of Directors and all subordinate committees thereof?

Yes [X] No []

18.

Has the reporting entity an established procedure for disclosure to its Board of Directors or trustees of any material interest or affiliation on the part of any of its officers, directors, trustees or responsible employees that is in conflict or is likely to conflict with the official duties of such person?

Yes [X] No []

19.

FINANCIAL

19.

Has this statement been prepared using a basis of accounting other than Statutory Accounting Principles (e.g., Generally Accepted Accounting Principles)?

Yes [] No [X]

20.1

Total amount loaned during the year (inclusive of Separate Accounts, exclusive of policy loans):

20.11

To directors or other officers

\$

0

20.12

To stockholders not officers

\$

0

20.13

Trustees, supreme or grand (Fraternal only)

\$

0

20.2

Total amount of loans outstanding at the end of year (inclusive of Separate Accounts, exclusive of policy loans):

20.21

To directors or other officers

\$

0

20.22

To stockholders not officers

0

20.23

Trustees, supreme or grand (Fraternal only)

0

21.1

Were any assets reported in this statement subject to a contractual obligation to transfer to another party without the liability for such obligation being reporting in the statement?

Yes [] No [X]

21.2

If yes, state the amount thereof at December 31 of the current year:

21.21

Rented from others

\$

0

21.22

Borrowed from others

\$

0

21.23

Leased from others

\$

0

21.24

Other

\$

0

22.1

Does this statement include payments for assessments as described in the *Annual Statement Instructions* other than guaranty fund or guaranty association assessments?

Yes [] No [X]

22.2

If answer is yes:

22.21

Amount paid as losses or risk adjustment

\$

0

22.22

Amount paid as expenses

\$

0

22.23

Other amounts paid

\$

0

23.1

Does the reporting entity report any amounts due from parent, subsidiaries or affiliates on Page 2 of this statement?

Yes [X] No []

Annual Statement for the year 2019 of the **Senior Health Insurance Company of Pennsylvania**

GENERAL INTERROGATORIES

PART 1 - COMMON INTERROGATORIES

23.2

If yes, indicate any amounts receivable from parent included in the Page 2 amount:

\$0

INVESTMENT

24.01

Were all the stocks, bonds and other securities owned December 31 of current year, over which the reporting entity has exclusive control, in the actual possession of the reporting entity on said date (other than securities lending programs addressed in 24.03)?

Yes [X]No []

24.02

If no, give full and complete information, relating thereto:

24.03

For security lending programs, provide a description of the program including value for collateral and amount of loaned securities, and whether collateral is carried on or off-balance sheet (an alternative is to reference Note 17 where this information is also provided).

24.04

Does the company's security lending program meet the requirements for a conforming program as outlined in the *Risk-Based Capital Instructions*?

Yes []No []N/A [X]

24.05

If answer to 24.04 is yes, report amount of collateral for conforming programs.

\$0

24.06

If answer to 24.04 is no, report amount of collateral for other programs

\$0

24.07

Does your securities lending program require 102% (domestic securities) and 105% (foreign securities) from the counterparty at the outset of the contract?

Yes []No []N/A [X]

24.08

Does the reporting entity non-admit when the collateral received from the counterparty falls below 100%?

Yes []No []N/A [X]

24.09.

Does the reporting entity or the reporting entity's securities lending agent utilize the Master Securities Lending Agreement (MSLA) to conduct securities lending?

Yes []No []N/A [X]

24.10

For the reporting entity's security lending program, state the amount of the following as of December 31 of the current year:

24.101

Total fair value of reinvested collateral assets reported on Schedule DL, Parts 1 and 2:

\$0

24.102

Total book adjusted/carrying value of reinvested collateral assets reported on Schedule DL, Parts 1 and 2:

\$0

24.103

Total payable for securities lending reported on the liability page:

\$0

25.1

Were any of the stocks, bonds or other assets of the reporting entity owned at December 31 of the current year not exclusively under the control of the reporting entity or has the reporting entity sold or transferred any assets subject to a put option contract that is current in force? (Exclude securities subject to Interrogatory 21.1 and 24.03.)

Yes [X]No []

25.2

If yes, state the amount thereof at December 31 of the current year:

25.21

Subject to repurchase agreements

\$0

25.22

Subject to reverse repurchase agreements

\$0

25.23

Subject to dollar repurchase agreements

\$0

25.24

Subject to reverse dollar repurchase agreements

\$0

25.25

Placed under option agreements

\$0

25.26

Letter stock or securities restricted as sale – excluding FHLB Capital Stock

\$0

25.27

FHLB Capital Stock

\$513,300

25.28

On deposit with states

\$18,762,440

25.29

On deposit with other regulatory bodies

\$0

25.30

Pledged as collateral – excluding collateral pledged to an FHLB

\$0

25.31

Pledged as collateral to FHLB – including assets backing funding agreements

\$0

25.32

Other

\$0

25.3

For category (25.26) provide the following:

1 Nature of Restriction	2 Description	3 Amount
		\$

26.1

Does the reporting entity have any hedging transactions reported on Schedule DB?

Yes []No [X]

26.2

If yes, has a comprehensive description of the hedging program been made available to the domiciliary state?
If no, attach a description with this statement.

Yes []No []N/A [X]

Lines 26.3 through 26.5: FOR LIFE/FRATERNAL REPORTING ENTITIES ONLY:

26.3

Does the reporting entity utilize derivatives to hedge variable annuity guarantees subject to fluctuations as a results of interest rate sensitivity?

Yes []No [X]

26.4

If the response to 26.3 is yes, does the reporting entity utilize:

26.41

Special accounting provision of SSAP No. 108

Yes []No []

26.42

Permitted accounting practice

Yes []No []

26.43

Other accounting guidance

Yes []No []

26.5

By responding yes to 26.41 regarding utilizing the special accounting provisions of SSAP No. 108, the reporting entity attests to the following:

Yes []No []

- The reporting entity has obtained explicit approval from the domiciliary state.
- Hedging strategy subject to the special accounting provisions is consistent with the requirements of VM-21.
- Actuarial certification has been obtained which indicates that the hedging strategy is incorporated within the establishment of VM-21 reserves and provides the impact of the hedging strategy within the Actuarial Guidance Conditional Tail Expectation Amount.
- Financial Officer Certification has been obtained which indicates that the hedging strategy meets the definition of a Clearly Defined Hedging Strategy within VM-21 and the Clearly Defined Hedging Strategy is the hedging strategy being used by the company in its actual day-to-day risk mitigation efforts.

27.1

Were any preferred stocks or bonds owned as of December 31 of the current year mandatorily convertible into equity, or, at the option of the issuer, convertible into equity?

Yes []No [X]

27.2

If yes, state the amount thereof at December 31 of the current year:

\$0

28.

Excluding items in Schedule E-Part 3-Special Deposits, real estate, mortgage loans and investments held physically in the reporting entity's offices, vaults or safety deposit boxes, were all stocks, bonds and other securities, owned throughout the current year held pursuant to a custodial agreement with a qualified bank or trust company in accordance with Section 1, III - General Examination Considerations, F. Outsourcing of Critical Functions, Custodial or Safekeeping Agreements of the NAIC *Financial Condition Examiners Handbook*?

Yes [X]No []

28.01

For agreements that comply with the requirements of the NAIC *Financial Condition Examiners Handbook*, complete the following:

1 Name of Custodian(s)	2 Custodian's Address
The Bank of New York Mellon	1 Wall Street, 14th Floor, New York, NY 10286

28.02

For all agreements that do not comply with the requirements of the NAIC *Financial Condition Examiners Handbook*, provide the name, location and a complete explanation

GENERAL INTERROGATORIES

PART 1 - COMMON INTERROGATORIES

1	2	3
Name(s)	Location(s)	Complete Explanation(s)

28.03 Have there been any changes, including name changes, in the custodian(s) identified in 28.01 during the current year? Yes [] No [X]

28.04 If yes, give full and complete information relating thereto:

1	2	3	4
Old Custodian	New Custodian	Date of Change	Reason

28.05 Investment management – Identify all investment advisors, investment managers, broker/dealers, including individuals that have the authority to make investment decisions on behalf of the reporting entity. For assets that are managed internally by employees of the reporting entity, note as such. ["...that have access to the investment accounts", "... handle securities"].

1	2
Name of Firm or Individual	Affiliation
New England Asset Management	U
Conning Asset Management Company	U
John Robison, Chief Investment Officer	I

28.0597 For those firms/individuals listed in the table for Question 28.05, do any firms/individuals unaffiliated with the reporting entity (i.e. designated with a "U") manage more than 10% of the reporting entity's invested assets? Yes [X] No []

28.0598 For firms/individuals unaffiliated with the reporting entity (i.e. designated with a "U") listed in the table for Question 28.05, does the total assets under management aggregate to more than 50% of the reporting entity's invested assets? Yes [X] No []

28.06 For those firms or individuals listed in the table for 28.05 with an affiliation code of "A" (affiliated) or "U" (unaffiliated), provide the information for the table below.

1	2	3	4	5
Central Registration Depository Number	Name of Firm or Individual	Legal Entity Identifier (LEI)	Registered With	Investment Management Agreement (IMA) Filed
105900	New England Asset Management	JR85E5PS4GQFZTFC1	SEC	No
107423	Conning Asset Management Company	49300Z0GMKK37BDV4	SEC	No

29.1 Does the reporting entity have any diversified mutual funds reported in Schedule D-Part 2 (diversified according to the Securities and Exchange Commission (SEC) in the Investment Company Act of 1940 [Section 5 (b) (1)])? Yes [] No [X]

29.2 If yes, complete the following schedule:

1	2	3
CUSIP	Name of Mutual Fund	Book/Adjusted Carrying Value
		\$
29.2999 TOTAL		\$

29.3 For each mutual fund listed in the table above, complete the following schedule:

1	2	3	4
Name of Mutual Fund (from above table)	Name of Significant Holding of the Mutual Fund	Amount of Mutual Fund's Book/Adjusted Carrying Value Attributable to the Holding	Date of Valuation
		\$	

30. Provide the following information for all short-term and long-term bonds and all preferred stocks. Do not substitute amortized value or statement value for fair value.

		1	2	3
		Statement (Admitted) Value	Fair Value	Excess of Statement over Fair Value (-), or Fair Value over Statement (+)
30.1	Bonds	\$ 1,721,888,236	\$ 1,803,159,706	\$ 81,271,470
30.2	Preferred Stocks	\$ 86,271,292	\$ 86,859,728	\$ 588,436
30.3	Totals	\$ 1,808,159,528	\$ 1,890,019,434	\$ 81,859,906

30.4 Describe the sources or methods utilized in determining the fair values:

See Fair Value Disclosure in Note 20.A of Notes to Financial Statement

31.1 Was the rate used to calculate fair value determined by a broker or custodian for any of the securities in Schedule D? Yes [X] No []

31.2 If the answer to 31.1 is yes, does the reporting entity have a copy of the broker's or custodian's pricing policy (hard copy or electronic copy) for all brokers or custodians used as a pricing source? Yes [] No [X]

31.3 If the answer to 31.2 is no, describe the reporting entity's process for determining a reliable pricing source for purposes of disclosure of fair value for Schedule D: Prices are obtained from the dealer/market makers for these securities. These prices are non-binding but represent the best estimate of fair value per market conditions

32.1 Have all the filing requirements of the Purposes and Procedures Manual of the NAIC Investment Analysis Office been followed? Yes [X] No []

32.2 If no, list exceptions:

33. By self-designating 5GI securities, the reporting entity is certifying the following elements for each self-designation 5GI security:
a. Documentation necessary to permit a full credit analysis of the security does not exist or an NAIC CRP credit rating for an FE or PL security is not available.
b. Issuer or obligor is current on all contracted interest and principal payments.
c. The insurer has an actual expectation of ultimate payment of all contracted interest and principal.
Has the reporting entity self-designated 5GI securities? Yes [] No [X]

34. By self-designating PLGI securities, the reporting entity is certifying the following elements of each self-designated PLGI security:
a. The security was purchased prior to January 1, 2018.
b. The reporting entity is holding capital commensurate with the NAIC Designation reported for the security.
c. The NAIC Designation was derived from the credit rating assigned by an NAIC CRP in its legal capacity as an NRSRO which is shown on a current private letter rating held by the insurer and available for examination by state insurance regulators.

GENERAL INTERROGATORIES

PART 1 - COMMON INTERROGATORIES

- d.

The reporting entity is not permitted to share this credit rating of the PL security with the SVO.
- Has the reporting entity self-designated PLGI securities?

Yes [☐] No [☒]
35.

By assigning FE to a Schedule BA non-registered private fund, the reporting entity is certifying the following elements of each self-designated FE fund:
- a.

The shares were purchased prior to January 1, 2019.
- b.

The reporting entity is holding capital commensurate with the NAIC Designation reported for the security.
- c.

The security had a public credit rating(s) with annual surveillance assigned by an NAIC CRP in its legal capacity as an NRSRO prior to January 1, 2019.
- d.

The fund only or predominantly holds bonds in its portfolio.
- e.

The current reported NAIC Designation was derived from the public credit rating(s) with annual surveillance assigned by an NAIC CRP in its legal capacity as an NRSRO.
- f.

The public credit rating(s) with annual surveillance assigned by an NAIC CRP has not lapsed.
- Has the reporting entity assigned FE to Schedule BA non-registered private funds that complied with the above criteria?

Yes [☐] No [☒]

OTHER

- 36.1

Amount of payments to trade associations, service organizations and statistical or rating bureaus, if any?

\$ 0
- 36.2

List the name of the organization and the amount paid if any such payment represented 25% or more of the total payments to trade associations, service organizations and statistical or rating bureaus during the period covered by this statement.

1 Name	2 Amount Paid
	\$
- 37.1

Amount of payments for legal expenses, if any?

\$ 1,182,189
- 37.2

List the name of the firm and the amount paid if any such payment represented 25% or more of the total payments for legal expenses during the period covered by this statement.

1 Name	2 Amount Paid
Stradley Ronon Stevens & Young LLP	\$ 486,310
- 38.1

Amount of payments for expenditures in connection with matters before legislative bodies, officers or departments of government, if any?

\$ 0
- 38.2

List the name of the firm and the amount paid if any such payment represented 25% or more of the total payment expenditures in connection with matters before legislative bodies, officers or departments of government during the period covered by this statement.

1 Name	2 Amount Paid
	\$

GENERAL INTERROGATORIES

PART 2 – LIFE, ACCIDENT AND HEALTH COMPANIES/FRATERNAL BENEFIT SOCIETIES INTERROGATORIES

Life, Accident and Health Companies/Fraternal Benefit Societies:

1.1	Does the reporting entity have any direct Medicare Supplement Insurance in force?			Yes [☐]	No [☒ X]
1.2	If yes, indicate premium earned on U.S. business only.	\$		0	
1.3	What portion of Item (1.2) is not reported on the Medicare Supplement Insurance Experience Exhibit?	\$		0	
1.3	Reason for excluding:				
1.4	Indicate amount of earned premium attributable to Canadian and/or Other Alien not included in Item (1.2) above.	\$		0	
1.5	Indicate total incurred claims on all Medicare Supplement insurance.	\$		0	
1.6	Individual policies:				
	Most current three years:				
1.61	Total premium earned	\$		0	
1.62	Total incurred claims	\$		0	
1.63	Number of covered lives	\$		0	
	All years prior to most current three years:				
1.64	Total premium earned	\$		0	
1.65	Total incurred claims	\$		0	
1.66	Number of covered lives	\$		0	
1.7	Group policies:				
	Most current three years:				
1.71	Total premium earned	\$		0	
1.72	Total incurred claims	\$		0	
1.73	Number of covered lives	\$		0	
	All years prior to most current three years:				
1.74	Total premium earned	\$		0	
1.75	Total incurred claims	\$		0	
1.76	Number of covered lives	\$		0	
2.	Health Test:				
		1	2		
		Current Year	Prior Year		
2.1	Premium Numerator	\$	0	\$	0
2.2	Premium Denominator	\$	78,564,611	\$	1,237,392,658
2.3	Premium Ratio (2.1/2.2)		0.0%		0.0%
2.4	Reserve Numerator	\$	49,738,445	\$	49,770,059
2.5	Reserve Denominator	\$	2,167,641,605	\$	2,270,616,300
2.6	Reserve Ratio (2.4/2.5)		2.3%		2.2%
3.1	Does the reporting entity have Separate Accounts?			Yes [☐]	No [☒ X]
3.2	If yes, has a Separate Accounts statement been filed with this Department			Yes [☐]	No [☐] N/A[☐]
3.3	What portion of capital and surplus funds of the reporting entity covered by assets in the Separate Accounts statement, is not currently distributable from the Separate Accounts to the general account for use by the general account?	\$		0	
3.4	State the authority under which Separate Accounts are maintained:				
3.5	Was any of the reporting entity's Separate Accounts business reinsured as of December 31?			Yes [☐]	No [☐]
3.6	Has the reporting entity assumed by reinsurance any Separate Accounts business as of December 31?			Yes [☐]	No [☐]
3.7	If the reporting entity has assumed Separate Accounts business, how much, if any, reinsurance assumed receivable for reinsurance of Separate Accounts reserve expense allowances is included as a negative amount in the liability for "Transfers to Separate Accounts due or accrued (net)?"	\$		0	
4.	For reporting entities having sold annuities to another insurer where the insurer purchasing the annuities has obtained a release of liability from the claimant (payee) as the result of the purchase of an annuity from the reporting entity only:				
4.1	Amount of loss reserves established by these annuities during the current year:	\$		0	
4.2	List the name and location of the insurance company purchasing the annuities and the statement value on the purchase date of the annuities.				
		1	2		
		P&C Insurance Company	Statement Value on		
		and	Purchase Date of Annuities		
		Location	(i.e., Present Value)		
5.1	Do you act as a custodian for health savings accounts?			Yes [☐]	No [☒ X]
5.2	If yes, please provide the amount of custodial funds held as of the reporting date.	\$		0	
5.3	Do you act as an administrator for health savings accounts?			Yes [☐]	No [☒ X]
5.4	If yes, please provide the balance of the funds administered as of the reporting date.	\$		0	
6.1	Are any of the captive affiliates reported on Schedule S, Part 3, authorized reinsurers?			Yes [☐]	No [☐] N/A [☒ X]

GENERAL INTERROGATORIES

PART 2 – LIFE, ACCIDENT AND HEALTH COMPANIES/FRATERNAL BENEFIT SOCIETIES INTERROGATORIES

6.2 If the answer to 6.1 is yes, please provide the following:

1 Company Name	2 NAIC Company Code	3 Domiciliary Jurisdiction	4 Reserve Credit	Assets Supporting Reserve Credit		
				5 Letters of Credit	6 Trust Agreements	7 Other
			\$	\$	\$	\$

7. Provide the following for individual ordinary life insurance* policies (U.S. business only) for the current year (prior to reinsurance assumed or ceded).

7.1	Direct premiums written	\$	0
7.2	Total incurred claims	\$	0
7.3	Number of covered lives		0

*Ordinary Life Insurance Includes
Term (whether full underwriting, limited underwriting, jet issue, "short form app")
Whole Life (whether full underwriting, limited underwriting, jet issue, "short form app")
Variable Life (with or without secondary guarantee)
Universal Life (with or without secondary guarantee)
Variable Universal Life (with or without secondary guarantee)

8.	Is the reporting entity licensed or chartered, registered, qualified, eligible or writing business in at least two states?	Yes [X]	No []
8.1	If no, does the reporting entity assume reinsurance business that covers risks residing in at least one state other than the state of domicile of the reporting entity?	Yes []	No []

Life, Accident and Health Companies Only:

9.1	Are personnel or facilities of this reporting entity used by another entity or entities or are personnel or facilities of another entity or entities used by this reporting entity (except for activities such as administration of jointly underwritten group contracts and joint mortality or morbidity studies)?"	Yes [X]	No []
9.2	Net reimbursement of such expenses between reporting entities:		
9.21	Paid	\$	12,778,644
9.22	Received	\$	0
10.1	Does the reporting entity write any guaranteed interest contracts?	Yes []	No [X]
10.2	If yes, what amount pertaining to these items is included in:		
10.21	Page 3, Line 1	\$	0
10.22	Page 4, Line 1	\$	0
11.	For stock reporting entities only:		
11.1	Total amount paid in by stockholders as surplus funds since organization of the reporting entity:	\$	1,198,824,011
12.	Total dividends paid stockholders since organization of the reporting entity:		
12.11	Cash	\$	217,094,930
12.12	Stock	\$	140,004
13.1	Does the reporting entity reinsure any Workers' Compensation Carve-Out business defined as: Reinsurance (including retrocessional reinsurance) assumed by life and health insurers of medical, wage loss and death benefits of the occupational illness and accident exposures, but not the employers liability exposures, of business originally written as workers' compensation insurance.	Yes []	No [X]
13.2	If yes, has the reporting entity completed the <i>Workers' Compensation Carve-Out Supplement</i> to the Annual Statement?	Yes []	No []
13.3	If 13.1 is yes, the amounts of earned premiums and claims incurred in this statement are:		

	1 Reinsurance Assumed	2 Reinsurance Ceded	3 Net Retained
13.31 Earned premium	\$ 0	\$ 0	\$ 0
13.32 Paid claims	\$ 0	\$ 0	\$ 0
13.33 Claim liability and reserve (beginning of year)	\$ 0	\$ 0	\$ 0
13.34 Claim liability and reserve (end of year)	\$ 0	\$ 0	\$ 0
13.35 Incurred claims	\$ 0	\$ 0	\$ 0

13.4 If reinsurance assumed included amounts with attachment points below \$1,000,000, the distribution of the amounts reported in Lines 13.31 and 13.34 for Column (1) are:

	Attachment Point	1 Earned Premium	2 Claim Liability and Reserve
13.41	<\$25,000	\$ 0	\$ 0
13.42	\$25,000 — 99,999	\$ 0	\$ 0
13.43	\$100,000 — 249,999	\$ 0	\$ 0
13.44	\$250,000 — 999,999	\$ 0	\$ 0
13.45	\$1,000,000 or more	\$ 0	\$ 0

13.5	What portion of earned premium reported in 13.31, Column 1 was assumed from pools?	\$	0

Fraternal Benefit Societies Only:

14.	Is the reporting entity organized and conducted on the lodge system, with ritualistic form of work and representative form of government?	Yes []	No []
15.	How often are meetings of the subordinate branches required to be held?		
16.	How are the subordinate branches represented in the supreme or governing body?		
17.	What is the basis of representation in the governing body?		

Annual Statement for the year 2019 of the

Senior Health Insurance Company of Pennsylvania

FIVE-YEAR HISTORICAL DATA

Show amounts in whole dollars only, no cents; show percentages to one decimal place, i.e., 17.6.

\$000 omitted for amounts of life insurance

	1 2019	2 2018	3 2017	4 2016	5 2015
Life Insurance in Force (Exhibit of Life Insurance)					
1. Ordinary - whole life and endowment (Line 34, Col. 4).....					
2. Ordinary - term (Line 21, Col. 4, less Line 34, Col. 4).....					
3. Credit life (Line 21, Col. 6).....					
4. Group, excluding FEGLI/SGLI (Line 21, Col. 9 less Lines 43 & 44, Col. 4).....					
5. Industrial (Line 21, Col. 2).....					
6. FEGLI/SGLI (Lines 43 & 44, Col. 4).....					
7. Total (Line 21, Col. 10).....	0	0	0	0	0
7.1 Total in force for which VM-20 deterministic/stochastic reserves are calculated.....				XXX	XXX
New Business Issued (Exhibit of Life Insurance)					
8. Ordinary - whole life and endowment (Line 34, Col. 2).....					
9. Ordinary - term (Line 2, Col. 4, less Line 34, Col. 2).....					
10. Credit life (Line 2, Col. 6).....					
11. Group (Line 2, Col. 9).....					
12. Industrial (Line 2, Col. 2).....					
13. Total (Line 2, Col. 10).....	0	0	0	0	0
Premium Income - Lines of Business (Exhibit 1-Part 1)					
14. Industrial life (Line 20.4, Col. 2).....					
15.1 Ordinary life insurance (Line 20.4, Col.. 3).....					
15.2 Ordinary individual annuities (Line 20.4, Col. 4).....					
16. Credit life (group and individual) (Line 20.4, Col. 5).....					
17.1 Group life insurance (Line 20.4, Col. 6).....					
17.2 Group annuities (Line 20.4, Col. 7).....					
18.1 A&H - group (Line 20.4, Col. 8).....	1,422,165	25,442,802	1,042,753	(25,926,020)	2,790,823
18.2 A&H - credit (group and individual) (Line 20.4, Col. 9).....					
18.3 A&H - other (Line 20.4, Col. 10).....	77,142,447	1,211,949,856	44,419,490	(1,127,056,295)	133,931,987
19. Aggregate of all other lines of business (Line 20.4, Col. 11).....					
20. Total.....	78,564,611	1,237,392,658	45,462,243	(1,152,982,315)	136,722,811
Balance Sheet (Pages 2 and 3)					
21. Total admitted assets excluding Separate Accounts business (Page 2, Line 26, Col. 3)....	1,907,181,137	2,186,058,273	2,688,468,510	2,744,535,287	2,879,794,716
22. Total liabilities excluding Separate Accounts business (Page 3, Line 26).....	2,823,279,366	2,652,931,248	2,675,819,343	2,716,512,099	2,824,037,145
23. Aggregate life reserves (Page 3, Line 1).....					
23.1 Excess VM-20 deterministic/stochastic reserve over NPR related to Line 7.1.....				XXX	XXX
24. Aggregate A&H reserves (Page 3, Line 2).....	2,766,443,751	2,608,580,649	1,217,465,047	1,296,352,123	2,635,480,160
25. Deposit-type contract funds (Page 3, Line 3).....					
26. Asset valuation reserve (Page 3, Line 24.01).....	206,126	58,003	28,206,999	32,191,000	37,970,000
27. Capital (Page 3, Lines 29 & 30).....	7,500,005	7,500,005	7,500,005	7,500,005	7,500,005
28. Surplus (Page 3, Line 37).....	(923,598,234)	(474,372,980)	5,149,161	20,523,182	48,257,565
Cash Flow (Page 5)					
29. Net cash from operations (Line 11).....	(251,697,543)	(228,071,464)	(180,642,597)	(1,386,055,168)	(172,813,814)
Risk-Based Capital Analysis					
30. Total adjusted capital.....	(915,731,212)	(466,814,972)	40,856,166	60,214,187	93,727,570
31. Authorized control level risk-based capital.....	59,722,365	51,352,310	28,828,614	36,717,738	58,321,985
Percentage Distribution of Cash, Cash Equivalents and Invested Assets (Page 2, Col. 3) (Line No. /Page 2, Line 12, Col. 3) x 100.0					
32. Bonds (Line 1).....	91.3	92.6	72.5	80.5	81.2
33. Stocks (Lines 2.1 and 2.2).....	4.8	5.1	2.9	5.2	3.3
34. Mortgage loans on real estate (Lines 3.1 and 3.2).....	0.7	0.8	1.2	1.8	2.1
35. Real estate (Line 4.1, 4.2 and 4.3).....					
36. Cash, cash equivalents and short-term investments (Line 5).....	2.5	1.0	19.1	6.6	3.1
37. Contract loans (Line 6).....					
38. Derivatives (Line 7).....					
39. Other invested assets (Line 8).....	0.8	0.5	4.2	5.7	10.4
40. Receivables for securities (Line 9).....	0.0		0.0	0.2	
41. Securities lending reinvested collateral assets (Line 10).....					
42. Aggregate write-ins for invested assets (Line 11).....					
43. Cash, cash equivalents and invested assets (Line 12).....	100.0	100.0	100.0	100.0	100.0

Annual Statement for the year 2019 of the

Senior Health Insurance Company of Pennsylvania

FIVE-YEAR HISTORICAL DATA

(continued)

	1 2019	2 2018	3 2017	4 2016	5 2015
Investments in Parent, Subsidiaries and Affiliates					
44. Affiliated bonds (Sch. D Summary, Line 12, Col. 1).....					
45. Affiliated preferred stocks (Sch. D Summary, Line 18, Col. 1).....					
46. Affiliated common stocks (Sch. D Summary, Line 24, Col. 1).....	2,975,269				
47. Affiliated short-term investments (subtotal included in Sch. DA, Verif., Col. 5, Line 10).....					
48. Affiliated mortgage loans on real estate					
49. All other affiliated.....					
50. Total of above Lines 44 to 49.....	2,975,269	0	0	0	0
51. Total investment in parent included in Lines 44 to 49 above.....					
Total Nonadmitted and Admitted Assets					
52. Total nonadmitted assets (Page 2, Line 28, Col. 2).....	9,949,027	19,565,734	55,065	53,950	57,595
53. Total admitted assets (Page 2, Line 28, Col. 3).....	1,907,181,137	2,186,058,273	2,688,468,510	2,744,535,287	2,879,794,716
Investment Data					
54. Net investment income (Exhibit of Net Investment Income).....	69,898,628	81,934,413	100,395,540	148,680,691	159,278,380
55. Realized capital gains (losses) (Page 4, Line 34, Column 1).....	(44,066,405)	(175,822,458)	6,491,743	(23,658,295)	10,206,450
56. Unrealized capital gains (losses) (Page 4, Line 38, Column 1).....	842,233	131,852	3,163,766	6,180,235	(15,016,725)
57. Total of above Lines 54, 55 and 56.....	26,674,456	(93,756,193)	110,051,048	131,202,632	154,468,106
Benefits and Reserve Increase (Page 6)					
58. Total contract/certificate benefits - life (Lines 10, 11, 12, 13, 14 and 15, Col. 1 minus Lines 10, 11, 12, 13, 14 and 15, Cols. 6, 7 & 8).....					
59. Total contract/certificate benefits - A&H (Lines 13 & 14, Col. 6).....	371,758,091	390,323,186	199,171,910	308,511,558	413,521,598
60. Increase in life reserves - other than group and annuities (Line 19, Col. 2).....					
61. Increase in A&H reserves (Line 19, Col. 6).....	157,863,106	1,391,115,603	(78,887,076)	(1,339,128,038)	(100,507,596)
62. Dividends to policyholders and refunds to members (Line 30, Col 1).....					
Operating Percentages					
63. Insurance expense percent (Page 6, Col. 1, Lines 21, 22, & 23 less Line (6) / (Page 6, Col. 1, Line 1 plus Exhibit 7, Col. 2, Line 2) x 100.00.....	44.6	3.2	47.7	(2.7)	29.4
64. Lapse percent (ordinary only) [(Exhibit of Life Insurance, Col. 4, Lines 14 & 15) / 1/2 (Exhibit of Life Insurance, Col. 4, Lines 1 & 21)] x 100.00.....					
65. A&H loss percent (Schedule H, Part 1, Lines 5 & 6, Col. 2).....	659.3	51.5	259.1	89.2	263.6
66. A&H cost containment percent (Schedule H, Part 1, Line 4, Col. 2).....	0.2	0.0	1.2	(0.1)	0.3
67. A&H expense percent excluding cost containment expenses (Schedule H, Part 1, Line 10, Col. 2).....	48.1	3.4	49.7	(2.9)	30.7
A&H Claim Reserve Adequacy					
68. Incurred losses on prior years' claims - group health (Sch. H, Part 3, Line 3.1, Col. 2).....	21,441,957	23,710,984	12,030,545	16,093,686	26,958,966
69. Prior years' claim liability and reserve - group health (Sch. H, Part 3, Line 3.2, Col. 2).....	23,338,313	22,699,092	11,990,691	26,759,010	24,321,970
70. Incurred losses on prior years' claims - health other than group (Sch. H, Part 3, Line 3.1, Col. 1 less Col. 2).....	961,510,874	981,095,409	511,372,752	611,712,185	1,004,808,131
71. Prior years' claim liability and reserve - health other than group (Sch. H, Part 3, Line 3.2, Col. 1 less Col. 2).....	935,631,618	909,860,269	484,840,984	958,623,938	958,289,818
Net Gains From Operations After Dividends to Policyholders/Members' Refunds and Federal Income Taxes by Lines of Business (Page 6.x, Line 33)					
72. Industrial life (Page 6.1, Col. 2).....					
73. Ordinary - life (Page 6.1, Col. 1 less Cols. 2, 10 and 12).....					
74. Ordinary - individual annuities (Page 6, Col. 4).....					
75. Ordinary - supplementary contracts.....	XXX				
76. Credit life (Page 6.1, Col. 10 plus Page 6.2, Col. 7).....					
77. Group life (Page 6.2, Col. 1 less Col. 7 less Col. 9).....					
78. Group annuities (Page 6, Col. 5).....					
79. A&H - group (Page 6.5, Col. 3).....		(5,330,981)	(737,443)	1,168,637	(4,122,548)
80. A&H - credit (Page 6.5, Col. 10).....					
81. A&H - other (Page 6.5, Col. 1 less Cols. 3 and 10).....	(417,967,639)	(318,765,355)	(19,704,154)	(23,507,603)	(15,105,585)
82. Aggregate of all other lines of business (Page 6, Col. 8).....					
83. Fraternal (Page 6, Col. 7).....					
84. Total (Page 6, Col. 1).....	(417,967,639)	(324,096,336)	(20,441,597)	(22,338,965)	(19,228,134)

NOTE: If a party to a merger, have the two most recent years of this exhibit been restated due to a merger in compliance with the disclosure requirements of SSAP No. 3, Accounting Changes and Correction of Errors?

Yes [] No []

If no, please explain:



DIRECT BUSINESS IN GRAND TOTAL DURING THE YEAR
NAIC Group Code.....0 NAIC Company Code.....76325

LIFE INSURANCE

	1	2	3	4	5
	Ordinary	Credit Life (Group and Individual)	Group	Industrial	Total
DIRECT PREMIUMS AND ANNUITY CONSIDERATIONS					
1. Life insurance.....					0
2. Annuity considerations.....					0
3. Deposit-type contract funds.....		XXX		XXX	0
4. Other considerations.....					0
5. Totals (Sum of Lines 1 to 4).....	0	0	0	0	0
DIRECT DIVIDENDS TO POLICYHOLDERS/REFUNDS TO MEMBERS					
Life insurance:					
6.1 Paid in cash or left on deposit.....					0
6.2 Applied to pay renewal premiums.....					0
6.3 Applied to provide paid-up additions or shorten the endowment or premium-paying period.....					0
6.4 Other.....					0
6.5 Totals (Sum of Lines 6.1 to 6.4).....	0	0	0	0	0
Annuities:					
7.1 Paid in cash or left on deposit.....					0
7.2 Applied to provide paid-up annuities.....					0
7.3 Other.....					0
7.4 Totals (Sum of Lines 7.1 to 7.3).....	0	0	0	0	0
8. Grand Totals (Lines 6.5 + 7.4).....	0	0	0	0	0
DIRECT CLAIMS AND BENEFITS PAID					
9. Death benefits.....					0
10. Matured endowments.....					0
11. Annuity benefits.....					0
12. Surrender values and withdrawals for life contracts.....					0
13. Aggregate write-ins for miscellaneous direct claims and benefits paid.....	0	0	0	0	0
14. All other benefits, except accident and health.....					0
15. Totals.....	0	0	0	0	0

DETAILS OF WRITE-INS

1301.					0
1302.					0
1303.					0
1398. Summary of remaining write-ins for Line 13 from overflow page.....	0	0	0	0	0
1399. Total (Lines 1301 through 1303 plus 1398)(Line 13 above).....	0	0	0	0	0

	Ordinary		Credit Life (Group and Individual)		Group		Industrial		Total	
	1	2	3	4	5	6	7	8	9	10
	No. of Pols. & Certifs.	Amount	No. of Ind. Pols. & Gr. Certifs.	Amount	No. of Certifs.	Amount	No. of Pols. & Certifs.	Amount	No. of Pols. & Certifs.	Amount
DIRECT DEATH BENEFITS AND MATURED ENDOWMENTS INCURRED										
16. Unpaid December 31, prior year.....									0	0
17. Incurred during current year.....									0	0
Settled during current year:										
18.1 By payment in full.....									0	0
18.2 By payment on compromised claims.....									0	0
18.3 Totals paid.....	0	0	0	0	0	0	0	0	0	0
18.4 Reduction by compromise.....									0	0
18.5 Amount rejected.....									0	0
18.6 Total settlements.....	0	0	0	0	0	0	0	0	0	0
19. Unpaid Dec. 31, current year (Lines 16 + 17 - 18.6).....	0	0	0	0	0	0	0	0	0	0
POLICY EXHIBIT					No. of Pol.					
20. In force December 31, prior year.....				(a).....					0	0
21. Issued during year.....									0	0
22. Other changes to in force (Net).....									0	0
23. In force December 31 of current year.....	0	0	0	(a).....0	0	0	0	0	0	0

(a) Includes Individual Credit Life Insurance, prior year \$.....0 current year \$.....0.
Includes Group Credit Life Insurance Loans less than or equal to 60 months at issue, prior year \$.....0 current year \$.....0.
Loans greater than 60 months at issue BUT NOT GREATER THAN 120 MONTHS, prior year \$.....0 current year \$.....0.

ACCIDENT AND HEALTH INSURANCE

	1	2	3	4	5
	Direct Premiums	Direct Premiums Earned	Policyholder Dividends Paid, Refunds to Members or Credited on Direct Business	Direct Losses Paid	Direct Losses Incurred
24. Group policies (b).....	553,440	696,731		4,931,308	4,480,908
24.1 Federal Employee Health Benefits Plan premium (b).....					
24.2 Credit (group and individual).....					
24.3 Collectively renewable policies/certificates (b).....					
24.4 Medicare Title XVIII exempt from state taxes or fees.....					
Other Individual Policies:					
25.1 Non-cancelable (b).....					
25.2 Guaranteed renewable (b).....	58,544,203	75,086,483		338,322,153	314,349,936
25.3 Non-renewable for stated reasons only (b).....	22,491	23,526		40,565	(8,412)
25.4 Other accident only.....					
25.5 All other (b).....					
25.6 Totals (Sum of Lines 25.1 to 25.5).....	58,566,694	75,110,009	0	338,362,718	314,341,524
26. Totals (Lines 24 + 24.1 + 24.2 + 24.3 + 24.4 + 25.6).....	59,120,134	75,806,740	0	343,294,026	318,822,432

(b) For health business on indicated lines report: Number of persons insured under PPO managed products.....0 and number of persons insured under indemnity only products.....0.

Annual Statement for the year 2019 of the **Senior Health Insurance Company of Pennsylvania**

EXHIBIT OF NUMBER OF POLICIES, CONTRACTS, CERTIFICATES, INCOME PAYABLE
AND ACCOUNT VALUES IN FORCE FOR SUPPLEMENTARY CONTRACTS,
ANNUITIES, ACCIDENT & HEALTH AND OTHER POLICIES

SUPPLEMENTARY CONTRACTS

	Ordinary		Group	
	1 Involving Life Contingencies	2 Not Involving Life Contingencies	3 Involving Life Contingencies	4 Not Involving Life Contingencies
1. In force end of prior year.....	.....	.....	.....	.....
2. Issued during year.....	.....	.....	.....	.....
3. Reinsurance assumed.....	.....	.....	.....	.....
4. Increased during year (net).....	.....	.....	.....	.....
5. Total (Lines 1 to 4).....	0	0	0	0
Deductions during year:				
6. Decreased (net).....	.....	.....	.....	.....
7. Reinsurance ceded.....	.....	.....	.....	.....
8. Totals (Lines 6 and 7).....	0	0	0	0
9. In force end of year.....	0	0	0	0
10. Amount on deposit.....	(a).....			(a).....
11. Income now payable.....				
12. Amount of income payable.....	(a).....	(a).....	(a).....	(a).....

ANNUITIES

	Ordinary		Group	
	1 Immediate	2 Deferred	3 Contracts	4 Certificates
1. In force end of prior year.....	.....	.....	.....	.....
2. Issued during year.....	.....	.....	.....	.....
3. Reinsurance assumed.....	.....	.....	.....	.....
4. Increased during year (net).....	.....	.....	.....	.....
5. Total (Lines 1 to 4).....	0	0	0	0
Deductions during year:				
6. Decreased (net).....	.....	.....	.....	.....
7. Reinsurance ceded.....	.....	.....	.....	.....
8. Totals (Lines 6 and 7).....	0	0	0	0
9. In force end of year.....	0	0	0	0
Income now payable:				
10. Amount of income payable.....	(a).....	XXX.....	XXX.....	(a).....
Deferred fully paid:				
11. Account balance.....	XXX.....	(a).....	XXX.....	(a).....
Deferred not fully paid:				
12. Account balance.....	XXX.....	(a).....	XXX.....	(a).....

ACCIDENT AND HEALTH INSURANCE

	Group		Credit		Other	
	1 Certificates	2 Premiums in force	3 Policies	4 Premiums in force	5 Policies	6 Premiums in force
1. In force end of prior year.....	1,294	1,616,781	.....	.....	.....48,649	86,663,119
2. Issued during year.....	.....	.....	.....	.....	.....	.....
3. Reinsurance assumed.....	.....	.....	.....	.....	.....	.....
4. Increased during year (net).....	.....	.....XXX.....	.....	.....XXX.....	.....	.....XXX.....
5. Total (Lines 1 to 4).....	1,294	XXX.....	0	XXX.....	48,649	XXX.....
Deductions during year:						
6. Conversions.....	235	XXX.....	XXX.....	XXX.....	XXX.....	XXX.....
7. Decreased (net).....	.....	.....XXX.....	.....	.....XXX.....	5,520	XXX.....
8. Reinsurance ceded.....	.....	.....XXX.....	.....	.....XXX.....	.....	.....XXX.....
9. Totals (Lines 6 to 8).....	235	XXX.....	0	XXX.....	5,520	XXX.....
10. In force end of year.....	1,059	(a).....1,308,714	0	(a).....	43,129	(a).....74,333,137

DEPOSIT FUNDS AND DIVIDEND ACCUMULATIONS

	1 Deposit Funds	2 Dividend Accumulations
	Contracts	Contracts
1. In force end of prior year.....	.....	.....
2. Issued during year.....	.....	.....
3. Reinsurance assumed.....	.....	.....
4. Increased during year (net).....	.....	.....
5. Total (Lines 1 to 4).....	0	0
Deductions during year:		
6. Decreased (net).....	.....	.....
7. Reinsurance ceded.....	.....	.....
8. Totals (Lines 6 and 7).....	0	0
9. In force end of year.....	0	0
10. Amount of account balance.....	(a).....	(a).....

(a) See the Annual Audited Financial Reports section of the Annual Statement Instructions.

Annual Statement for the year 2019 of the

Senior Health Insurance Company of Pennsylvania

FORM FOR CALCULATING THE INTEREST MAINTENANCE RESERVE

Interest Maintenance Reserve

	1 Amount
1. Reserve as of December 31, prior year.....	1,564,865
2. Current year's realized pre-tax capital gains/(losses) of \$.....4,656,834 transferred into the reserve net of taxes of \$....(977,935).....	3,678,897
3. Adjustment for current year's liability gains/(losses) released from the reserve.....	0
4. Balance before reduction for amount transferred to Summary of Operations (Line 1 + Line 2 + Line 3).....	5,243,762
5. Current year's amortization released to Summary of Operations (Amortization, Line 1, Column 4).....	497,421
6. Reserve as of December 31, current year (Line 4 minus Line 5).....	4,746,341

Amortization

Year of Amortization	1 Reserve as of December 31, Prior Year	2 Current Year's Realized Capital Gains/(Losses) Transferred into the Reserve Net of Taxes	3 Adjustment for Current Year's Liability Gains/(Losses) Released from the Reserve	4 Balance Before Reduction for the Current Year's Amortization (Cols. 1 + 2 + 3)
1. 2019.....	152,863	344,558		497,421
2. 2020.....	102,734	644,106		746,840
3. 2021.....	87,317	598,744		686,061
4. 2022.....	70,864	504,117		574,981
5. 2023.....	53,661	408,186		461,847
6. 2024.....	48,782	309,763		358,545
7. 2025.....	58,169	233,921		292,090
8. 2026.....	66,394	190,939		257,333
9. 2027.....	76,165	144,297		220,462
10. 2028.....	85,726	95,701		181,427
11. 2029.....	90,433	43,915		134,348
12. 2030.....	85,715	17,795		103,510
13. 2031.....	82,562	15,424		97,986
14. 2032.....	77,862	13,102		90,964
15. 2033.....	75,301	10,458		85,759
16. 2034.....	67,396	7,987		75,383
17. 2035.....	56,934	6,745		63,679
18. 2036.....	45,989	6,745		52,734
19. 2037.....	34,153	6,893		41,046
20. 2038.....	22,854	7,029		29,883
21. 2039.....	16,482	7,017		23,499
22. 2040.....	16,523	7,240		23,763
23. 2041.....	16,097	7,561		23,658
24. 2042.....	16,326	7,722		24,048
25. 2043.....	15,956	8,205		24,161
26. 2044.....	14,667	8,366		23,033
27. 2045.....	11,674	7,883		19,557
28. 2046.....	8,381	6,274		14,655
29. 2047.....	5,089	4,505		9,594
30. 2048.....	1,796	2,734		4,530
31. 2049 and Later.....		965		965
32. Total (Lines 1 to 31).....	1,564,865	3,678,897	0	5,243,762

ASSET VALUATION RESERVE

	Default Component			Equity Component			7 Total Amount (Cols. 3 + 6)
	1 Other Than Mortgage Loans	2 Mortgage Loans	3 Total (Cols. 1 + 2)	4 Common Stock	5 Real Estate and Other Invested Assets	6 Total (Cols. 4 + 5)	
1. Reserve as of December 31, prior year.....	0	58,003	58,003	0	0	0	58,004
2. Realized capital gains/(losses) net of taxes - General Account.....	(26,746,425)		(26,746,425)	167,638	(7,552,704)	(7,385,066)	(34,131,491)
3. Realized capital gains/(losses) net of taxes - Separate Accounts.....			0			0	0
4. Unrealized capital gains/(losses) - net of deferred taxes - General Account.....	301,032		301,032	84,644		84,644	385,676
5. Unrealized capital gains/(losses) - net of deferred taxes - Separate Accounts.....			0			0	0
6. Capital gains credited/(losses charged) to contract benefits, payments or reserves.....			0			0	0
7. Basic contribution.....	2,698,383	29,414	2,727,797		823	823	2,728,620
8. Accumulated balances (Lines 1 through 5, minus 6 plus 7).....	(23,747,010)	87,417	(23,659,593)	252,282	(7,551,881)	(7,299,599)	(30,959,192)
9. Maximum reserve.....	15,336,443	133,838	15,470,281	601,632	2,079,198	2,680,831	18,151,112
10. Reserve objective.....	10,013,298	102,680	10,115,978	599,784	2,076,400	2,676,185	12,792,163
11. 20% of (Line 10 minus Line 8).....	6,752,062	3,053	6,755,114	69,500	1,925,656	1,995,157	8,750,271
12. Balance before transfers (Lines 8 + 11).....	(16,994,948)	90,469	(16,904,479)	321,783	(5,626,225)	(5,304,442)	(22,208,921)
13. Transfers.....	45,235	(45,235)	(0)	(160,891)	160,891	(0)	(1)
14. Voluntary contribution.....			0			0	0
15. Adjustment down to maximum/up to zero.....	16,949,714		16,949,714		5,465,334	5,465,334	22,415,048
16. Reserve as of December 31, current year (Lines 12 + 13 + 14 + 15).....	0	45,234	45,235	160,891	0	160,892	206,126

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ASSET VALUATION RESERVE

Basic Contribution, Reserve Objective and Maximum Reserve Calculations

Default Component

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Line Number	NAIC Desig- nation	Description	1	2	3	4	Basic Contribution		Reserve Objective		Maximum Reserve	
			Book/Adjusted Carrying Value	Reclassify Related Party Encumbrances	Add Third Party Encumbrances	Balance for AVR Reserve Calculations (Cols. 1 + 2 + 3)	5	6	7	8	9	10
							Factor	Amount (Cols. 4 x 5)	Factor	Amount (Cols. 4 x 7)	Factor	Amount (Cols. 4 x 9)
LONG-TERM BONDS												
1		Exempt obligations.....	23,648,054	XXX	XXX	23,648,054	0.0000	0	0.0000	0	0.0000	0
2	1	Highest quality.....	1,236,645,801	XXX	XXX	1,236,645,801	0.0005	618,323	0.0016	1,978,633	0.0033	4,080,931
3	2	High quality.....	410,591,075	XXX	XXX	410,591,075	0.0021	862,241	0.0064	2,627,783	0.0106	4,352,265
4	3	Medium quality.....	14,285,525	XXX	XXX	14,285,525	0.0099	141,427	0.0263	375,709	0.0376	537,136
5	4	Low quality.....	19,255,293	XXX	XXX	19,255,293	0.0245	471,755	0.0572	1,101,403	0.0817	1,573,157
6	5	Lower quality.....	6,462,482	XXX	XXX	6,462,482	0.0630	407,136	0.1128	728,968	0.1880	1,214,947
7	6	In or near default.....	11,000,000	XXX	XXX	11,000,000	0.0000	0	0.2370	2,607,000	0.2370	2,607,000
8		Total unrated multi-class securities acquired by conversion.....		XXX	XXX	0	XXX		XXX		XXX	
9		Total long-term bonds (sum of Lines 1 through 8).....	1,721,888,230	XXX	XXX	1,721,888,230	XXX	2,500,882	XXX	9,419,496	XXX	14,365,436
PREFERRED STOCKS												
10	1	Highest quality.....		XXX	XXX	0	0.0005	0	0.0016	0	0.0033	0
11	2	High quality.....	84,177,542	XXX	XXX	84,177,542	0.0021	176,773	0.0064	538,736	0.0106	892,282
12	3	Medium quality.....	2,093,750	XXX	XXX	2,093,750	0.0099	20,728	0.0263	55,066	0.0376	78,725
13	4	Low quality.....		XXX	XXX	0	0.0245	0	0.0572	0	0.0817	0
14	5	Lower quality.....		XXX	XXX	0	0.0630	0	0.1128	0	0.1880	0
15	6	In or near default.....		XXX	XXX	0	0.0000	0	0.2370	0	0.2370	0
16		Affiliated life with AVR.....		XXX	XXX	0	0.0000	0	0.0000	0	0.0000	0
17		Total preferred stocks (sum of Lines 10 through 16).....	86,271,292	XXX	XXX	86,271,292	XXX	197,501	XXX	593,802	XXX	971,007
SHORT-TERM BONDS												
18		Exempt obligations.....		XXX	XXX	0	0.0000	0	0.0000	0	0.0000	0
19	1	Highest quality.....		XXX	XXX	0	0.0005	0	0.0016	0	0.0033	0
20	2	High quality.....		XXX	XXX	0	0.0021	0	0.0064	0	0.0106	0
21	3	Medium quality.....		XXX	XXX	0	0.0099	0	0.0263	0	0.0376	0
22	4	Low quality.....		XXX	XXX	0	0.0245	0	0.0572	0	0.0817	0
23	5	Lower quality.....		XXX	XXX	0	0.0630	0	0.1128	0	0.1880	0
24	6	In or near default.....		XXX	XXX	0	0.0000	0	0.2370	0	0.2370	0
25		Total short-term bonds (sum of Lines 18 through 24).....	0	XXX	XXX	0	XXX	0	XXX	0	XXX	0
DERIVATIVE INSTRUMENTS												
26		Exchange traded.....		XXX	XXX	0	0.0005	0	0.0016	0	0.0033	0
27	1	Highest quality.....		XXX	XXX	0	0.0005	0	0.0016	0	0.0033	0
28	2	High quality.....		XXX	XXX	0	0.0021	0	0.0064	0	0.0106	0
29	3	Medium quality.....		XXX	XXX	0	0.0099	0	0.0263	0	0.0376	0
30	4	Low quality.....		XXX	XXX	0	0.0245	0	0.0572	0	0.0817	0
31	5	Lower quality.....		XXX	XXX	0	0.0630	0	0.1128	0	0.1880	0
32	6	In or near default.....		XXX	XXX	0	0.0000	0	0.2370	0	0.2370	0
33		Total derivative instruments.....	0	XXX	XXX	0	XXX	0	XXX	0	XXX	0
34		Total (Lines 9 + 17 + 25 + 33).....	1,808,159,522	XXX	XXX	1,808,159,522	XXX	2,698,383	XXX	10,013,298	XXX	15,336,443

ASSET VALUATION RESERVE (continued)

Basic Contribution, Reserve Objective and Maximum Reserve Calculations

Default Component

Line Number	NAIC Desig- nation	Description	1	2	3	4	Basic Contribution		Reserve Objective		Maximum Reserve	
			Book/Adjusted Carrying Value	Reclassify Related Party Encumbrances	Add Third Party Encumbrances	Balance for AVR Reserve Calculations (Cols. 1 + 2 + 3)	5	6	7	8	9	10
							Factor	Amount (Cols. 4 x 5)	Factor	Amount (Cols. 4 x 7)	Factor	Amount (Cols. 4 x 9)
		MORTGAGE LOANS										
		In good standing:										
35		Farm mortgages - CM1 - highest quality.....			XXX.....	0	0.0011	0	0.0057	0	0.0074	0
36		Farm mortgages - CM2 - high quality.....			XXX.....	0	0.0040	0	0.0114	0	0.0149	0
37		Farm mortgages - CM3 - medium quality.....			XXX.....	0	0.0069	0	0.0200	0	0.0257	0
38		Farm mortgages - CM4 - low medium quality.....			XXX.....	0	0.0120	0	0.0343	0	0.0428	0
39		Farm mortgages - CM5 - low quality.....			XXX.....	0	0.0183	0	0.0486	0	0.0628	0
40		Residential mortgages-insured or guaranteed.....			XXX.....	0	0.0003	0	0.0007	0	0.0011	0
41		Residential mortgages-all other.....			XXX.....	0	0.0015	0	0.0034	0	0.0046	0
42		Commercial mortgages-insured or guaranteed.....			XXX.....	0	0.0003	0	0.0007	0	0.0011	0
43		Commercial mortgages-all other - CM1 - highest quality.....	7,349,411		XXX.....	7,349,411	0.0011	8,084	0.0057	41,892	0.0074	54,386
44		Commercial mortgages-all other - CM2 - high quality.....	5,332,340		XXX.....	5,332,340	0.0040	21,329	0.0114	60,789	0.0149	79,452
45		Commercial mortgages-all other - CM3 - medium quality.....			XXX.....	0	0.0069	0	0.0200	0	0.0257	0
46		Commercial mortgages-all other - CM4 - low medium quality.....			XXX.....	0	0.0120	0	0.0343	0	0.0428	0
47		Commercial mortgages-all other - CM5 - low quality.....			XXX.....	0	0.0183	0	0.0486	0	0.0628	0
		Overdue, not in process:										
48		Farm mortgages.....			XXX.....	0	0.0480	0	0.0868	0	0.1371	0
49		Residential mortgages-insured or guaranteed.....			XXX.....	0	0.0006	0	0.0014	0	0.0023	0
50		Residential mortgages-all other.....			XXX.....	0	0.0029	0	0.0066	0	0.0103	0
51		Commercial mortgages-insured or guaranteed.....			XXX.....	0	0.0006	0	0.0014	0	0.0023	0
52		Commercial mortgages-all other.....			XXX.....	0	0.0480	0	0.0868	0	0.1371	0
		In process of foreclosure:										
53		Farm mortgages.....			XXX.....	0	0.0000	0	0.1942	0	0.1942	0
54		Residential mortgages-insured or guaranteed.....			XXX.....	0	0.0000	0	0.0046	0	0.0046	0
55		Residential mortgages-all other.....			XXX.....	0	0.0000	0	0.0149	0	0.0149	0
56		Commercial mortgages-insured or guaranteed.....			XXX.....	0	0.0000	0	0.0046	0	0.0046	0
57		Commercial mortgages-all other.....			XXX.....	0	0.0000	0	0.1942	0	0.1942	0
58		Total Schedule B mortgages (sum of Lines 35 through 57).....	12,681,751	0	XXX.....	12,681,751	XXX.....	29,414	XXX.....	102,680	XXX.....	133,838
59		Schedule DA mortgages.....			XXX.....	0	0.0034	0	0.0114	0	0.0149	0
60		Total mortgage loans on real estate (Lines 58 + 59).....	12,681,751	0	XXX.....	12,681,751	XXX.....	29,414	XXX.....	102,680	XXX.....	133,838

ASSET VALUATION RESERVE

Basic Contribution, Reserve Objective and Maximum Reserve Calculations

Equity and Other Invested Asset Component

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Line Number	NAIC Desig- nation	Description	1	2	3	4	Basic Contribution		Reserve Objective		Maximum Reserve	
			Book/Adjusted Carrying Value	Reclassify Related Party Encumbrances	Add Third Party Encumbrances	Balance for AVR Reserve Calculations (Cols. 1 + 2 + 3)	5	6	7	8	9	10
							Factor	Amount (Cols. 4 x 5)	Factor	Amount (Cols. 4 x 7)	Factor	Amount (Cols. 4 x 9)
		COMMON STOCK										
1		Unaffiliated public.....	89,817	XXX	XXX	89,817	0.0000	0	(a).....0.2000	17,963	(a).....0.2000	17,963
2		Unaffiliated private.....		XXX	XXX	0	0.0000	0	0.1945	0	0.1945	0
3		Federal Home Loan Bank.....	513,300	XXX	XXX	513,300	0.0000	0	0.0061	3,131	0.0097	4,979
4		Affiliated life with AVR.....		XXX	XXX	0	0.0000	0	0.0000	0	0.0000	0
		Affiliated Investment Subsidiary:										
5		Fixed income exempt obligations.....				0	XXX		XXX		XXX	
6		Fixed income highest quality.....				0	XXX		XXX		XXX	
7		Fixed income high quality.....				0	XXX		XXX		XXX	
8		Fixed income medium quality.....				0	XXX		XXX		XXX	
9		Fixed income low quality.....				0	XXX		XXX		XXX	
10		Fixed income lower quality.....				0	XXX		XXX		XXX	
11		Fixed income in or near default.....				0	XXX		XXX		XXX	
12		Unaffiliated common stock public.....				0	0.0000	0	(a).....	0	(a).....	0
13		Unaffiliated common stock private.....				0	0.0000	0	0.1945	0	0.1945	0
14		Real estate.....				0	(b).....	0	(b).....	0	(b).....	0
15		Affiliated - certain other (see SVO Purposes and Procedures Manual).....		XXX	XXX	0	0.0000	0	0.1580	0	0.1580	0
16		Affiliated - all other.....	2,975,269	XXX	XXX	2,975,269	0.0000	0	0.1945	578,690	0.1945	578,690
17		Total common stock (sum of Lines 1 through 16).....	3,578,386	0	0	3,578,386	XXX	0	XXX	599,784	XXX	601,632
		REAL ESTATE										
18		Home office property (General Account only).....				0	0.0000	0	0.0912	0	0.0912	0
19		Investment properties.....				0	0.0000	0	0.0912	0	0.0912	0
20		Properties acquired in satisfaction of debt.....				0	0.0000	0	0.1337	0	0.1337	0
21		Total real estate (sum of Lines 18 through 20).....	0	0	0	0	XXX	0	XXX	0	XXX	0
		OTHER INVESTED ASSETS										
		INVESTMENTS WITH THE UNDERLYING CHARACTERISTICS OF BONDS										
22		Exempt obligations.....		XXX	XXX	0	0.0000	0	0.0000	0	0.0000	0
23	1	Highest quality.....		XXX	XXX	0	0.0005	0	0.0016	0	0.0033	0
24	2	High quality.....		XXX	XXX	0	0.0021	0	0.0064	0	0.0106	0
25	3	Medium quality.....		XXX	XXX	0	0.0099	0	0.0263	0	0.0376	0
26	4	Low quality.....		XXX	XXX	0	0.0245	0	0.0572	0	0.0817	0
27	5	Lower quality.....		XXX	XXX	0	0.0630	0	0.1128	0	0.1880	0
28	6	In or near default.....		XXX	XXX	0	0.0000	0	0.2370	0	0.2370	0
29		Total with bond characteristics (sum of Lines 22 through 28).....	0	XXX	XXX	0	XXX	0	XXX	0	XXX	0

ASSET VALUATION RESERVE (continued)

Basic Contribution, Reserve Objective and Maximum Reserve Calculations

Equity and Other Invested Asset Component

Line Number	NAIC Desig- nation	Description	1	2	3	4	Basic Contribution		Reserve Objective		Maximum Reserve	
			Book/Adjusted Carrying Value	Reclassify Related Party Encumbrances	Add Third Party Encumbrances	Balance for AVR Reserve Calculations (Cols. 1 + 2 + 3)	5	6	7	8	9	10
							Factor	Amount (Cols. 4 x 5)	Factor	Amount (Cols. 4 x 7)	Factor	Amount (Cols. 4 x 9)
		INVESTMENTS WITH THE UNDERLYING CHARACTERISTICS OF PREFERRED STOCKS										
30	1	Highest quality.....	1,645,981	XXX	XXX	1,645,981	0.0005	823	0.0016	2,634	0.0033	5,432
31	2	High quality.....		XXX	XXX	.0	0.0021	.0	0.0064	.0	0.0106	.0
32	3	Medium quality.....		XXX	XXX	.0	0.0099	.0	0.0263	.0	0.0376	.0
33	4	Low quality.....		XXX	XXX	.0	0.0245	.0	0.0572	.0	0.0817	.0
34	5	Lower quality.....		XXX	XXX	.0	0.0630	.0	0.1128	.0	0.1880	.0
35	6	In or near default.....		XXX	XXX	.0	0.0000	.0	0.2370	.0	0.2370	.0
36		Affiliated life with AVR.....		XXX	XXX	.0	0.0000	.0	0.0000	.0	0.0000	.0
37		Total with preferred stock characteristics (sum of Lines 30 through 36).....	1,645,981	XXX	XXX	1,645,981	XXX	823	XXX	2,634	XXX	5,432
		INVESTMENTS WITH THE UNDERLYING CHARACTERISTICS OF MORTGAGE LOANS										
		In Good Standing Affiliated:										
38		Mortgages - CM1 - highest quality.....			XXX	.0	0.0011	.0	0.0057	.0	0.0074	.0
39		Mortgages - CM2 - high quality.....			XXX	.0	0.0040	.0	0.0114	.0	0.0149	.0
40		Mortgages - CM3 - medium quality.....			XXX	.0	0.0069	.0	0.0200	.0	0.0257	.0
41		Mortgages - CM4 - low medium quality.....			XXX	.0	0.0120	.0	0.0343	.0	0.0428	.0
42		Mortgages - CM5 - low quality.....			XXX	.0	0.0183	.0	0.0486	.0	0.0628	.0
43		Residential mortgages-insured or guaranteed.....			XXX	.0	0.0003	.0	0.0007	.0	0.0011	.0
44		Residential mortgages-all other.....		XXX	XXX	.0	0.0015	.0	0.0034	.0	0.0046	.0
45		Commercial mortgages-insured or guaranteed.....			XXX	.0	0.0003	.0	0.0007	.0	0.0011	.0
		Overdue, Not in Process Affiliated:										
46		Farm mortgages.....			XXX	.0	0.0480	.0	0.0868	.0	0.1371	.0
47		Residential mortgages-insured or guaranteed.....			XXX	.0	0.0006	.0	0.0014	.0	0.0023	.0
48		Residential mortgages-all other.....			XXX	.0	0.0029	.0	0.0066	.0	0.0103	.0
49		Commercial mortgages-insured or guaranteed.....			XXX	.0	0.0006	.0	0.0014	.0	0.0023	.0
50		Commercial mortgages-all other.....			XXX	.0	0.0480	.0	0.0868	.0	0.1371	.0
		In Process of foreclosure Affiliated:										
51		Farm mortgages.....			XXX	.0	0.0000	.0	0.1942	.0	0.1942	.0
52		Residential mortgages-insured or guaranteed.....			XXX	.0	0.0000	.0	0.0046	.0	0.0046	.0
53		Residential mortgages-all other.....			XXX	.0	0.0000	.0	0.0149	.0	0.0149	.0
54		Commercial mortgages-insured or guaranteed.....			XXX	.0	0.0000	.0	0.0046	.0	0.0046	.0
55		Commercial mortgages-all other.....			XXX	.0	0.0000	.0	0.1942	.0	0.1942	.0
56		Total Affiliated (Sum of Lines 38 through 55).....	.0	.0	XXX	.0	XXX	.0	XXX	.0	XXX	.0
57		Unaffiliated - In Good Standing with Covenants.....			XXX	.0	(c)	.0	(c)	.0	(c)	.0
58		Unaffiliated - In Good Standing Defeased with Government Securities.....			XXX	.0	0.0011	.0	0.0057	.0	0.0074	.0
59		Unaffiliated - In Good Standing Primarily Senior.....			XXX	.0	0.0040	.0	0.0114	.0	0.0149	.0
60		Unaffiliated - In Good Standing All Other.....			XXX	.0	0.0069	.0	0.0200	.0	0.0257	.0
61		Unaffiliated - Overdue, Not in Process.....			XXX	.0	0.0480	.0	0.0868	.0	0.1371	.0
62		Unaffiliated - In Process of Foreclosure.....			XXX	.0	0.0000	.0	0.1942	.0	0.1942	.0
63		Total Unaffiliated (Sum of Lines 57 through 62).....	.0	.0	XXX	.0	XXX	.0	XXX	.0	XXX	.0
64		Total with Mortgage Loan Characteristics (Lines 56 + 63).....	.0	.0	XXX	.0	XXX	.0	XXX	.0	XXX	.0

Annual Statement for the year 2019 of the

Senior Health Insurance Company of Pennsylvania

ASSET VALUATION RESERVE (continued)

Basic Contribution, Reserve Objective and Maximum Reserve Calculations

Equity and Other Invested Asset Component

Line Number	NAIC Designation	Description	1	2	3	4	Basic Contribution		Reserve Objective		Maximum Reserve	
			Book/Adjusted Carrying Value	Reclassify Related Party Encumbrances	Add Third Party Encumbrances	Balance for AVR Reserve Calculations (Cols. 1 + 2 + 3)	5	6	7	8	9	10
							Factor	Amount (Cols. 4 x 5)	Factor	Amount (Cols. 4 x 7)	Factor	Amount (Cols. 4 x 9)
		INVESTMENTS WITH THE UNDERLYING CHARACTERISTICS OF COMMON STOCK										
65		Unaffiliated public.....		XXX	XXX	0	0.0000	0	(a).....	0	(a).....	0
66		Unaffiliated private.....		XXX	XXX	0	0.0000	0	0.1945	0	0.1945	0
67		Affiliated life with AVR.....		XXX	XXX	0	0.0000	0	0.0000	0	0.0000	0
68		Affiliated certain other (see SVO Purposes and Procedures Manual).....		XXX	XXX	0	0.0000	0	0.1580	0	0.1580	0
69		Affiliated other - all other.....		XXX	XXX	0	0.0000	0	0.1945	0	0.1945	0
70		Total with Common Stock Characteristics (Sum of Lines 65 through 69).....	0	XXX	XXX	0	XXX	0	XXX	0	XXX	0
		INVESTMENTS WITH THE UNDERLYING CHARACTERISTICS OF REAL ESTATE										
71		Home office property (general account only).....				0	0.0000	0	0.0912	0	0.0912	0
72		Investment properties.....				0	0.0000	0	0.0912	0	0.0912	0
73		Properties acquired in satisfaction of debt.....				0	0.0000	0	0.1337	0	0.1337	0
74		Total with Real Estate Characteristics (Sum of Lines 71 through 73).....	0	0	0	0	XXX	0	XXX	0	XXX	0
		LOW INCOME HOUSING TAX CREDIT INVESTMENTS										
75		Guaranteed federal low income housing tax credit.....				0	0.0003	0	0.0006	0	0.0010	0
76		Non-guaranteed federal low income housing tax credit.....				0	0.0063	0	0.0120	0	0.0190	0
77		Guaranteed state low income housing tax credit.....				0	0.0003	0	0.0006	0	0.0010	0
78		Non-guaranteed state low income housing tax credit.....				0	0.0063	0	0.0120	0	0.0190	0
79		All other low income housing tax credit.....				0	0.0273	0	0.0600	0	0.0975	0
80		Total LIHTC (Sum of Lines 75 through 79).....	0	0	0	0	XXX	0	XXX	0	XXX	0
		ALL OTHER INVESTMENTS										
81		NAIC 1 working capital finance investments.....		XXX		0	0.0000	0	0.0042	0	0.0042	0
82		NAIC 2 working capital finance investments.....		XXX		0	0.0000	0	0.0137	0	0.0137	0
83		Other invested assets - Schedule BA.....	13,125,106	XXX		13,125,106	0.0000	0	0.1580	2,073,767	0.1580	2,073,767
84		Other short-term invested assets - Schedule DA.....		XXX		0	0.0000	0	0.1580	0	0.1580	0
85		Total All Other (sum of Lines 81, 82, 83 and 84).....	13,125,106	XXX	0	13,125,106	XXX	0	XXX	2,073,767	XXX	2,073,767
86		Total Other Invested Assets - Schedule BA & DA (Sum of Lines 29, 37, 64, 70, 74, 80 and 85).....	14,771,087	0	0	14,771,087	XXX	823	XXX	2,076,400	XXX	2,079,198

(a) Times the company's weighted average portfolio beta (Minimum .1215, Maximum .2431).

(b) Determined using same factors and breakdowns used for directly owned real estate.

(c) This will be the factor associated with the risk category determined in the company generated worksheet.

SCHEDULE H - ACCIDENT AND HEALTH EXHIBIT

		Total		Group Accident and Health		Credit A&H (Group and Individual)		Collectively Renewable		Other Individual Contracts									
										Non-Cancelable		Guaranteed Renewable		Non-Renewable for Stated Reasons Only		Other Accident Only		All Other	
		1 Amount	2 %	3 Amount	4 %	5 Amount	6 %	7 Amount	8 %	9 Amount	10 %	11 Amount	12 %	13 Amount	14 %	15 Amount	16 %	17 Amount	18 %
PART 1 - ANALYSIS OF UNDERWRITING OPERATIONS																			
1.	Premiums written.....	78,564,612	XXX	1,422,165	XXX	-	XXX	-	XXX	-	XXX	77,119,635	XXX	22,812	XXX	-	XXX	-	XXX
2.	Premiums earned.....	80,672,475	XXX	1,471,834	XXX	-	XXX	-	XXX	-	XXX	79,177,115	XXX	23,526	XXX	-	XXX	-	XXX
3.	Incurred claims.....	343,522,577	425.8	6,678,252	453.7	0	0.0	0	0.0	0	0.0	336,852,736	425.4	(8,411)	(35.8)	0	0.0	0	0.0
4.	Cost containment expenses.....	146,777	0.2	2,542	0.2	-	0.0	-	0.0	-	0.0	144,231	0.2	4	0.0	-	0.0	-	0.0
5.	Incurred claims and cost containment expenses (Lines 3 and 4).....	343,669,354	426.0	6,680,794	453.9	0	0.0	0	0.0	0	0.0	336,996,967	425.6	(8,407)	(35.7)	0	0.0	0	0.0
6.	Increase in contract reserves.....	188,206,480	233.3	3,730,616	253.5	0	0.0	0	0.0	0	0.0	184,478,663	233.0	(2,800)	(11.9)	0	0.0	0	0.0
7.	Commissions (a).....	5,654,040	7.0	165,888	11.3	-	0.0	-	0.0	-	0.0	5,486,929	6.9	1,223	5.2	-	0.0	-	0.0
8.	Other general insurance expenses.....	29,248,903	36.3	506,549	34.4	-	0.0	-	0.0	-	0.0	28,741,522	36.3	832	3.5	-	0.0	-	0.0
9.	Taxes, licenses and fees.....	3,889,990	4.8	67,369	4.6	-	0.0	-	0.0	-	0.0	3,822,510	4.8	111	0.5	-	0.0	-	0.0
10.	Total other expenses incurred.....	38,792,933	48.1	739,806	50.3	0	0.0	0	0.0	0	0.0	38,050,961	48.1	2,166	9.2	0	0.0	0	0.0
11.	Aggregate write-ins for deductions.....	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
12.	Gain from underwriting before dividends or refunds.....	(489,996,292)	(607.4)	(9,679,382)	(657.6)	0	0.0	0	0.0	0	0.0	(480,349,476)	(606.7)	32,567	138.4	0	0.0	0	0.0
13.	Dividends or refunds.....	0	0.0	-	0.0	-	0.0	-	0.0	-	0.0	-	0.0	-	0.0	-	0.0	-	0.0
14.	Gain from underwriting after dividends or refunds.....	(489,996,292)	(607.4)	(9,679,382)	(657.6)	0	0.0	0	0.0	0	0.0	(480,349,476)	(606.7)	32,567	138.4	0	0.0	0	0.0

DETAILS OF WRITE-INS

1101.	.....	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
1102.	.....	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
1103.	.....	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
1198.	Summary of remaining write-ins for Line 11 from overflow page.....	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
1199.	Total (Lines 1101 through 1103 plus 1198) (Line 11 above).....	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0

(a) Includes \$.....0 reported as 'Contract, membership and other fees retained by agents.'

SCHEDULE H - ACCIDENT AND HEALTH EXHIBIT (continued)

	1	2	3	4	Other Individual Contracts				
					5	6	7	8	9
	Total	Group Accident and Health	Credit A&H (Group and Individual)	Collectively Renewable	Non-Cancelable	Guaranteed Renewable	Non-Renewable for Stated Reasons Only	Other Accident Only	All Other
PART 2 - RESERVES AND LIABILITIES									
A. Premium Reserves:									
1. Unearned premiums.....	12,001,851	218,552	-	-	-	11,778,391	4,908	-	
2. Advance premiums.....	1,462,254	14,467	-	-	-	1,446,484	1,303	-	
3. Reserve for rate credits.....	0	-	-	-	-	-	-	-	
4. Total premium reserves, current year.....	13,464,105	233,019	0	0	0	13,224,875	6,211	0	0
5. Total premium reserves, prior year.....	15,765,356	284,928				15,473,085	7,343		
6. Increase in total premium reserves.....	(2,301,251)	(51,909)	0	0	0	(2,248,210)	(1,132)	0	0
B. Contract Reserves:									
1. Additional reserves (a).....	1,859,365,860	30,472,028	-	-	-	1,828,606,953	286,879		
2. Reserve for future contingent benefits.....	0	-	-	-	-	-	-	-	
3. Total contract reserves, current year.....	1,859,365,860	30,472,028	0	0	0	1,828,606,953	286,879	0	0
4. Total contract reserves, prior year.....	1,671,159,380	26,741,412				1,644,128,290	289,679		
5. Increase in contract reserves.....	188,206,480	3,730,616	0	0	0	184,478,663	(2,800)	0	0
C. Claim Reserves and Liabilities:									
1. Total current year.....	932,810,659	20,862,412	0	0	0	911,905,206	43,041	0	0
2. Total prior year.....	958,969,931	23,338,313				935,539,601	92,017		
3. Increase.....	(26,159,272)	(2,475,901)	0	0	0	(23,634,395)	(48,976)	0	0

PART 3 - TEST OF PRIOR YEAR'S CLAIM RESERVES AND LIABILITIES

1. Claims Paid During the Year:									
1.1 On claims incurred prior to current year.....	327,667,476	8,048,297				319,584,725	34,454		
1.2 On claims incurred during current year.....	42,014,373	1,105,856				40,902,406	6,111		
2. Claim Reserves and Liabilities, December 31, current year:									
2.1 On claims incurred prior to current year.....	655,285,355	13,393,660				641,886,828	4,867		
2.2 On claims incurred during current year.....	277,525,304	7,468,752				270,018,378	38,174		
3. Test:									
3.1 Lines 1.1 and 2.1.....	982,952,831	21,441,957	0	0	0	961,471,553	39,321	0	0
3.2 Claim reserves and liabilities, December 31, prior year.....	958,969,931	23,338,313				935,539,601	92,017		
3.3 Line 3.1 minus Line 3.2.....	23,982,900	(1,896,356)	0	0	0	25,931,952	(52,696)	0	0

PART 4 - REINSURANCE

A. Reinsurance Assumed:									
1. Premiums written.....	4,762,558	752,793	-	-	-	4,009,765	-		
2. Premiums earned.....	4,876,022	775,103	-	-	-	4,100,919	-		
3. Incurred claims.....	24,996,645	2,197,343	-	-	-	22,799,302	-		
4. Commissions.....	482,173	79,268	-	-	-	402,905	-		
B. Reinsurance Ceded:									
1. Premiums written.....	10,295	-	-	-	-	10,295			
2. Premiums earned.....	10,288	-	-	-	-	10,288			
3. Incurred claims.....	296,501	-	-	-	-	296,501			
4. Commissions.....	244	-	-	-	-	244			

(a) Includes \$.....636,536,764 premium deficiency reserve.

	1 Medical	2 Dental	3 Other	4 Total
A. Direct:				
1. Incurred claims.....			318,822,432	318,822,432
2. Beginning claim reserves and liabilities.....			885,942,063	885,942,063
3. Ending claim reserves and liabilities.....			861,420,525	861,420,525
4. Claims paid.....	0	0	343,343,970	343,343,970
B. Assumed Reinsurance:				
5. Incurred claims.....			24,996,645	24,996,645
6. Beginning claim reserves and liabilities.....			73,702,436	73,702,436
7. Ending claim reserves and liabilities.....			72,223,363	72,223,363
8. Claims paid.....	0	0	26,475,718	26,475,718
C. Ceded Reinsurance:				
9. Incurred claims.....			296,501	296,501
10. Beginning claim reserves and liabilities.....			687,988	687,988
11. Ending claim reserves and liabilities.....			855,232	855,232
12. Claims paid.....	0	0	129,257	129,257
D. Net:				
13. Incurred claims.....	0	0	343,522,576	343,522,576
14. Beginning claim reserves and liabilities.....	0	0	958,956,510	958,956,510
15. Ending claim reserves and liabilities.....	0	0	932,788,656	932,788,656
16. Claims paid.....	0	0	369,690,430	369,690,430
E. Net Incurred Claims and Cost Containment Expenses:				
17. Incurred claims and cost containment expenses.....			343,669,353	343,669,353
18. Beginning reserves and liabilities.....			959,031,665	959,031,665
19. Ending reserves and liabilities.....			932,918,182	932,918,182
20. Paid claims and cost containment expenses.....	0	0	369,782,836	369,782,836

Annual Statement for the year 2019 of the

Senior Health Insurance Company of Pennsylvania

SCHEDULE T - PREMIUMS AND ANNUITY CONSIDERATIONS (b)

Allocated by States and Territories

States, Etc.			1	Direct Business Only					
				Life Contracts		4	5	6	7
				2	3				
			Active Status (a)	Life Insurance Premiums	Annuity Considerations	Accident and Health Insurance Premiums, Including Policy, Membership and Other Fees	Other Considerations	Total Columns 2 through 5	Deposit-Type Contracts
1.	Alabama.....	AL.....	L.....			106,514		106,514	
2.	Alaska.....	AK.....	L.....			33,188		33,188	
3.	Arizona.....	AZ.....	L.....			1,421,606		1,421,606	
4.	Arkansas.....	AR.....	L.....			294,050		294,050	
5.	California.....	CA.....	L.....			5,183,274		5,183,274	
6.	Colorado.....	CO.....	L.....			650,164		650,164	
7.	Connecticut.....	CT.....	N.....			104,227		104,227	
8.	Delaware.....	DE.....	L.....			158,088		158,088	
9.	District of Columbia.....	DC.....	L.....			37,270		37,270	
10.	Florida.....	FL.....	L.....			5,102,403		5,102,403	
11.	Georgia.....	GA.....	L.....			972,991		972,991	
12.	Hawaii.....	HI.....	L.....			144,435		144,435	
13.	Idaho.....	ID.....	L.....			119,857		119,857	
14.	Illinois.....	IL.....	L.....			3,374,402		3,374,402	
15.	Indiana.....	IN.....	L.....			1,634,548		1,634,548	
16.	Iowa.....	IA.....	L.....			1,397,413		1,397,413	
17.	Kansas.....	KS.....	L.....			1,018,522		1,018,522	
18.	Kentucky.....	KY.....	L.....			839,943		839,943	
19.	Louisiana.....	LA.....	L.....			413,911		413,911	
20.	Maine.....	ME.....	L.....			465,326		465,326	
21.	Maryland.....	MD.....	L.....			1,807,150		1,807,150	
22.	Massachusetts.....	MA.....	L.....			510,020		510,020	
23.	Michigan.....	MI.....	L.....			1,467,232		1,467,232	
24.	Minnesota.....	MN.....	L.....			853,598		853,598	
25.	Mississippi.....	MS.....	L.....			338,643		338,643	
26.	Missouri.....	MO.....	L.....			1,530,613		1,530,613	
27.	Montana.....	MT.....	L.....			263,422		263,422	
28.	Nebraska.....	NE.....	L.....			653,491		653,491	
29.	Nevada.....	NV.....	L.....			148,496		148,496	
30.	New Hampshire.....	NH.....	L.....			112,549		112,549	
31.	New Jersey.....	NJ.....	L.....			1,210,622		1,210,622	
32.	New Mexico.....	NM.....	L.....			262,823		262,823	
33.	New York.....	NY.....	N.....			340,722		340,722	
34.	North Carolina.....	NC.....	L.....			2,114,765		2,114,765	
35.	North Dakota.....	ND.....	L.....			679,940		679,940	
36.	Ohio.....	OH.....	L.....			2,692,556		2,692,556	
37.	Oklahoma.....	OK.....	L.....			1,049,596		1,049,596	
38.	Oregon.....	OR.....	L.....			270,698		270,698	
39.	Pennsylvania.....	PA.....	L.....			7,288,325		7,288,325	
40.	Rhode Island.....	RI.....	N.....			32,940		32,940	
41.	South Carolina.....	SC.....	L.....			744,826		744,826	
42.	South Dakota.....	SD.....	L.....			471,979		471,979	
43.	Tennessee.....	TN.....	L.....			936,968		936,968	
44.	Texas.....	TX.....	L.....			5,707,739		5,707,739	
45.	Utah.....	UT.....	L.....			372,626		372,626	
46.	Vermont.....	VT.....	N.....			34,790		34,790	
47.	Virginia.....	VA.....	L.....			1,326,097		1,326,097	
48.	Washington.....	WA.....	L.....			1,386,979		1,386,979	
49.	West Virginia.....	WV.....	L.....			116,884		116,884	
50.	Wisconsin.....	WI.....	L.....			827,992		827,992	
51.	Wyoming.....	WY.....	L.....			72,529		72,529	
52.	American Samoa.....	AS.....	N.....					0	
53.	Guam.....	GU.....	N.....					0	
54.	Puerto Rico.....	PR.....	N.....					0	
55.	US Virgin Islands.....	VI.....	L.....					0	
56.	Northern Mariana Islands.....	MP.....	N.....					0	
57.	Canada.....	CAN.....	N.....			6,481		6,481	
58.	Aggregate Other Alien.....	OT.....	XXX.....	0	0	13,907	0	13,907	0
59.	Subtotal.....		XXX.....	0	0	59,120,134	0	59,120,134	0
90.	Reporting entity contributions for employee benefit plans.....		XXX.....					0	
91.	Dividends or refunds applied to purchase paid-up additions and annuities.....		XXX.....					0	
92.	Dividends or refunds applied to shorten endowment or premium paying period.....		XXX.....					0	
93.	Premium or annuity considerations waived under disability or other contract provisions.....		XXX.....			14,626,335		14,626,335	
94.	Aggregate other amounts not allocable by State.....		XXX.....	0	0	0	0	0	0
95.	Totals (Direct Business).....		XXX.....	0	0	73,746,469	0	73,746,469	0
96.	Plus reinsurance assumed.....		XXX.....			4,795,804		4,795,804	
97.	Totals (All Business).....		XXX.....	0	0	78,542,273	0	78,542,273	0
98.	Less reinsurance ceded.....		XXX.....			10,295		10,295	
99.	Totals (All Business) less reinsurance ceded.....		XXX.....	0	0	(c) 78,531,977	0	78,531,977	0

DETAILS OF WRITE-INS								
58001.	Aggregate Other Alien.....	XXX.....			13,907		13,907	
58002.	.....	XXX.....					0	
58003.	.....	XXX.....					0	
58998.	Summ. of remaining write-ins for line 58 from overflow page.....	XXX.....	0	0	0	0	0	0
58999.	Total (Lines 58001 thru 58003 plus 58998) (Line 58 above).....	XXX.....	0	0	13,907	0	13,907	0
9401.	.....	XXX.....					0	
9402.	.....	XXX.....					0	
9403.	.....	XXX.....					0	
9498.	Summ. of remaining write-ins for line 94 from overflow page.....	XXX.....	0	0	0	0	0	0
9499.	Total (Lines 9401 thru 9403 plus 9498) (Line 94 above).....	XXX.....	0	0	0	0	0	0

(a) Active Status Counts:

L - Licensed or Chartered - Licensed insurance carrier or domiciled RRG.....	48	R - Registered - Non-domiciled RRGs.....	0
E - Eligible - Reporting entities eligible or approved to write surplus lines in the state	0	Q - Qualified - Qualified or accredited reinsurer.....	0
		N - None of the above - Not allowed to write business in the state.....	9

(b) Explanation of basis of allocation by states, etc., of premiums and annuity considerations.

(c) Column 4 should balance with Exhibit 1, Lines 6.4, 10.4 and 16.4, Cols. 8, 9, and 10, or with Schedule H, Part 1, Column 1, Line 1. Indicate which:

SCHEDULE T - PART 2

INTERSTATE COMPACT - EXHIBIT OF PREMIUMS WRITTEN

Allocated by States and Territories

States, Etc.			Direct Business Only				6 Totals	
			1 Life (Group and Individual)	2 Annuities (Group and Individual)	3 Disability Income (Group and Individual)	4 Long-Term Care (Group and Individual)		5 Deposit-Type Contracts
1.	Alabama.....	AL						0
2.	Alaska.....	AK						0
3.	Arizona.....	AZ						0
4.	Arkansas.....	AR						0
5.	California.....	CA						0
6.	Colorado.....	CO						0
7.	Connecticut.....	CT						0
8.	Delaware.....	DE						0
9.	District of Columbia.....	DC						0
10.	Florida.....	FL						0
11.	Georgia.....	GA						0
12.	Hawaii.....	HI						0
13.	Idaho.....	ID						0
14.	Illinois.....	IL						0
15.	Indiana.....	IN						0
16.	Iowa.....	IA						0
17.	Kansas.....	KS						0
18.	Kentucky.....	KY						0
19.	Louisiana.....	LA						0
20.	Maine.....	ME						0
21.	Maryland.....	MD						0
22.	Massachusetts.....	MA						0
23.	Michigan.....	MI						0
24.	Minnesota.....	MN						0
25.	Mississippi.....	MS						0
26.	Missouri.....	MO						0
27.	Montana.....	MT						0
28.	Nebraska.....	NE						0
29.	Nevada.....	NV						0
30.	New Hampshire.....	NH						0
31.	New Jersey.....	NJ						0
32.	New Mexico.....	NM						0
33.	New York.....	NY						0
34.	North Carolina.....	NC						0
35.	North Dakota.....	ND						0
36.	Ohio.....	OH						0
37.	Oklahoma.....	OK						0
38.	Oregon.....	OR						0
39.	Pennsylvania.....	PA						0
40.	Rhode Island.....	RI						0
41.	South Carolina.....	SC						0
42.	South Dakota.....	SD						0
43.	Tennessee.....	TN						0
44.	Texas.....	TX						0
45.	Utah.....	UT						0
46.	Vermont.....	VT						0
47.	Virginia.....	VA						0
48.	Washington.....	WA						0
49.	West Virginia.....	WV						0
50.	Wisconsin.....	WI						0
51.	Wyoming.....	WY						0
52.	American Samoa.....	AS						0
53.	Guam.....	GU						0
54.	Puerto Rico.....	PR						0
55.	US Virgin Islands.....	VI						0
56.	Northern Mariana Islands.....	MP						0
57.	Canada.....	CAN						0
58.	Aggregate Other Alien.....	OT						0
59.	Totals.....		0	0	0	0	0	0

NONE

SCHEDULE Y – INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP

PART 1 – ORGANIZATIONAL CHART



SCHEDULE Y

PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Group Code	Group Name	NAIC Company Code	ID Number	Federal RSSD	CIK	Name of Securities Exchange if Publicly Traded (U.S. or International)	Names of Parent, Subsidiaries or Affiliates	Domiciliary Location	Relationship to Reporting Entity	Directly Controlled by (Name of Entity/Person)	Type of Control (Ownership Board, Management, Attorney-in-Fact, Influence, Other)	If Control is Ownership Provide Percentage	Ultimate Controlling Entity(ies)/Person(s)	Is an SCA Filing Required? (Y/N)	*
Members															
.....			75-3269792..	.....	.....	.....	SENIOR HEALTH CARE OVERSIGHT TRUST	PA.....	UDP.....	.....	.....	.....	.....	.....N.....	.....
.....		76325...	23-0704970..	.....	.....	.....	SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA	PA.....	RE.....	SENIOR HEALTH CARE OVERSIGHT TRUST	OWNERSHIP....	100.000	SENIOR HEALTH CARE OVERSIGHT TRUST	N.....	.....
.....			45-4844825..	.....	.....	.....	FUZION ANALYTICS, INC.....	DE.....	NIA.....	SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA	OWNERSHIP....	100.000	SENIOR HEALTH CARE OVERSIGHT TRUST	N.....	.....

SCHEDULE Y

PART 2 - SUMMARY OF INSURER'S TRANSACTIONS WITH ANY AFFILIATES

1	2	3	4	5	6	7	8	9	10	11	12	13
NAIC Company Code	ID Number	Names of Insurers and Parent, Subsidiaries or Affiliates	Shareholder Dividends	Capital Contributions	Purchases, Sales or Exchanges of Loans, Securities, Real Estate, Mortgage Loans or Other Investments	Income/ (Disbursements) Incurred in Connection with Guarantees or Undertakings for the Benefit of any Affiliate(s)	Management Agreements and Service Contracts	Income/ (Disbursements) Incurred under Reinsurance Agreements	*	Any Other Material Activity Not in the Ordinary Course of the Insurer's Business	Totals	Reinsurance Recoverable/ (Payable) on Losses and/or Reserve Credit Taken/ (Liability)
Affiliated Transactions												
	45-4844825.....	FUZION ANALYTICS, INC.....					12,778,644	.....			.....12,778,644	
76325.....	23-0704970.....	SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA.....					(12,778,644)	.....			.....(12,778,644)	
9999999.	Control Totals.....		0	0	0	0	0	0	XXX	0	0	0

Senior Health Insurance Company in Rehabilitation

Balance Sheet

(\$ in thousands)

	YTD 06/30/2020	Year Ended 12/31/2019
Assets		
Bonds	\$ 1,604,419	\$ 1,721,888
Preferred stock	79,903	86,271
Common stock	4,153	3,578
Mortgage loans	12,212	12,682
Cash and short term investments	30,918	46,682
Other invested assets	12,612	15,701
Receivable for securities	-	136
Total invested assets	<u>1,744,217</u>	<u>1,886,938</u>
Investment income due and accrued	11,720	12,082
Uncollected premiums	997	928
Federal income tax recoverable	2,364	2,364
Guaranty funds receivable	1,218	1,209
Reimbursement from insurance carrier	1,006	3,588
Other	184	72
Total Assets	<u>\$ 1,761,706</u>	<u>\$ 1,907,181</u>
Liabilities and Capital and Surplus		
Liabilities		
Active life reserves	\$ 1,177,017	\$ 1,234,831
Premium deficiency reserves	761,096	636,537
Claim reserves	896,046	932,811
Premiums paid in advance	1,365	1,462
Interest maintenance reserve	5,525	4,746
Accounts payable and other liabilities	<u>8,386</u>	<u>12,892</u>
Total Liabilities	<u>\$ 2,849,435</u>	<u>\$ 2,823,279</u>
Capital and Surplus		
Common stock	\$ 2,500	\$ 2,500
Preferred capital stock	5,000	5,000
Surplus notes	50,000	50,000
Unassigned surplus	<u>(1,145,229)</u>	<u>(973,598)</u>
Total Capital and Surplus	<u>\$ (1,087,729)</u>	<u>\$ (916,098)</u>
Total Liabilities and Capital and Surplus	<u>\$ 1,761,706</u>	<u>\$ 1,907,181</u>

Senior Health Insurance Company in Rehabilitation

Income Statement

(\$ in thousands)

	YTD 06/30/2020	Year Ended 12/31/2019
Premiums	\$ 35,628	\$ 80,672
Investment Income	36,164	77,412
Investment Expense	<u>(525)</u>	<u>(10,695)</u>
Total Income	71,267	147,389
Benefits Paid	178,970	369,626
Change in Claim Reserves	(36,765)	(26,160)
Change in ALR	(57,366)	(74,651)
Change in PDR Reserves	<u>124,559</u>	<u>262,914</u>
Total Benefits	<u>209,398</u>	<u>531,729</u>
Commissions	2,568	5,654
General Insurance Expenses	16,464	29,396
Insurance Taxes, Licenses and Fees	<u>381</u>	<u>3,888</u>
Total Benefits and Expenses	228,811	570,667
Federal Income Taxes	<u>-</u>	<u>207</u>
Net Loss before Realized Losses	(157,544)	(423,485)
Realized Losses	<u>(13,110)</u>	<u>(38,549)</u>
Net Loss	<u>\$ (170,654)</u>	<u>\$ (462,034)</u>
Cash from Operations	<u>\$ (121,810)</u>	<u>\$ (251,711)</u>

Senior Health Insurance Company in Rehabilitation

Income Statement

(\$ in thousands)

	Quarter Ended 09/30/2020	Year Ended 12/31/2019
Premiums	\$ 52,217	\$ 80,672
Investment Income	51,509	77,412
Investment Expense	<u>(794)</u>	<u>(10,695)</u>
Total Income	102,932	147,389
Benefits Paid	261,760	369,626
Change in Claim Reserves	(47,675)	(26,160)
Change in ALR	(91,744)	(74,651)
Change in PDR Reserves	<u>96,122</u>	<u>262,914</u>
Total Benefits	<u>218,463</u>	<u>531,729</u>
Commissions	3,651	5,654
General Insurance Expenses	24,153	29,396
Insurance Taxes, Licenses and Fees	<u>722</u>	<u>3,890</u>
Total Benefits and Expenses	246,989	570,669
Federal Income Taxes	<u>(217)</u>	<u>205</u>
Net Loss before Realized Losses	(143,840)	(423,485)
Realized Losses	<u>(6,281)</u>	<u>(38,549)</u>
Net Loss	<u>\$ (150,121)</u>	<u>\$ (462,034)</u>
Cash from Operations	<u>\$ (169,210)</u>	<u>\$ (251,711)</u>

Senior Health Insurance Company in Rehabilitation

Balance Sheet

(\$ in thousands)

	Quarter Ended 09/30/2020	Year Ended 12/31/2019
Assets		
Bonds	\$ 1,548,916	\$ 1,721,888
Preferred stock	79,903	86,271
Common stock	4,264	3,578
Mortgage loans	11,967	12,682
Cash and short term investments	47,736	46,682
Other invested assets	9,263	15,701
Receivable for securities	-	136
Total invested assets	<u>1,702,049</u>	<u>1,886,938</u>
Investment income due and accrued	10,852	12,082
Uncollected premiums	879	928
Federal income tax recoverable	2,581	2,364
Guaranty funds receivable	1,220	1,209
Reimbursement from insurance carrier	1,497	3,588
Other	127	72
Total Assets	<u><u>\$ 1,719,205</u></u>	<u><u>\$ 1,907,181</u></u>
Liabilities and Capital and Surplus		
Liabilities		
Active life reserves	\$ 1,141,574	\$ 1,234,831
Premium deficiency reserves	732,659	636,537
Claim reserves	885,098	932,811
Premiums paid in advance	1,214	1,462
Interest maintenance reserve	5,849	4,746
Accounts payable and other liabilities	<u>23,188</u>	<u>12,892</u>
Total Liabilities	<u>\$ 2,789,582</u>	<u>\$ 2,823,279</u>
Capital and Surplus		
Common stock	\$ 2,500	\$ 2,500
Preferred capital stock	5,000	5,000
Surplus notes	50,000	50,000
Unassigned surplus	<u>(1,127,877)</u>	<u>(973,598)</u>
Total Capital and Surplus	<u>\$ (1,070,377)</u>	<u>\$ (916,098)</u>
Total Liabilities and Capital and Surplus	<u><u>\$ 1,719,205</u></u>	<u><u>\$ 1,907,181</u></u>

Senior Health Insurance Company in Rehabilitation Investment Summary

Core Portfolio

	<u>9/30/2020</u>	<u>12/31/2019</u>	<u>Incr(Decr)</u>
Bonds and Short Term Investments	\$ 1,585,652,266	\$ 1,757,570,714	\$ (171,918,448)
Sutton Capital Trust	72,143,500	72,143,500	-
Preferred and Common Stock Unaffiliated	7,759,540	14,641,092	(6,881,552)
Common Stock - Fuzion Analytics	4,263,838	2,975,269	1,288,569
Mortgage Loans	11,966,574	12,681,751	(715,177)
Other Invested Assets	1,612,467	1,645,981	(33,514)
	<u>\$ 1,683,398,184</u>	<u>\$ 1,861,658,307</u>	<u>\$ (178,260,123)</u>

Non-Core Portfolio

	<u>9/30/2020</u>	<u>12/31/2019</u>	<u>Incr(Decr)</u>
AB Private Credit	\$ 16,373,979	\$ 19,435,088	\$ (3,061,109)
Phonex	-	89,817	(89,817)
Sun Trust COOF	262,862	271,266	(8,404)
Equipment Finance V	11,000,000	11,000,000	-
PPCO	-	3,335,380	(3,335,380)
Kingdom	930,000	930,000	-
Rent Path	-	-	-
PPCA	-	-	-
	<u>\$ 28,566,841</u>	<u>\$ 35,061,551</u>	<u>\$ (6,494,710)</u>

Senior Health Insurance Company in Rehabilitation
Income Statement
(\$ in thousands)

	Year Ended 12/31/2020	Year Ended 12/31/2019
Premiums	\$ 66,982	\$ 80,672
Investment Income	70,421	77,412
Investment Expense	(1,053)	(10,695)
Gain/Loss Transferred to IMR	(16,210)	(3,679)
Transamerica Service Fees	144	-
Total Income	<u>120,284</u>	<u>143,710</u>
Benefits Paid	333,201	369,626
Change in Claim Reserves	(143,406)	(26,160)
Change in ALR	(128,983)	(74,651)
Change in PDR Reserves	170,775	262,914
Loss from Transamerica Recapture	168,507	-
Total Benefits	<u>400,094</u>	<u>531,729</u>
Commissions	4,622	5,654
General Insurance Expenses	31,306	29,396
Insurance Taxes, Licenses and Fees	1,132	3,890
Total Benefits and Expenses	437,154	570,669
Federal and State Income Taxes	<u>(505)</u>	<u>205</u>
Net Loss before Realized Gains/ Losses	(316,365)	(427,164)
Realized Gains/Losses	<u>10,518</u>	<u>(34,870)</u>
Net Loss	<u><u>\$ (305,847)</u></u>	<u><u>\$ (462,034)</u></u>
Cash from Operations	<u><u>\$ (208,461)</u></u>	<u><u>\$ (251,711)</u></u>

Senior Health Insurance Company in Rehabilitation

Balance Sheet

(\$ in thousands)

	Year Ended 12/31/2020	Year Ended 12/31/2019
Assets		
Bonds	\$ 1,201,083	\$ 1,721,888
Preferred stock	77,608	86,271
Common stock	4,735	3,578
Mortgage loans	11,717	12,682
Cash and short term investments	46,100	46,682
Other invested assets	9,862	15,701
Receivable for securities	-	136
Total invested assets	1,351,105	1,886,938
Investment income due and accrued	9,362	12,082
Uncollected premiums	961	928
Federal income tax recoverable	1,380	2,364
Guaranty funds receivable	1,135	1,209
Reimbursement from insurance carrier	421	3,588
Transamerica receivable	5,408	-
Other	136	72
Total Assets	<u>\$ 1,369,908</u>	<u>\$ 1,907,181</u>
Liabilities and Capital and Surplus		
Liabilities		
Active life reserves	\$ 1,047,771	\$ 1,234,831
Premium deficiency reserves	762,600	636,537
Claim reserves	732,814	932,811
Premiums paid in advance	972	1,462
Interest maintenance reserve	18,457	4,746
Transamerica liability	21,073	-
Accounts payable and other liabilities	8,728	12,892
Total Liabilities	<u>\$ 2,592,415</u>	<u>\$ 2,823,279</u>
Capital and Surplus		
Common stock	\$ 2,500	\$ 2,500
Preferred capital stock	5,000	5,000
Surplus notes	50,000	50,000
Unassigned surplus	(1,280,007)	(973,598)
Total Capital and Surplus	<u>\$ (1,222,507)</u>	<u>\$ (916,098)</u>
Total Liabilities and Capital and Surplus	<u>\$ 1,369,908</u>	<u>\$ 1,907,181</u>

Exhibit 1

Impacts of Liquidation on Policyholders and Guaranty Associations Contribution

Data extracted from Comparison File with calculations

	Baseline			Liquidation			
	1	2	3 (1-2)	4	5	6	7 (5-6)
	PV of benefits	PV of premiums	PVFB - PVFP	PV of benefits GA limit	PV of benefits	PV of premiums	PVFB - PVFP
Total	2,549,059,475	221,335,076	2,327,724,399	1,956,095,423	2,245,568,821	314,813,980	1,930,754,840

The Rehabilitator has advised that the SHIP “funding gap” is \$1,224,000,000 (see 11/20/20 Phase I Results Exhibit) and the Plan calls for the entire burden to fall on policyholders. The figures presented in the Comparison File indicate that, in liquidation, policyholders would bear a burden of only \$396,969,558 – a difference of \$827,030,441 in comparison with the Plan. These figures are calculated in Table 1.

Another method of estimating the support provided by guaranty associations in liquidation (which policyholders would forgo under the Plan) is to use the above figures and the 49% estate dividend projected by the Rehabilitator (11/20/10 Phase I Results Exhibit). This calculation is set forth in Table 2.

Table 2

Guaranty Association Claims in Liquidation	
PV of benefits GA limit (column 4)	\$ 1,956,095,423
PV of premiums (column 6)	- 314,813,980
Subtotal	\$ 1,641,281,443
49% Liquidation Dividend on GA Claims	- 804,227,907
Net Guaranty Association Support	\$ 837,053,536

Table 1

Liquidation Impact on Policyholders	
Benefit Loss Borne by Policyholders	
PV of “Baseline” Benefits (column 1)	\$ 2,549,059,475
PV of Liquidation Benefits (column 5)	- 2,245,568,821
Subtotal	\$ 303,490,655
Premium Increase Borne by Policyholders	
PV of Liquidation Premiums (column 6)	\$ 314,813,980
PV of “Baseline” Premiums (column 2)	- 221,335,076
Subtotal	\$ 93,478,904
Total	\$ 396,969,559
Policyholder Burdens Rehabilitation vs. Liquidation	
“Funding Gap” Borne in Rehabilitation	\$ 1,224,000,000
Burden Borne in Liquidation	- 396,969,559
Difference (Borne by GAs)	\$ 827,030,441

Exhibit 2

Policyholder Comparison for Each Phase I Option vs. Liquidation (Table 1)

	Option 1	Option 2	Option 2a	Option 3	Option 4
Policyholders Better Off in Rehabilitation (by count)	12,650	1,993	2,021	5,598	27,621
Policyholders Better Off in Liquidation (by count)	<u>20,611</u>	<u>31,268</u>	<u>31,240</u>	<u>27,663</u>	<u>5,640</u>
Total	33,261	33,261	33,261	33,261	33,261
Policyholders Better Off in Rehabilitation (%)	38.03%	5.99%	6.08%	16.83%	83.04%
Policyholders Better Off in Liquidation (%)	<u>61.97%</u>	<u>94.01%</u>	<u>93.92%</u>	<u>83.17%</u>	<u>16.96%</u>
	100%	100%	100%	100%	100%

Rehabilitator's Analysis of Phase I Options on "Funding Gap" (Table 2)

	(figures in millions)				
SHIP "funding gap"	\$ 1,224	\$ 1,224	\$ 1,224	\$ 1,224	\$ 1,224
"Funding gap" addressed in Phase I (Methodology 1)	<u>- 887</u>	<u>- 1,050</u>	<u>- 1,026</u>	<u>- 959</u>	<u>- 227</u>
"Funding gap" remaining for Phase II (Methodology 1)	\$ 337	\$ 174	\$ 198	\$ 265	\$ 997
SHIP "funding gap"	\$ 1,224	\$ 1,224	\$ 1,224	\$ 1,224	\$ 1,224
"Funding gap" addressed in Phase I (Methodology 2)	<u>- 1,133</u>	<u>- 1,331</u>	<u>- 1,296</u>	<u>- 1,336</u>	<u>- 227</u>
"Funding gap" remaining for Phase II (Methodology 2)	\$ 91	n/a	n/a	n/a	\$ 997

REHABILITATOR'S PRE-HEARING MEMORANDUM
PROPOSED
EXHIBIT 7

SHIP - Rehabilitation Plan

Comparison test summary

Figures are as of 6/30/2020 and exclude assumed business and policies currently on non-forfeiture.

Rehabilitation Plan Option results are based on Phase I of the Rehabilitation Plan and are subject to change under Phase II

Purpose:

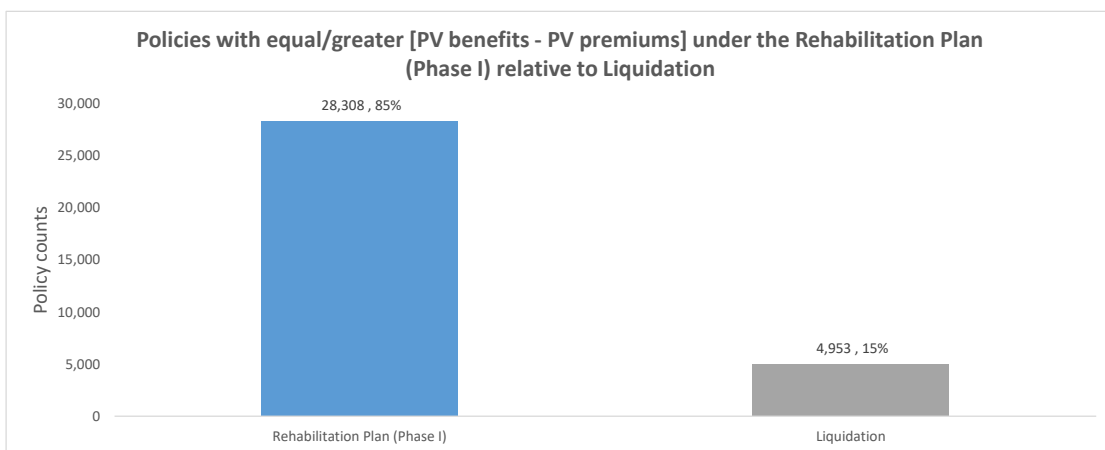
This spreadsheet enables a user to compare the Rehabilitation Plan against a potential Liquidation by comparing the richness of the two potential outcomes based on the present value ("PV") of benefits less the PV of premiums. The PV of Liquidation benefits assumes that guaranty associations will charge if knew rate increases for benefits within applicable statutory limits, and includes an estimated 48.8% (Cell E33) of uncovered benefits that policyholders could retain in the event of a potential Liquidation. In the exhibit below, the left (blue) bar indicates the number of policyholders for whom there is at least one Rehabilitation Plan Option with a value equal to or greater than projected under a potential Liquidation. The right (grey) bar indicates the number of policyholders for whom Liquidation is projected to be richer than the Plan.

Instructions:

Adjust the three toggles in Cells B13:B15 to filter the policies included in the exhibit. Adjust the toggle in Cell B89 to select the illustrative election rate scenario. Adjust the toggle in Cell B90 to select whether uncovered benefits are funded in a liquidation in this exhibit.

Nationwide summary of all policies

All states	Select issue state
All lives	Select active/disabled status
Both statuses	Select premium paying status

**As of 6/30/20:**

Est. operational cost / year (\$ millions)	\$30.0
Assets (\$ millions)	
Total assets	\$1,762.5
Less trust fund	-\$301.9
Less est. 5-year operational costs	-\$150.0
Net assets	\$1,310.6
Liabilities (\$ millions)	
Total liabilities	\$2,836.7
Less assumed business	-\$152.0
Net liabilities	\$2,684.7
Liquidation dividend¹	48.8%

¹ Liquidation dividend is defined as the percentage of uncovered benefits that would be paid to the policyholder in the event of a liquidation

IN THE COMMONWEALTH OF PENNSYLVANIA

- - -

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

- - -

Monday, May 17, 2021

- - -

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

- - -

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1 WITNESS INDEX

2 NAME PAGE

Richard Cantilo

3

Direct

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4

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1 P R O C E E D I N G S

2 JUDGE LEAVITT: Good morning.

3 Please be seated. All right. We are here
4 today on the Rehabilitator, Jessica Altman,
5 Second Amended Rehabilitation Plan. All of you
6 should have received the decorum order. Just
7 to remind you, if you are speaking, you may
8 remove your mask. And, in fact, I urge you to
9 do so for the sake of the court reporter and
10 for the sake of the Court.

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

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

1 January 2020?

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

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

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

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

25 So we knew even then in 2018 and

1 2019 that if management wasn't able to fix the
2 problem, the Department would have to step in
3 and even move for rehabilitation or a
4 liquidation order.

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

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

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

25 But the first really intense

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

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

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

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

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

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

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

25 We concluded, for SHIP, that was no

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

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

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

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

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

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

1 So that one didn't get very far.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 could not be described that way.

2 Q. Mr. Cantilo, you used the term
3 "feasible." Can you explain what you meant
4 when you said feasible?

5 A. Yes. I meant a plan that would be
6 practical to enrollment and would have a
7 material impact on the reduction of the
8 company's deficit, obviously, while addressing
9 the other goals that were already described.

10 Q. How did you come to that
11 understanding of the word "feasible"?

12 A. Well, the Pennsylvania statute does
13 not provide specific requirements for the
14 components of the rehabilitation plan, but I
15 think if you read the statute on when you
16 should go from rehabilitation to liquidation,
17 it compels that conclusion, because if a plan
18 is futile, then that is one of the routes to
19 going to liquidation.

20 We wanted a plan that would not be
21 futile, and I converted that to feasible.

22 Q. If the plan does not eliminate the
23 deficit, what impact will it have on the
24 deficit for SHIP?

25 A. So it will not eliminate the deficit

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

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

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

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

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

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

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

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

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

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

1 BY MR. BROADBENT:

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

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

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

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

1 amount is adequate on an If Knew basis.

2 So, say a policy is paying a
3 thousand dollars a year in annual premium, but
4 for the benefits that policy offers, we
5 calculate the If Knew premium would be \$1,500,
6 we have a program that would reduce those
7 benefits to a thousand dollars on an If Knew
8 basis, so that now every policyholder is on the
9 same basis. That's like we are all paying the
10 same rate for each pound of potatoes.

11 The second option is what we call
12 the basic policy endorsement. We have selected
13 what we think are the key components of
14 long-term care that people want to have, if
15 they can't afford everything, these are the
16 things they want to have.

17 And we created an array of those
18 that we think will generate affordable
19 premiums. And so there are some limits on what
20 we're going to do with those options. We're
21 going to have a maximum benefit period that is
22 no greater than 80 percent of the current
23 premium or four years. For most people, we
24 think four years of benefit period is a basic
25 long-term care insurance policy. Sure, if you

1 have the money and you would like to have a
2 longer period, but four years is a pretty
3 reasonable benefit period.

4 We are doing the same thing with the
5 daily benefit. We're going to take 80 percent
6 of the current daily benefit or \$300 and use
7 the lower to -- as a basic daily benefit for
8 that policy.

9 There will be an inflation component
10 if there is one in the policy already, but it
11 would be capped at one and a half percent, not
12 five percent. There is a variation on the
13 policy that we, again, very creatively call 2A,
14 and the differences are that you can take a
15 benefit period out to five years and the
16 inflation to two percent, and you'll pay a
17 little more premium for that variation.

18 Q. Mr. Cantilo --

19 A. One very important aspect of the
20 basic policy is if you select this option, you
21 will not be affected by Phase Two. It is what
22 we call a one and done option, which makes it,
23 we think, very attractive to policyholders.

24 Q. How did you and the other team
25 members working on the plan identify what

1 should be included in the basic policy?

2 A. So we are lucky because there are
3 several members of our team that have a lot of
4 industry experience, and I and others also have
5 a lot of experience where we did a lot of
6 policyholder outreach.

7 So we are basing those judgments on
8 what we interpret to be the opinions expressed
9 by policyholders throughout the country about
10 what they find valuable in their long-term care
11 insurance policies and which are the things
12 they are willing to give up.

13 Now, it's not a perfect world. So
14 some of the things they find valuable are the
15 most expensive and we're not necessarily going
16 to retain them in the policy, but I think the
17 fundamental coverage responds to those
18 policyholders around the country.

19 The next option, Option 3, is a
20 paid-up policy or a non-forfeiture option. But
21 unlike the one I described earlier that is
22 common in the industry that just takes
23 accumulated premium less claims, here we are
24 putting a floor on that policy of two and a
25 half years of benefit period, unless your

1 policy already has less than that. We are not
2 going to lengthen your benefit period. But if
3 you have a five-year policy, even if you take
4 an NFO, you have to have at least 30 months of
5 coverage. That makes that option, Option 3,
6 very attractive, because unlike the typical NFO
7 that gives you at most months of coverage, here
8 you have two and a half years, which is a
9 pretty reasonable period of coverage.

10 We also floored the maximum daily
11 benefit at 80 percent of the current level of
12 \$300, which, again, is a reasonable maximum
13 daily benefit. So not a luxurious policy,
14 certainly not what anyone would call a Cadillac
15 policy, but I think this is a solid Chevy
16 policy that we're offering as an alternative.
17 And I don't mean to be pejorative about Chevys
18 when I say that.

19 And then the last option is the
20 option that we hope the fewest policyholders
21 will select, but it's out there, and that is
22 pay whatever it takes to keep your current
23 policy.

24 Q. A policyholder electing Option 1,
25 does he or she get to decide which benefits to

1 depressed asset. Probably should not have done
2 so, but that is water under the bridge, so.

3 JUDGE LEAVITT: Okay.

4 BY MR. BROADBENT:

5 Q. When will these changes take effect?

6 A. For TransAmerica, it took effect in
7 the year end. With the Court's permission, for
8 American Health & Life and for Primerica, it
9 would become effective with the effective date
10 of the plan.

11 Q. Moving to the concerns of the state
12 insurance regulators, I think one of the
13 concerns to which you testified was the
14 Rehabilitator and the Court approving SHIP's
15 rates throughout the country.

16 Can you elaborate on what your
17 understanding is of that concern?

18 A. Certainly. There is a tradition
19 that has been codified in most of the states of
20 having the state of issue of an insurance
21 policy be the principal regulator for the rates
22 for those policies.

23 So even though an insurer might be
24 down in Tennessee, for the policies and issues
25 in Pennsylvania, it is the Pennsylvania

1 department that scrutinizes the rates and
2 eventually approves or rejects rate increases.
3 And that is so regardless of where the
4 policyholder resides.

5 So the policy may have been issued
6 by a Tennessee domiciled insurer to a
7 Pennsylvania resident who then moved to
8 Nebraska, and after that, moved to California
9 and eventually moved to Illinois.
10 Notwithstanding, it's going to be a
11 Pennsylvania department that regulates the
12 rates of that policy all the way through the
13 life of the policy, because that's the state in
14 which the policy was issued.

15 My own view is that that arrangement
16 is a matter of convenience allocating
17 responsibility for rate approval to one rather
18 than each state of issue rather than having
19 them all owned by the state of domicile. Doing
20 them by state of residence, obviously, would be
21 complicated because you would have several
22 departments passing on the same rate over
23 different periods of time.

24 Based on that tradition, the, what I
25 understand the Maine, Massachusetts and

1 Washington regulators to be suggesting is that
2 they, and not this Court or this Rehabilitator,
3 ought to be approving rate increases for the
4 policies issued by SHIP or its predecessors in
5 those three states.

6 And -- but we disagree with that
7 notion because we believe that the
8 Rehabilitator and this Court have the power to
9 just modify rates and benefits under the
10 policies of the rehabilitation plan.

11 But that's my understanding of that
12 principal objection.

13 Q. Do you understand the regulators to
14 assert that they can -- they are the only party
15 that can approve rate increases for residents
16 in their states?

17 A. No. Their position, consistent with
18 the statutes, is that they are the only ones
19 who can approve rate increases from policies
20 issued in those states, regardless of whether
21 -- which, of course, creates some ironic
22 consequences. So on my Slide 97, I explained
23 that just for these three states, we have 34
24 residents of Maine issued policies in other
25 states. So if Maine set the rates for all of

1 the policies issued in that state, it would do
2 so for 34 residents of other states. It would
3 be 84 for the policies issued in Massachusetts,
4 and 89 for the policies issued in Washington.

5 So all together, for this group of
6 regulators, they would be setting rates for 207
7 policies issued in those states, but the
8 holders reside in other states, so they
9 wouldn't be protecting their own residents.

10 Conversely, if you look at the next
11 slide, there are 21 Maine residents who hold
12 policies issued in other states and 83
13 Massachusetts and 87 Washington residents who
14 hold policies issued in other states, which is
15 to say, if these three regulators set the
16 rates, they will not be doing so for these 191
17 residents of their state because those policies
18 were issued in other states.

19 So all together, having -- giving
20 effect to their rules, so to speak, that the
21 issued state sets the rate, means that 400
22 policyholders will have their rates set by
23 states in which they don't reside because of
24 this rule.

25 Q. In a receivership, why wouldn't you

1 follow the standard rule of having the issued
2 state control the rate process?

3 A. Well, I guess my first opinion is
4 that's how we got here. One of the biggest
5 problems SHIP faces is uneven response to rate
6 approvals, as we described earlier today in
7 great detail.

8 But, more importantly, I don't think
9 you can rehabilitate or liquidate a large
10 insurance company with little pieces being
11 addressed by each of the 50 states.

12 The tradition in this country has
13 been that a multistate troubled insurer is
14 managed by its domiciliary regulator through
15 the entire policy over the rehabilitation
16 process.

17 And the notion that that rule should
18 apply with respect to contract modifications
19 but not with respect to rate modifications does
20 not make common sense to me. I don't see a
21 qualitative difference between the two.

22 Q. Does the plan address the issued
23 state rate?

24 A. Yes. After we received these
25 objections, following the original plan which

1 was filed in April of last year, we added to
2 the plan what we called the issue state rate
3 approval section, and that's a fairly
4 complicated section aimed exactly at addressing
5 this concern.

6 So under this section, what would
7 happen is every state will be given the option,
8 if this Court approves the plan, to opt out of
9 the rate approval section. If they do, in an
10 opt out state, the Rehabilitator will file an
11 application for rate increases for the policies
12 issued in that state to the If Knew level. The
13 regulator will do whatever he or she thinks is
14 appropriate with that application, but if that
15 application is not completely approved, say
16 it's only half approved, as it happens so
17 often, we will then adjust the benefits under
18 those policies to what that regulator has
19 approved.

20 That is essential. If we don't have
21 that, we will continue having the other
22 policyholders subsidize the policies. So we
23 will stop the subsidy, but we will let the opt
24 out states set their own rates. Each opt out
25 policyholder will still have four options.

1 They are not exactly the same as the plan but
2 they are similar. So they will be able to keep
3 -- even though the regulator may not have
4 approved a full rate increase, one of the
5 options we will give them is a voluntary paid
6 in full rate to keep your current policy. So
7 we are not going to punish those policyholders
8 because their states opted out and they're not
9 letting them keep their current policy. If
10 they really want to keep their current policy,
11 they can voluntarily pay the premium.

12 But if they don't, if they want to
13 pay the premium approved by the opt out state,
14 then the benefits of the policy will be
15 adjusted to that level.

16 Or if they don't want to pay any
17 premium increase, just like the opt-in
18 policyholders, they will have a downgrade
19 option so that they don't have to pay any rate
20 increase. And they also have a non-forfeiture
21 option, but there will be no requirement by
22 that state or that policy, it will not be
23 enhanced by that plan option.

24 Q. Mr. Cantilo, under ordinary
25 circumstances, that is, outside of the

1 statute.

2 We won't be approving that, but
3 we're not going to block policyholders from
4 doing it voluntarily. I thought that was a
5 persuasive argument, so we included that as an
6 Option B in the program.

7 Q. Do policyholders governed by the opt
8 out states have Phase Two of the plan?

9 A. Yes. And, again, just as for
10 opt-ins, Phase Two will be very similar for opt
11 out states. Again, we will file rate increase
12 applications in each of the opt out states, but
13 on a self-sustaining basis, individually,
14 Seriatim again, and again, they will have the
15 ability to approve them individually or in
16 groups.

17 Q. Have you received a reaction from
18 state regulators, generally, to the issue state
19 rate approval option?

20 A. The only formal reaction has been
21 the filing by the state regulators in this case
22 that that doesn't satisfy them. I think there
23 was a passing comment on this in the Louisiana
24 case but really not germane to any of the
25 issues in that case.

1 Other than that, I had informal
2 conversations with a number of regulators who
3 think this is creative and a good way of
4 slashing the cat, so to speak, or whatever the
5 expression would be.

6 A lot of people are not going to
7 come out in public and say that because it
8 would mean surrendering to the Pennsylvania
9 Insurance Commissioner the ability to set
10 rates, and that has become a very contentious
11 issue.

12 But in terms of harmonizing their
13 concerns with the exigencies of SHIP's
14 circumstances, they think this would create an
15 effective solution.

16 Q. Is all of this explained in the
17 plan?

18 A. Yes.

19 Q. Will states opting out hurt the
20 plan?

21 A. No. Ironically, we anticipate, we
22 can be surprised, but we anticipate that the
23 results of states opting out will be a deeper
24 reduction in benefits because of more rate
25 approvals.

1 So in terms of the company, states
2 opting out will probably be helpful. In terms
3 of policyholders, we think it will be harmful.
4 So although it will not hurt the plan in terms
5 of reducing the deficit, it is likely to hurt
6 the plan in terms of providing policyholders
7 the best options.

8 Q. To be clear, what options do opt out
9 policyholders not have?

10 A. Well, one of the most important ones
11 that they won't have is the enhanced
12 non-forfeiture option and the basic policies.
13 Those are not forms approved in the opt out
14 states, so we are not going to use them. Those
15 would be part of the participation in the plan.

16 MR. BROADBENT: Your Honor, I
17 will pause again momentarily to let you know we
18 are moving to the question of rehabilitation
19 and liquidation, and I wanted to make sure Your
20 Honor had sufficient time to ask the questions
21 that Your Honor may have had on this issue at
22 this time.

23 JUDGE LEAVITT: No, I'm fine.

24 MR. BROADBENT: Thank you.

25 BY MR. BROADBENT:

1 300,000 --

2 JUDGE LEAVITT: Okay.

3 THE WITNESS: And so for this
4 policyholder, Your Honor, I would not recommend
5 Option 4 because Option 4 is a higher premium,
6 and I think that's the whole point about the
7 benefit of choice under the plan.

8 JUDGE LEAVITT: So the column
9 labeled current shows the annual premium of
10 \$2,760.

11 THE WITNESS: Right, Your
12 Honor. That would be one of those ones I
13 mentioned earlier that is vastly underpriced.

14 JUDGE LEAVITT: Right. I see.
15 Okay. I got it.

16 THE WITNESS: Well, apart from
17 this aspect of their measure that I think is a
18 little bit oversimplified in their analysis,
19 there are other ways of measuring the value of
20 each of these options. On Slide 104, I know
21 some of them are obvious ones.

22 So one they suggest is the present
23 value future benefits less the present value
24 future premiums. You could also take the
25 present value future benefits over annual

1 premium, what some people call the bang for the
2 buck measure, how much insurance are you
3 getting for each dollar.

4 But with respect to both of these
5 measures, Your Honor, what you are looking at
6 are projections. We don't know those numbers.
7 And if I gave you the numbers today, they would
8 be wrong tomorrow. Every day, those
9 projections are going to change.

10 The third option that I have up
11 there is not susceptible to that problem. That
12 is a maximum policy value. That is not going
13 to change. That is the product of that
14 policy's maximum benefit period times its
15 maximum daily benefit. Unless you modify the
16 policy, that's a static number and it will be
17 that way until the policy ends.

18 The other part of that formula is
19 annual premium which, again, does not change.
20 That's not a projection. So if you are going
21 to give policyholders guidance, I think you
22 should give them guidance at a static, not that
23 you know it was wrong the day after you give it
24 to them.

25 The fourth measure is another bang

1 for the buck approach, not one that we are
2 particularly recommending, but if you are going
3 to use the bang for the buck approach, at least
4 use policy value rather than present value
5 future benefits because, as I said earlier,
6 again, it's a known number. It's not going to
7 change.

8 And then the last measure, which I
9 think is the obvious one, is the actual policy
10 coverage. You know, when I buy life insurance,
11 I buy a million dollars worth of life
12 insurance. That's my policy. I don't buy a
13 policy that some actuary has projected will
14 cost my insurance company \$187,000 compared to
15 Mr. Robinson's \$176,000 for the same million
16 dollars.

17 That is how people buy insurance.
18 They buy the policy amount and that amount is
19 in their policy forms. Many of SHIP's forms
20 use a term "benefit account value" or "lifetime
21 maximum," but it's, basically, this formula.
22 If you're going to use any formula to suggest
23 to policyholders what relative values are, I
24 think that is a more meaningful one.

25 Just for the sake of illustration of

1 how all of these things fall out, Oliver Wyman
2 calculated, beginning on Slide 105, how
3 policyholders fare with each of these measures.
4 So this first slide, 105, is the one about
5 which the intervening state regulators have
6 written.

7 In this case, which is their
8 measure, in Phase One, 85 percent of
9 policyholders have at least one option, which
10 is at least as good as liquidation.

11 The other 15 percent arguably do
12 better using this measure than liquidation, or
13 other than liquidation.

14 Your Honor, even if you stop there,
15 even if this is all the information you had, I
16 would submit to you that because in
17 Pennsylvania we evaluate the better off
18 standard for policyholders as a group, not
19 every last one of them, that a plan that's
20 better for 85 percent is good enough.

21 But let me go on. We then looked at
22 the second measure I described to you, the bang
23 for the buck actuarial measure. In that one,
24 only 79 percent of policyholders do better. 21
25 percent would do better with liquidation.

1 Then in the next slide, Your Honor,
2 we analyzed the first maximum policy value
3 option and you can see that with that one, 89
4 percent of policyholders are better off and 11
5 percent do not have a better rehab option than
6 liquidation.

7 And then if you use my simple
8 approach of maximum policy value -- sorry, I
9 skipped over it. This is an actual policy less
10 premium, and that one is 96 percent in favor,
11 four percent do better in liquidation.

12 And then if you use simple policy
13 value, every policyholder has at least one
14 option in a plan that offers the same policy
15 values on liquidation.

16 Now, these are actuarial techniques.
17 So I can't sit here, Your Honor, and tell you
18 this one is right and this one is wrong. This
19 is the exercise of professional judgment.

20 I can tell you that no policyholder
21 ever knows what the present value future
22 benefits of his or her policy is or the present
23 value future premium or what the difference
24 between those two numbers is. But most
25 policyholders will be able to tell you, I have

1 half a million in insurance or three-quarters
2 of a million dollars in insurance or \$100,000
3 of insurance, I think that's what policyholders
4 look at. If you're going to give them
5 guidance, Your Honor, I think you ought to give
6 them guidance that is familiar to them.

7 We did put, on Slide 110, a table
8 that shows all the results I just summarized.
9 So no matter which measure you pick, Your
10 Honor, you see in Phase One, this plan offers
11 the majority of policyholders at least one
12 option to liquidation.

13 Now, the intervening state
14 regulators will tell you, that may be true, but
15 you are ignoring Phase Two. Well, that's
16 right. This doesn't have Phase Two in it
17 because I don't know what Phase Two will look
18 like. But I will make two suggestions to Your
19 Honor.

20 The first is, assume for a moment
21 that the world turns upside down and Phase Two
22 reverses these columns. That's not going to
23 happen. But let's just assume that. Even if
24 that were the case, Your Honor, just in Phase
25 One, we will have accomplished a lot of good.

1 And if we have to go into liquidation at the
2 time of Phase Two, so be it. But we will have
3 right sized the policy so that we have everyone
4 on a level playing field and we will have
5 chopped that deficit by half or more.

6 B, I'm not sure that they do worse
7 in Phase Two. We just can't tell yet how Phase
8 Two will be. But if most of our policyholders
9 choose Options 2 or 3 rather than Option 4 in
10 Phase One, it's not so bad in Phase Two. They
11 don't even get hit in Phase Two. So there is a
12 lot of speculation when we consider how is this
13 going to look in Phase Two.

14 BY MR. BROADBENT:

15 Q. Mr. Cantilo, I want to make sure --

16 A. You want me to stop talking?

17 Q. I want to make sure the record is
18 clear about this measure No. 5. Does the plan
19 provide every policyholder the opportunity to
20 buy coverage as valuable as they could have in
21 liquidation?

22 A. Yes.

23 Q. Do these computational measures
24 account for all of the factors on which a
25 policyholder might base a decision?

1 into account but incredibly important. Sorry.

2 Q. I notice that the rehab plan does
3 not offer a cashout option. Why is that?

4 A. So there are some states that permit
5 them. Most states or many states do not.

6 In our view, and by "our," I mean
7 mine and Commissioner Altman, as well as our
8 advisory team, cashout options are pretty
9 cynical. They offer policyholders some sum of
10 money, typically less than \$50,000, to give up
11 their long-term care coverage forever and ever.

12 If a policyholder really can't pay
13 anymore, the non-forfeiture option is a much
14 better course. That at least preserves some
15 coverage. These policies were sold as policies
16 without a cash value for a reason, and to now
17 manufacture an artificial cash value to induce
18 them to give up their coverage, as I say, I
19 think is pretty cynical. And there are a lot
20 of insurance regulators around the country that
21 feel strongly that way and will not approve
22 cashout options.

23 Q. Throughout your testimony,
24 Mr. Cantilo, you referred to the likelihood of
25 success of the plan. Do you know whether the

1 plan will reduce SHIP's deficit?

2 A. If a plan is implemented, it will
3 reduce SHIP's deficit. What I can't tell you
4 is whether it will eliminate it.

5 In all likelihood, it will not
6 eliminate it. In all likelihood, it will just
7 reduce it materially.

8 We have actually done some modelling
9 of that very important issue, and so if you
10 look at Slide 113, here are 11 scenarios. I
11 will be clear, Your Honor, that these are
12 artificial. We cannot pick what policyholders
13 will actually do, but each of these columns
14 represents a particular hypothetical take rate
15 for each option under the plan, and those take
16 rates are in the yellow boxes below that.

17 So, for example, Your Honor, in
18 Scenario 1, we assume that seven percent of the
19 policyholders will take Option 1, four percent
20 Option 2 and so on, and that the vast majority,
21 81 percent, will take Option 4, pay whatever it
22 takes to keep my policy.

23 If that were the scenario that
24 occurs, Your Honor, we will reduce the deficit
25 by \$525 million as shown above the bar there,

1 which is a little bit less than half of the
2 deficit.

3 Scenario 2 moves more people away
4 from Option 4 to the other options and
5 increases the reduction of the deficit and so
6 on. If you go all the way to the right, Your
7 Honor, to Scenario 11, where a very small
8 number of policyholders elect to pay the high
9 premium and keep their policy and the rest are
10 spread evenly among the other options, that
11 wipes out the deficit.

12 Now, I hasten to add, Your Honor, we
13 are not predicting Scenario 11. This is a
14 demonstration that the policyholders will be
15 the masters of the fate of the company here,
16 and if they stubbornly decide to stick to their
17 expensive policies, probably the most we can
18 hope to accomplish is cut the deficit in half.

19 But we worked hard in making the
20 other options attractive and hope fervently
21 that policyholders will select the other boxes.

22 The next graph will show why that is
23 so important. On this chart, Your Honor, we
24 show how effective each individual option is in
25 reducing the deficit. So on the left side is

1 zero, meaning zero percent of policyholders
2 take that option, and on the right side is a
3 hundred.

4 If a hundred percent of the
5 policyholders chose Option 4, which is the
6 bottom of the curve here, the one that ends at
7 227, if every policyholder says, I will pay
8 whatever it takes, don't mess with my policy,
9 we're only going to eliminate \$227 million of
10 the deficit.

11 On the other hand, Your Honor, if
12 100 percent of the policyholders decide to take
13 Option 3, we would create a \$136 million
14 surplus. And you can see in between where the
15 other options fall on this analysis.

16 Again, no one of these options is
17 going to get a hundred percent take rate. So
18 if you wanted to predict, you would move your
19 marker to the portion of the line for each
20 graph and add them up, and that's what we did
21 in the prior slide.

22 We attempted one more way to try to
23 figure out which way things would work out with
24 the plan, and that is Slide 115, which makes
25 the assumption that every policyholder will

1 select the economically rational policy. That
2 is an assumption that is much more sympathetic
3 to the U.S. policy by the state regulators.
4 It's probably not realistic because I think,
5 Your Honor, they ignore subjective factors.

6 But if you did that, you can see
7 that those take rates would produce deficit
8 reductions in the \$750 million range. And the
9 exact assumptions are spelled out in that blue
10 box just to the right.

11 Q. Mr. Cantilo, do any of these
12 scenarios take into account for Phase Two?

13 A. They do not. We, as I said, we have
14 not projected Phase Two yet. But as I also
15 suggested, if we do Phase One, chop \$700
16 million off the deficit and then decide we have
17 to liquidate, we're in better shape, especially
18 with right sizing the policies, than we are
19 today.

20 Q. I'm going to change topics here and
21 ask, Mr. Cantilo, why does the plan propose to
22 suspend payments on accrued commissions to stop
23 the accrual on the policyholder election date?

24 A. The basic reason is we don't think
25 the plan should put agents in a better position

1 me to sit here. Hopefully my voice will carry
2 throughout the room and not too much of a
3 volume.

4 Secondly, in demonstration of the
5 comity that regulators can show one another,
6 the Rehabilitators' counsel has graciously
7 agreed to project various documents onto the
8 screen when I get there so everyone can see
9 those. So, thank you.

10 CROSS-EXAMINATION

11 BY MR. LESLIE:

12 Q. Mr. Cantilo, were the approximately
13 39,000 long-term care policies you testified to
14 yesterday as in force on the date the
15 rehabilitation order entered, were they
16 enforceable contracts as against SHIP?

17 A. I have not analyzed each one
18 individually, but I have no reason to believe
19 that they were not enforceable contracts.

20 Q. So you don't contend that they were
21 unlawful contracts that were fraudulent or
22 lacked consideration or in some other way were
23 not suitable to be enforced?

24 A. I do not.

25 Q. Were the premium rates charged on

1 those policies the rates that were approved by
2 insurance regulators across the United States
3 and at that point in time the date that the
4 rehabilitation order entered?

5 A. Again, I have not evaluated each one
6 individually, but I have no reason to believe
7 that they were not all approved by the
8 regulators when issued.

9 Q. So on the date that the
10 rehabilitation order entered, were there any
11 outstanding litigation over rates, SHIP rates
12 with any regulator, were there any
13 administrative proceedings pending over rate
14 reviews?

15 A. There was no litigation pending of
16 which I am aware. There may still have been
17 pending at that time action by state insurance
18 regulators on previously filed rate increase
19 approvals or, rather, requests.

20 Q. But you don't know; you're saying
21 they may, but you don't know?

22 A. I don't remember precisely. I know
23 that there were some before the plan was filed
24 in April. I don't know whether all of them had
25 been resolved by the time the plan was filed in

1 April.

2 I do know that eventually we
3 withdrew the ones that had not been resolved
4 after the plan was filed.

5 Q. But you don't contend that the
6 premium rates that were being charged by SHIP
7 at that point in time were unlawful, they were
8 the approved rates; is that correct?

9 A. I do not contend they were unlawful.

10 Q. Okay. How many of those 39,000
11 policies are eligible for one of the options
12 under the proposed plan?

13 A. Assuming that the plan is approved,
14 all of the policies would be entitled to select
15 any of the options, although -- let me correct
16 that. All of the policies that have not
17 already taken non-forfeiture option status
18 would be able to select one of the four
19 options, although for a number of them, Options
20 1 and 4 would be meaningless.

21 Q. Do you recall how many of those
22 39,000 policyholders had already elected a
23 non-forfeiture option?

24 A. That would be 9,000.

25 Q. So is it correct that of the 39,000

1 Q. So under Scenario 1, 81 percent of
2 the policyholders would be expected to select
3 Option 4?

4 A. Right, as I mentioned yesterday.

5 Q. And does Option 4, of the five
6 options, does it have the best or the worst
7 effect in reducing the funding gap?

8 A. In general, Option 4 is the least
9 effective at reducing the funding gap.

10 Q. So if 81 percent of the
11 policyholders selected Option 4, after Phase
12 One, the funding gap would be the largest as
13 distinct from policyholders selecting Options 2
14 or 2A or 3?

15 A. Yes. I believe I addressed that
16 yesterday.

17 Q. Yes, you did.

18 A. I think the scenario you described
19 would result in about a \$525 million reduction
20 in the funding gap.

21 Q. Yes. Yesterday you testified, I
22 believe, about the -- that policyholders had an
23 option, had a least one option equal to what
24 would be the case in liquidation; is that
25 correct?

1 mistake in not approving them?

2 A. That was not the question you asked
3 me.

4 Q. Okay. So no rate filings were filed
5 for those years, but your If Knew Premium
6 illustration includes the If Knew Premium for
7 those years, notwithstanding the fact the rate
8 filings weren't submitted?

9 A. That's true.

10 Q. You think that's a fair portrayal of
11 the situation?

12 A. Yes.

13 Q. All right. Were the rates, as they
14 stood on the day the rehabilitation order
15 entered, were they lawful rates; had they been
16 lawfully approved?

17 A. I assume they were, yes.

18 Q. So does the rehabilitation plan seek
19 to modify rates that were lawfully approved or
20 disapproved?

21 A. The plan will modify the rates as
22 described in the plan, and I am assuming that
23 some or all of the rates that will be modified
24 were roughly approved.

25 Q. You, yesterday you showed us a chart

1 gap?

2 A. Is there a question?

3 Q. I am asking you if you agree with
4 that or not; is that correct?

5 A. Do I agree that those things
6 affected the funding gap, yes.

7 Q. Materially?

8 A. Yes.

9 Q. Is it your opinion that the
10 Rehabilitator of an insolvent life insurer has
11 the discretion to impose the entire cost burden
12 of the insolvency on the insurer's current
13 policyholders and not trigger the guaranty
14 associations?

15 A. Are you asking me if I think that's
16 the law?

17 Q. Is that your opinion, yes.

18 A. My opinion is that the discretion of
19 Rehabilitators and rehabilitation Courts can
20 include that, yes.

21 Q. So if the policy -- so the
22 policyholders of SHIP need to address through
23 these options or -- let me try it a different
24 way.

25 The five options made available

1 under Phase One of the plan, are they intended
2 to reduce the funding gap of \$1.2 billion?

3 A. The plan as a whole is intended to
4 reduce the funding gap.

5 Q. Is the goal to -- is the purpose of
6 the plan to eliminate the funding gap of \$1.2
7 billion?

8 A. It would be good if it did that, but
9 the plan would not fail, in my opinion, if it
10 failed to do that, no.

11 Q. So the reduction of the funding gap,
12 through the plan, who is bearing the burden of
13 that reduction?

14 A. If you describe the adjustments of
15 the policies as bearing the burden, the
16 policyholders would.

17 Q. Is there anyone other than the
18 policyholders that's bearing the burden of
19 those adjustments?

20 A. Putting aside tax considerations,
21 probably not.

22 Q. So that's about 20,000 policyholders
23 based on your testimony earlier in this cross?

24 A. No.

25 Q. No? How many policyholders?

1 A. Well, if you eliminate the
2 non-forfeiture options, 30,000.

3 Q. And you don't further reduce it for
4 the policyholders already paying the If Knew
5 Premium?

6 A. I think we already talked about
7 that. Those policyholders will have the
8 ability to voluntarily select Options 2, 2A or
9 3.

10 Q. Okay. But you would agree, then,
11 that the \$1.2 billion would be addressed by the
12 30,000 long-term care policyholders?

13 A. The projected \$1.2 billion funding
14 gap would be addressed by them, yes.

15 Q. Exclusively?

16 A. No.

17 Q. Okay. Who else?

18 A. As I said, the taxpayers.

19 Q. The taxpayers?

20 A. Yes.

21 Q. Who?

22 A. To the extent that our plan is
23 successful, we will eliminate potentially
24 hundreds of millions of dollars in federal
25 income tax liability. Doing that, I suppose

1 arguably shifts that burden to other taxpayers.

2 Q. I don't pretend to be a tax expert,
3 and yesterday I believe you testified that you
4 weren't either, for which you deserve credit,
5 but I'm going to just stick with the \$1.2
6 billion, because I don't believe it's net of
7 any kind of tax benefit; is it?

8 A. I think we're mixing apples and
9 oranges.

10 Q. I do, too.

11 A. \$1.2 billion is the projected
12 deficit for the company.

13 Q. And the policyholders of SHIP, the
14 30,000 long-term care policyholders of SHIP are
15 going to bear that through higher premium or
16 reduced benefits; right?

17 A. If the entire deficit is eliminated
18 under the plan, the answer is yes.

19 Q. Any portion of the deficit
20 eliminated by the plan is being borne by the
21 policyholders; isn't it?

22 A. Yes.

23 Q. Rather than spread to the guaranty
24 fund system?

25 A. Correct.

1 Q. You have testified that they spread
2 that loss in ways that are borne by taxpayers;
3 is that correct?

4 A. In part, yes.

5 Q. In part. So one of the purposes of
6 the life and health guaranty fund system is to
7 spread the loss of an insolvency broadly so as
8 not to concentrate it on the policyholders,
9 exclusively the policyholders of the insolvent
10 insurer; do you agree with?

11 A. I think that's one of the effects.
12 I'm not sure whether that was the purpose.

13 Q. Does it have that effect? Does the
14 triggering of the guaranty association spread
15 the loss broadly across the United States?

16 A. I just said I think that is the
17 effect, yes.

18 Q. And so why did the Rehabilitator of
19 SHIP decide that it was better to impose the
20 burden exclusively on the policyholders of
21 SHIP?

22 A. As I explained yesterday, there were
23 several factors. One is that the plan offers
24 policyholders benefits that would not be
25 available in liquidation.

1 Another is that in the case of SHIP,
2 there are many policyholders who are paying far
3 less for the coverage they are receiving than
4 they would be had the premiums been set
5 appropriately, which is in a sense to say that
6 they are underpaying for their coverages. That
7 is not a criticism of the policyholders, they
8 are paying everything they were asked to pay,
9 but they weren't asked to pay enough.

10 So shifting that burden, the burden
11 of underpriced policies to the taxpayers or to
12 other insureds in the State of California seems
13 unjustified under the circumstances.

14 Q. That sounds like a policy judgment;
15 do you agree?

16 A. You could call it that.

17 Q. Are the guaranty funds created by
18 statute?

19 A. Yes.

20 Q. So legislators who make policy
21 enacted those statutes across the United
22 States. Are you aware of any state that
23 doesn't have a life and health guaranty fund?

24 A. Not anymore, no.

25 Q. But the Pennsylvania Commissioner

1 Q. That would be an example of a
2 policyholder voluntarily choosing to give up
3 some coverage in exchange for the benefit of
4 lower premium and a lower benefit because of
5 their financial circumstances at that time?

6 A. That is possible, yes.

7 Q. Now, these adjustments in Phase One
8 are permanent; isn't that correct?

9 A. The adjustment resulting from
10 selecting Options 2, 2A or 3 under the plan are
11 intended to be permanent under the plan.

12 Q. Yeah.

13 A. Obviously, if the plan is
14 unsuccessful in keeping the company out of
15 liquidation, then other changes might result in
16 liquidation.

17 Q. So a policyholder, your hypothetical
18 policyholder that makes the decision you just
19 described, could their circumstances change in
20 Phase Two?

21 A. Yes.

22 Q. Okay. So that policyholder is
23 making a choice in Phase One which has a
24 permanent effect on that policyholder?

25 A. In the sense I just described, yes

1 Q. Well, in the sense that guaranty
2 association coverage may be given up?

3 A. Yes.

4 Q. And so in Phase Two, I believe the
5 plan says premium could be materially increased
6 for those selecting Option 4; is that correct?

7 A. That is correct.

8 Q. And benefits could be materially
9 reduced for those selecting Option 1; is that
10 correct?

11 A. That is correct.

12 Q. So our hypothetical policyholder who
13 gives up a certain level of guaranty fund
14 protection in Phase One may find a result in
15 Phase Two that looks very different than what
16 that policyholder thought the circumstances
17 were in Phase One?

18 A. That is possible, yes.

19 Q. So why do policyholders have to give
20 up guaranty association benefits in Phase One
21 permanently; why do they have to do that?

22 A. I'm not sure what you mean by "have
23 to."

24 Q. Well, the plan requires them to give
25 those benefits up permanently, it specifies

1 One.

2 Q. So do you see Phase Two as the phase
3 at which a funding gap that remains at the end
4 of Phase One is addressed and resolved?

5 A. Yes.

6 Q. So at the end of Phase Two, is it
7 your view there will be no funding gap?

8 A. That would be ideal, but as I think
9 I also said yesterday, we can't guarantee that
10 that will be the result.

11 Q. Yes. Yesterday you testified that
12 it was unlikely, I think highly unlikely, that
13 the plan could eliminate the funding gap.

14 Did you mean Phase One or did you
15 mean Phase One and Phase Two?

16 A. I meant Phase One and Phase Two.
17 Certainly Phase One but, as I said yesterday in
18 candor, given the magnitude of the funding, it
19 is possible that for Phase Two to eliminate the
20 remaining gap depending on what happens in
21 Phase One would put such a burden on
22 policyholders, that a different alternative
23 might be preferable.

24 Q. Could that be because the number of
25 policyholders that remain after Phase One whose

1 between the Rehabilitator and the Court.

2 Q. So you are envisioning that order
3 will be modified on this point?

4 A. No, no. That's something different.

5 Q. So will the Court review this and
6 approve this, if you need to have it,
7 alternative methodology?

8 A. Yes.

9 Q. But that's -- how does that arise?
10 It's not in the order. The order gives the
11 Rehabilitator the power to implement the plan.

12 A. Well, I haven't seen the order. You
13 obviously have a crystal ball that I don't
14 have, but I would envision that whatever order
15 the Court enters with respect to the plan would
16 be subject to the further orders of the Court,
17 as is typically the case.

18 Q. So you would be comfortable with the
19 Court approving the plan subject to approving
20 any Phase Two self-sustaining premium or
21 alternative adjustments?

22 A. Of course I would be comfortable
23 with that, yes.

24 Q. You would. Okay. That is great.

25 So would you -- then why, if the

1 Court would be asked to do that, why did the
2 modifications in Phase One have to be
3 permanent? Why couldn't they be voluntary
4 elections, after which everyone looks at the
5 situation and decides how it looks like it will
6 work? Why does Phase One have to be mandatory?

7 A. They are described that way in the
8 plan in fairness to the policyholders so that
9 they recognize the possibility that whatever
10 elections they make in Phase One will be
11 permanent to them. There is no guarantee about
12 anything about this plan going forward, and it
13 is certainly possible that the Court will want
14 to review aspects of the plan after Phase One.

15 Q. Okay. I mean, we are here to deal
16 with the plan as it is, to deal with it as the
17 order stands, and that order doesn't provide
18 for any judicial review.

19 It also doesn't provide for any
20 judicial review of disclosure to the
21 policyholders. Yesterday you testified about
22 trend-setting disclosure, I believe. Do you
23 envision the Court approving that disclosure?

24 A. We had not contemplated coming back
25 to the Court separately for that, no.

1 the same and a lot of cases all the work is the
2 same. So you would develop one model and you
3 would derive output from it that would be
4 needed for each of the ten states. But, in
5 general, it's the same information.

6 Q. In your experience, let me ask it
7 differently, do you have a sense of how long on
8 average it took from the time of submitting the
9 application to receiving an approval or denial
10 from the various states?

11 A. It really varies. Some states are
12 fairly quick. You might get an approval within
13 90 days. Others can take years.

14 Q. So, in other words, can you clarify
15 what you mean by "years"?

16 A. Yeah. There is at least one state
17 that, I think, the industry would consider it,
18 you know, positive if you received an approval
19 within two years.

20 Q. Now, in the plan, I believe
21 Mr. Cantilo testified the rates were calculated
22 on a seriatim basis.

23 Do you recall that?

24 A. Yes.

25 Q. How does that compare to what

1 ordinarily happens in the rate application
2 process?

3 A. So in a more traditional, you know,
4 application process, the company is requesting,
5 although their models might be developed on a
6 seriatim basis, they are requesting a premium
7 rate increase that might only be an aggregate
8 either for that specific state or even
9 nationwide. So just one average premium rate
10 increase.

11 It's becoming more common to be a
12 little more, I would say, I guess more, you
13 know, fine-tuned than that. I do see premium
14 rate increases varying by certain benefit
15 features, like do you have an inflation option
16 or not, do you have unlimited benefits or not.
17 But in general, it's some broader class of
18 policies that will get one average premium rate
19 increase.

20 In the case of a plan, every
21 individual policyholder is going to receive a
22 -- is going to have a premium rate increase
23 calculated based on his or her individual
24 policyholder characteristics, so the specific
25 features of the policy and the policyholder's

1 characteristics. So their individual claim
2 experience themselves won't be considered, but,
3 you know, all the various variants that make up
4 a given assumption, risk factor or risk class
5 will be considered.

6 And so whatever that policy's
7 specific combination of characteristics, you
8 know, creates, whatever assumptions that
9 derives -- or drives from that unique
10 combination will determine that policy rate
11 increase or premium rate.

12 Q. In the ordinary course, in your
13 experience, if a state approves an aggregate
14 rate increase, what impact will that have on
15 the policyholders who may be already paying If
16 Knew Premium?

17 A. Well, so if -- at any -- it will
18 just increase the amounts of subsidies that are
19 occurring if there are any. Generally there
20 aren't in today's blocks levels of subsidy
21 going on.

22 Even within a state, we tend to see
23 that policies issued to older people with less
24 rich benefits tend to be paying more, you know,
25 than I would say relative to an If Knew Premium

1 rate than younger people with more rich
2 benefits.

3 And so just applying or just
4 applying an aggregate rate increase, it doesn't
5 solve that. It just perpetuates it.

6 Q. You may have just done this, sir,
7 but you used the term "subsidies." Can you
8 just define that term as you use it?

9 A. Yeah. I think in this context, it's
10 just the fact that some policies are paying,
11 you know, if there is an actuarially
12 appropriate premium rate for -- on a seriatim
13 basis, then there are at any time quite a few
14 people paying a lot more than that and then
15 there's quite a few people that are paying a
16 lot less than that, so just the fact that there
17 are subsidies going on.

18 Q. In the ordinary course, if a company
19 submits rate applications to a number of
20 states, is it unusual to receive differing
21 responses from those states as to whether the
22 rates are approved or disapproved?

23 A. Yes. It is quite common, and often
24 not very well explained. So you can apply --
25 you can prepare all of the same materials

1 provided to, you know, all the states and, you
2 know, you will get a mixed reaction.

3 Every state has its own -- it
4 changes quite frequently, too, even within a
5 state. Every state has its own approach to
6 reviewing the rates. They, you know, they have
7 different requirements, their own internal
8 rules, statutory rules for what they will
9 approve and not approve, and the measuring
10 sticks they have for determining what is
11 actuarially justified.

12 Q. So what impact on the policyholders
13 does that varying response for the rate from
14 the regulators have?

15 A. It means that, depending on what
16 state your policy was issued in, you can
17 receive a different premium rate. You could be
18 paying a vastly different premium rate if you
19 live in one state compared to another, not live
20 in, but where the policy was issued.

21 Q. Just to clarify that last point, if
22 a policy was issued in state A and you now
23 reside in state B, in the ordinary course, who
24 determines the rate that would apply?

25 A. State A, the issuing state.

1 A. I prefer the word "projected."

2 Q. Yes. So the projected benefits, is
3 that where projection goes, into the projection
4 of the benefits, or does it go into all the
5 elements?

6 A. I'm sorry, could you repeat your
7 original question?

8 Q. I apologize. I'm trying to
9 understand where your word -- you suggested
10 "projection" is a better word, and I'm trying
11 to understand what projection, what it applies
12 to; could you help me with that?

13 A. When you used the word "prediction,"
14 I prefer the word "projection."

15 Q. Okay. In the computation of the
16 present value of benefits, is maximum policy
17 value a classic actuarial consideration?

18 A. In a long-term care policy, yes.
19 You need to know when a benefits -- a policy's
20 benefits might expire because it's reached its
21 maximum value.

22 Q. Sure. But when you predict -- I
23 think "predict" is your word, or "project,"
24 when you project the present value of benefits,
25 do you project the present value of benefits

1 based on the maximum policy value as an
2 actuary?

3 A. That is a -- yes. That is a pretty
4 important consideration. Yes.

5 Q. So the present value of benefits is
6 predicated or based upon the maximum policy
7 value?

8 A. The maximum policy value is taken
9 into consideration in developing a projection
10 of benefits, yes.

11 Q. Sure. Because it's the outer
12 boundary?

13 A. Yes.

14 Q. As other elements like elimination
15 periods, others factors that would bound the
16 coverage equivalent in understanding the
17 coverage for which you are predicting the
18 benefit, is that the nature of the maximum
19 policy value?

20 A. That is correct.

21 Q. Okay. When you project the present
22 value of a long-term care policy, do you look
23 at, in addition to the policy design, do you
24 look at past experience, do you look at the
25 assumptions that were utilized in setting the

1 can't remember what we were thinking at the
2 time.

3 Q. Okay.

4 A. We, you know --

5 Q. Okay.

6 MR. BROADBENT: I don't know
7 that the witness was finished with his answer,
8 please.

9 THE WITNESS: Yeah. I don't
10 know if I would characterize our thinking that
11 way. I just don't recall that at all.

12 BY MR. LESLIE:

13 Q. Okay. I will draw your attention to
14 -- I will draw your attention to Option 4,
15 please. Option 4 in Scenario 1, which is
16 derived in part from Penn Treaty, seems to be
17 an attractive option for active and disabled
18 policyholders, with 81 percent selecting it; is
19 that right?

20 A. Well, in these scenarios we are
21 showing 81 percent electing it, so in that
22 scenario, it would be.

23 Q. Let's go back to RP 17, please. I'm
24 sorry, RP 7. I apologize.

25 So this is the comparison

1 illustration that shows the relative benefits
2 in Phase One of the rehabilitation options
3 compared to liquidation; is that correct?

4 A. This shows -- I believe we looked at
5 this exhibit a few times. I would continue to
6 characterize it as comparing present value
7 benefits minus present value premiums under
8 liquidation and rehabilitation.

9 Q. Is this the comparison upon which
10 the assertion is made -- that you assert that
11 policyholders have at least one option equal to
12 or greater than liquidation?

13 A. For the purposes of this comparison.

14 Q. Isn't this the comparison that's in
15 the comparison file?

16 A. It is, yes.

17 Q. Isn't this the comparison the
18 Rehabilitator is relying upon for asserting
19 that over 80 percent of policyholders are
20 better off with a rehab option, at least one
21 option than they would be in liquidation?

22 A. I don't believe that is the case,
23 no.

24 Q. Well, okay. 85 percent, is the 85
25 percent, to get to the 85 percent, is that

1 materially influenced by the high percentage of
2 policyholders that the group guessed would
3 select Option 4?

4 A. I don't think this has anything to
5 do with selecting anything. This is showing
6 that 85 percent of the people would have one
7 option available to them in which PV benefits
8 minus PV premiums is greater than it would be
9 in liquidation.

10 Q. And which of those options is going
11 to have -- had the most significant effect in
12 generating this 85 percent?

13 A. My recollection is that Option 4.

14 Q. Would it be the 81 percent shown on
15 the earlier chart we just looked at or
16 illustration we just looked at?

17 A. That 81 percent -- I don't think
18 they are the same. They are not one and the
19 same.

20 Q. So where did -- what is the
21 underlying, where are the underlying numbers
22 that you used for purposes of coming up with
23 this 85 percent, what is it based on?

24 A. This is a mathematical exercise
25 comparing these measurements on a seriatim

1 basis.

2 Q. Do you believe that is a fair and
3 reasonable way to look at the relative benefits
4 of the proposed rehabilitation options to
5 liquidation?

6 MR. BROADBENT: Your Honor, I
7 am going to object again. We are now
8 revisiting territory I think we covered two or
9 three times and continuing to go on at length.
10 And if Your Honor is inclined to continue, I
11 will withdraw the objection, but I do think we
12 are now doubling and tripling the testimony
13 that Mr. Bodnar has already given as to these
14 documents.

15 MR. LESLIE: Your Honor, the
16 amount of time we have taken during this case
17 is a fraction of the Rehabilitator's time.
18 This witness has been very precise in his
19 answers. It has been important to build to
20 this point which is critical to a comparison of
21 rehab versus liquidation and the underlying
22 reasons for that.

23 So I apologize for having to repeat,
24 but I feel I am being required to do that by
25 the witness.

1 JUDGE LEAVITT: I think the
2 witness is being very cooperative. We have
3 spent a good amount of time on this particular
4 exhibit. It is -- I understand your point,
5 it's a good one. If you can finish up.

6 As I understand it, you're trying to
7 establish for the record that the liquidator's
8 argument that 85 percent of the SHIP
9 policyholders have one option that is superior
10 to, and I hate to use the term "superior," but
11 they will fare better than in a liquidation,
12 that's Option 4? Is that what you're trying to
13 get the witness to identify?

14 MR. LESLIE: Yes.

15 JUDGE LEAVITT: Do you know
16 the answer to the question?

17 THE WITNESS: Yes, Your Honor.
18 Using this measurement of present value
19 benefits minus present value premiums, 85
20 percent of the policyholders will have one
21 choice under the plan, at least one choice
22 under the plan, in which that value, that
23 metric is greater than or equal to what they
24 would receive in liquidation. That is using
25 this metric.

1 JUDGE LEAVITT: But what
2 option of the five options?

3 THE WITNESS: Oh, generally,
4 it's Option 4.

5 JUDGE LEAVITT: Okay.

6 BY MR. LESLIE:

7 Q. Which, Mr. Bodnar, is the option
8 that has the least effect on reducing the
9 funding gap; is that correct?

10 A. Yes. That is also true, yes.

11 MR. LESLIE: I am done, Your
12 Honor.

13 JUDGE LEAVITT: Thank you.
14 Just, we will break for lunch and then resume
15 cross examination. The Court would like a
16 clarification, Mr. Bodnar. You said you based
17 this exhibit on the Penn Treaty liquidation or
18 -- maybe not this one, but the comparison where
19 you are showing the various options and the
20 percentage of choices per option.

21 THE WITNESS: Yes. So the
22 exhibit that is on your screen now, Your Honor,
23 the very left-hand.

24 JUDGE LEAVITT: Option 1.

25 THE WITNESS: Scenario 1,

1 MR. SMITH: Before I begin the
2 examination of Mr. Edwards, I just wanted to
3 address the state insurance regulators'
4 exhibits along --

5 THE COURT REPORTER: I'm
6 sorry, excuse me. Thank you.

7 MR. SMITH: Before we begin,
8 if I may just offer the exhibits. We have
9 consulted with counsel for Rehabilitator, for
10 the agents, for the health insurers and for
11 NOLHGA, and they have no objections to the
12 admissibility of the exhibits, so I just would
13 like to identify them for the record.

14 JUDGE LEAVITT: All right.

15 MR. SMITH: I have hard
16 copies. The first exhibit is Exhibit SIR-1.
17 It is an Oliver Wyman 11/20/20 Phase One
18 rehabilitation plan results as of 6/30/2020
19 exhibit with a summary of rehabilitation plan
20 results (Phase One). I note for the record it
21 has also been previously identified as Exhibit
22 RP 21.

23 The second exhibit, SIR-2, is an
24 Oliver Wyman 1/26/21 actuarial report
25 supporting the rehabilitation plan, except

1 excerpt -- it is the cover page, Page 11 and
2 Page 77. And I note for the record this is an
3 excerpt of what has been previously marked as
4 RP-16.

5 The next exhibit is SIR-3, which is
6 Oliver Wyman 3/2/21 Phase One rehabilitation
7 plan funding gap exhibits as of 6/30/2020 with
8 Phase One funding gap reduction by plan option
9 and Phase One funding gap reduction by election
10 rate scenario. And I note for the record that
11 has been previously marked as Exhibit RP 19.

12 Exhibit SIR 4 is a SHIP 12/31/20
13 income statement and balance sheet. I believe
14 that was previously marked as RP 12.

15 The next five -- the next exhibits
16 are all under Exhibit 5. 5-1, SIR 1 -- excuse
17 me, SIR 5-1 is a page entitled Impacts of
18 Liquidation on Policyholders and Guaranty
19 Associations.

20 The next exhibit, SIR 5-2, is a
21 sheet entitled Policyholder Comparison For Each
22 Phase One Option Versus Liquidation.

23 The next exhibit, SIR 5-3, entitled
24 Effect of Phase One Scenarios on Funding Gap.

25 The next exhibit, SIR 5-4, is a

1 sheet entitled Best Interest Scenario
2 Calculation.

3 The next exhibit, SIR 5-5, is a
4 sheet entitled Rehabilitation Versus
5 Liquidation Calculations Reflecting "Best
6 Interest" Scenario in Phase Two Premium
7 Increases.

8 Next exhibit, SIR 5-6, is a sheet
9 entitled Rehabilitator's Calculation of Plan
10 Benefits (Option 2) Versus Rehabilitator's
11 Calculation of Guaranty Association Benefits.

12 The next exhibit, SIR 6, is a
13 3/12/21 letter from Eric A. Smith and Michael
14 J. Broadbent called Actuarial Advisors.

15 And Exhibit SIR 7 is a 3/30/21
16 letter from Michael J. Broadbent to J. David
17 Leslie and Eric Smith responding to Exhibit SIR
18 6. And we would ask that those exhibits be
19 admitted into evidence.

20 JUDGE LEAVITT: They are
21 admitted. There is no objection?

22 MR. HAMILTON: Dexter Hamilton
23 for the Rehabilitator, no objection, Your
24 Honor.

25 MR. DONLEY: No objection,

1 Your Honor.

2 COUNSEL: No objection.

3 JUDGE LEAVITT: Ms. Glawe?

4 MS. GLAWE: No objection, Your
5 Honor.

6 (Exhibits SIR 1 through SIR 7
7 were marked for identification and admitted
8 into evidence.)

9 MR. SMITH: If I may approach
10 the witness, we are going to be using hard copy
11 exhibits, if I may give SIR 1 through SIR 5-6
12 to the witness so he has them before him.

13 JUDGE LEAVITT: Yes.

14 BY MR. SMITH:

15 Q. Would you please state your name?

16 A. Frank Edwards.

17 Q. Mr. Edwards, do you have any
18 professional credentials?

19 A. I am an associate of the Society of
20 Actuaries and a member of the American Academy
21 of Actuaries.

22 Q. Thank you. Are you employed?

23 A. As consultant, vice president, chief
24 actuary.

25 THE COURT REPORTER: I'm

1 Q. Does the comparison file provide for
2 comparisons based on maximum policy values?

3 A. There is no mention of maximum
4 policy value in the comparison file.

5 Q. Mr. Edwards, do the materials
6 provided by the Rehabilitator on the box site
7 provide the size of the funding gap?

8 A. Yes. \$1.224 billion.

9 Q. And were you asked by the Intervenor
10 state insurance regulators to calculate the
11 amount of the funding gap that would be borne
12 by policyholders in a liquidation?

13 A. Yes.

14 Q. And is your calculation set forth on
15 an exhibit?

16 A. Exhibit 1.

17 Q. Are you referring to exhibit SIR
18 5-1?

19 A. I think so. Yes.

20 Q. What was the source of the data for
21 the calculations set forth on Exhibit 1?

22 A. All the information came from the
23 comparison files in that first liquidation.

24 Q. Looking at the top of the exhibit,
25 there is a chart headed baseline and the second

1 section liquidation. Can you describe what is
2 in that chart?

3 A. Soon as I can find it.

4 JUDGE LEAVITT: We're on SIR
5 1?

6 MR. SMITH: Yes, SIR 1 -- 5-1.

7 BY MR. SMITH:

8 Q. The one-page exhibit?

9 A. Yeah.

10 Q. Looking at the top of exhibit SIR
11 5-1, there is a chart. What does that chart
12 contain?

13 A. It shows the baseline information
14 compared to liquidation.

15 Q. And what is baseline?

16 A. Baseline, the current assumption
17 used by Oliver Wyman as the comparison file,
18 which I believe is 6/30/2020, showing the
19 present value benefits, present value premiums
20 and the net benefit values in Column 3.

21 Q. And what does the section entitled
22 liquidation contain?

23 A. They have another column showing the
24 adjustment of present value future benefits by
25 including the guaranty association limits shown

1 in Column 4, and then the present value
2 benefits is adjusted based on that limit and
3 the premiums are also adjusted based on what
4 the premiums would be charged by the liquidator
5 and that present value.

6 MR. HAMILTON: Excuse me, Your
7 Honor, I don't know if I have the same -- is
8 that this document?

9 MR. SMITH: I created some
10 confusion earlier. It is Exhibit SIR-5-1.

11 BY MR. SMITH:

12 Q. Mr. Edwards, looking at the line
13 beginning total in the top, what does that line
14 contain?

15 A. Those are the values summing all the
16 policy information total for each of the items
17 in the column. So that information is the sum
18 from the comparison file rehabilitation versus
19 liquidation of the 33,261 policyholders.

20 Q. So you mentioned the file is a
21 seriatim file containing individual policy
22 information, and this is the sum of those terms
23 for each policy?

24 A. Correct.

25 Q. And were you asked to calculate the

1 impact of liquidation on policyholders?

2 A. Yes.

3 Q. And does Table 1 reflect your
4 calculation?

5 A. Yes, it does.

6 Q. Table 1 on Exhibit SIR 5-1, excuse
7 me.

8 A. Yes. It shows the baseline
9 benefits, it reduces -- compares that to the
10 present value benefits, so you have the total
11 from Column 1, you subtract off the values in
12 Column 5 to get the change in the present value
13 of benefits.

14 Q. So what is the sum of contract
15 benefits lost in liquidation compared to the
16 baseline?

17 A. Say that again.

18 Q. What is the benefits lost by
19 policyholders?

20 A. The loss by policyholders is the
21 difference to the 827 million.

22 Q. I'm sorry, I'm jumping ahead. Can I
23 ask you, first of all, what is the 303,490,655
24 number?

25 A. That is the difference in present

1 value of benefits between the baseline and
2 liquidation.

3 Q. And then what --

4 A. The next row shows a difference in
5 the premiums that would be from the present
6 value basis paid by the policyholders. So you
7 take -- the benefits are reduced, premiums are
8 increased, and then get the net difference.

9 MR. HAMILTON: If I may, Your
10 Honor, I would like to interpose an objection
11 to this testimony. Based on Mr. Leslie's
12 proffer, Mr. Edwards is a fact witness, and for
13 him to testify about things like liquidation
14 impact on policyholders, premium interest borne
15 by policyholders, I would, on behalf of the
16 Rehabilitator, we take the position that those
17 are really expert determinations, and this fact
18 witness, there is no foundation been laid and
19 this fact witness does not really have the
20 grounding to make those expert determinations.

21 So we would object to these
22 questions along with this testimony.

23 JUDGE LEAVITT: Well, I will
24 sustain the objection to the extent there is
25 any actuarial value being given, but I look at

1 Table 1 as being nothing more than a series of
2 mathematical exercises, so --

3 THE WITNESS: That is correct,
4 Your Honor.

5 JUDGE LEAVITT: So I will
6 allow the testimony. Try to limit your
7 characterizations.

8 MR. SMITH: Thank you, Your
9 Honor. This is all based, of course, on the
10 Rehabilitator's comparison file.

11 JUDGE LEAVITT: Right.

12 BY MR. SMITH:

13 Q. So let me go back. What is the
14 total impact on policyholders calculated from
15 the comparison file, and just give me the
16 dollar number?

17 A. 827 -- or the 396,969,559.

18 Q. Did you compare that number to the
19 funding gap borne by policyholders in
20 rehabilitation?

21 A. Yes.

22 Q. And where is that shown on the
23 chart?

24 A. That is shown at the bottom of
25 Table 1, subtracting that off the 1.224 billion

1 to get a difference of 827,030,441.

2 Q. So approximately -- okay. Skip
3 that.

4 Did you also calculate the amount of
5 support provided by guaranty associations?

6 A. Yes.

7 Q. And how did you do that?

8 A. Table 2 using the values of the
9 comparison file, compare the present value
10 benefits in Column 4 based on the GA and the
11 present value premium to get the difference of
12 1.641281443, and then in the file there is a 49
13 percent liquidation dividend that was
14 determined by Oliver Wyman using that amount to
15 get to adjust that difference when you get the
16 804,227,907 to get the net guaranty association
17 support of 837,053,536.

18 Q. So just to clarify, the first line
19 PV of benefits GA limit, is that the amount
20 that guaranty funds would pay based upon the
21 calculations in the comparison file?

22 A. Yes.

23 Q. And the next line, PV of premiums,
24 is that the amount that guaranty funds perceive
25 as premiums?

1 A. Yes.

2 Q. So the net guaranty fund payments in
3 the course of the liquidation as calculated in
4 the comparison file would be the \$1.6 billion
5 number?

6 A. Yes.

7 Q. And then you multiplied that by the
8 49 percent liquidation dividend to get the
9 amount that would presumably be paid in this
10 situation by the estate to the guaranty
11 association?

12 A. Correct, which is also provided by
13 Oliver Wyman.

14 Q. So the net guaranty fund association
15 would be the 837 million?

16 A. Correct.

17 MR. HAMILTON: Your Honor, may
18 I have a continuing objection to this
19 testimony? I still have the same concern.
20 This witness is testifying about things that
21 would happen if the receivership were to go
22 into liquidation and the guaranty associations
23 would take certain actions.

24 There are certain numbers, but this
25 witness, to put it in this chart that he

1 witness who is doing mathematical calculations
2 to testify about a document and present to the
3 Court and put in this record a conclusion of
4 policyholders being better off.

5 That is an expert opinion.

6 JUDGE LEAVITT: I agree that
7 it is opinion and this witness has not been
8 qualified as an expert. Nevertheless, with
9 those qualifications. But I would ask,
10 Mr. Smith, that you, when you -- as you
11 question Mr. Edwards about these exhibits, you
12 have been very helpful in identifying where the
13 numbers come from in the Oliver Wyman work, but
14 I think what you need to do is define what you
15 mean by "better off" or anything that has -- is
16 in the nature of what most people would say is
17 expressing a value judgment.

18 MR. SMITH: Your Honor, I
19 stand admonished. I would only add that this
20 exhibit was prepared in the context of
21 responding to the comparison file which
22 permitted this particular comparison.

23 JUDGE LEAVITT: All right.

24 BY MR. SMITH:

25 Q. Looking at the next couple of lines

1 down, the -- just let me complete the analysis;
2 the first column under Option 1, what is the
3 61.97 percent number, Mr. Edwards?

4 A. Could you repeat that?

5 Q. Looking in the Option 1 column,
6 going down to the line which contains the
7 number 61.97 percent --

8 A. Correct.

9 Q. Can you just tell me what that
10 percentage means?

11 A. That is the percentage of the 61 is
12 better off, as we have used that name, for
13 liquidation 61.97, it's just a simple ratio of
14 the 20,611 over the 33,261.

15 Q. Okay. So for Option 1, 61.97
16 percent of the policyholders have a net present
17 value in liquidation that exceeds that in any
18 of the rehabilitation options; is that correct?

19 A. Correct.

20 Q. Excuse me. Moving quickly over to
21 the Option 4 column, what is the 83.04 percent
22 number?

23 A. That represents the percentage of
24 policyholders' net present value is greater in
25 rehabilitation versus liquidation.

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

In Re: Senior Health Insurance :
Company of Pennsylvania (in : **No. 1 SHP 2020**
Rehabilitation) :

**STATE INSURANCE REGULATORS’
APPLICATION FOR STAY PENDING APPEAL**

Pursuant to Pa. R.A.P. 123 and 1732(a), the Intervenor Superintendent of Insurance of the State of Maine, Commissioner of Insurance of the Commonwealth of Massachusetts, and Insurance Commissioner of the State of Washington (“State Insurance Regulators”), move for a stay pending appeal of the August 24, 2021 Order granting the application of the Insurance Commissioner of the Commonwealth of Pennsylvania as Rehabilitator (“Rehabilitator”) of Senior Health Insurance Company of Pennsylvania (“SHIP”) for approval of the Second Amended Plan of Rehabilitation (“Plan”), as well as the May 21, 2021 ruling granting the Rehabilitator’s motion in the nature of a directed verdict regarding issue state rate approval and the August 25, 2021 Order denying reconsideration. The State Insurance Regulators filed their appeal on September 21, 2021.

Introduction

This case involves an unprecedented plan of rehabilitation for an insolvent insurance company. The Plan places the entire \$1.2 billion burden of the

insolvency on 30,000 of SHIP's remaining policyholders through benefit cuts and premium increases even though, in a liquidation, based on the Rehabilitator's comparison analysis, the policyholders would only bear a loss of \$400 million, as guaranty associations would provide over \$800 million of additional support. The Plan also supersedes the authority of insurance regulators in other states to review rates for policies issued in their States.

The Court approved the Plan over the objections of the Intervenor State Insurance Regulators. It expressed fundamental disagreement with the Intervenor's position that the policyholders' best financial interest must be protected in an insolvency and that state regulators control rates in their states. The Court instead took the view that (a) SHIP's policies were historically "underpriced" so that policyholders should bear the burden of insolvency instead of the guaranty associations and those who fund them, and (b) the state-based rate review system historically resulted in "discriminatory" rates so that rates should be set nationwide by the Rehabilitator and the Court.

In their appeal, the State Insurance Regulators contend that the Rehabilitator was required as a matter of law to protect the financial interest of policyholders in their contracts, rather than pursuing other goals, and that the Rehabilitator and Court must take the policies as they find them. Deeming policyholders unworthy of guaranty association protection and deciding instead to protect those who fund

the guaranty associations is contrary to the purpose of the guaranty association statutes. The Plan was constitutionally required, but fails, to provide all policyholders an option with a value at least equal to the value they would receive in liquidation. Finally, the Plan exceeds statutory authority and violates the Full Faith & Credit Clause by displacing insurance regulators from their statutory role in reviewing rates applicable to policies issued in their States.¹

These novel and important issues should be resolved by the Supreme Court before the Plan is implemented and the rights of policyholders and insurance regulators permanently impaired. The Plan will not correct SHIP's insolvency. However, implementation of the Plan will alter the *status quo* and permanently reduce the contract rights of policyholders so that they will have less protection from insurance guaranty associations when SHIP is inevitably liquidated. It will also require insurance regulators to decide whether to "opt-out" of the Plan to the detriment of policyholders in their States.

The Rehabilitator is now moving to implement the Plan. In the "Approved SHIP Rehabilitation Plan" as corrected September 30, 2021, the Rehabilitator advised that:

¹ The appeal also involves additional and more specific issues. This relatively brief application does not address all grounds for the appeal. The State Insurance Regulators reserve and do not waive any grounds not discussed herein.

Implementation of the Plan commenced following the entry of the Court’s Memorandum Opinion and Order. We anticipate that most policyholders will be sent Policyholder Election Packages around year-end and be asked to make their elections by around mid March, 2022, becoming effective in April of next year.

Praecipe to Substitute Approved Plan of Rehabilitation, Exhibit A, p. 19

(September 30, 2021). This is consistent with the testimony at the hearing. *See* Memorandum Opinion dated August 24, 2021 (“Mem. Op.”) at 6, 47, 77.

Insurance regulators will need to make “opt-out” decisions following approximately November 15, 2021. *See* Rehabilitator’s Email to Commissioners dated September 20, 2021 (attached as Exhibit A hereto).

If the Plan is implemented before the appeal is heard and decided, the Rehabilitator may contend that the appeal is equitably moot and that the policyholders’ and regulators’ rights have been permanently altered despite the pending appeal. The Court should accordingly grant this application and stay its Orders pending appeal.

Standard for Stay Pending Appeal and Summary

The standard governing this application for stay is well-established.

On an application for stay pending appeal the movant is required to make a substantial case on the merits and to show that without the stay, irreparable injury will be suffered. Additionally, before granting a request for a stay, the court must be satisfied the issuance of the stay will not substantially harm other interested parties in the proceedings and will not adversely affect the public interest.

Maritrans G.P., Inc. v. Pepper, Hamilton & Scheetz, 573 A.2d 1001, 1003 (Pa. 1990) (decision of Nix, C.J.) (citing *Pa. Pub. Util. Comm'n v. Process Gas Consumers Grp.*, 467 A.2d 805, 808-809 (Pa. 1983)). A stay pending appeal should be granted here.

First, the State Insurance Regulators have a strong case on the merits of their arguments that the Plan should not be approved. As discussed below, the Plan is not feasible as required by law; constitutes an abuse of discretion and error of law because it does not serve the best financial interest of policyholders and ignores guaranty associations; fails to place policyholders in at least as good a position as in a liquidation as required by *Neblett v. Carpenter*, 305 U.S. 297 (1938); and exceeds statutory authority and violates the Full Faith and Credit Clause in superseding the regulatory authority of other States over rates.

Second, the policyholders of SHIP and the State Insurance Regulators will suffer irreparable injury if the Plan is implemented during the appeal. The Plan will permanently reduce policyholders' contract rights and displace state insurance regulators from their statutory role in reviewing rates. If the Plan is implemented before the appeal is decided, the Rehabilitator may contend that the appeal is equitably moot. If so, this would leave policyholders with reduced coverage and reduced guaranty association protection in the inevitable liquidation, and regulators with no role in determining rates in their States.

Third, issuance of a stay pending appeal will not harm other interested persons. It will preserve the *status quo*. Policyholders will continue to pay premiums at the lawfully approved rates as before, and those on claim will continue to receive claim payments as they have during the pendency of the Rehabilitator's application for approval of the Plan. The intervenor agents and brokers have settled their issues. *See* Memorandum Opinion dated September 13, 2021. Finally, so long as the appeal is pending, SHIP will not be liquidated and the intervenor health insurers will not need to pay guaranty association assessments.

Fourth, a stay will not adversely affect the public interest. This appeal protects the financial interests of policyholders that are intended to be protected by the insurer receivership statutes and the guaranty association system and protects the state-based rate regulatory system. The Rehabilitator may contend that delaying benefit cuts and premium increases under the Plan will ultimately increase the size of SHIP's insolvency and the burden on the guaranty associations, their member insurers and, in many States, on taxpayers when SHIP is liquidated. That is not cognizable "harm" because the guaranty associations were created specifically to protect policyholders in the event of an insolvency, and the legislatures have determined how to allocate the burden of that protection.

Factual Background

While most of the basic facts on which the State Insurance Regulators rely are referred to in the Court's Memorandum Opinion, some are omitted, understated or only noted in passing. The essential facts are set forth below.

1. SHIP's policies are enforceable contracts, and the premiums charged on the policies historically and on the rehabilitation date were lawfully approved rates. Tr. 227-229, 282.

2. SHIP is insolvent, with a deficit or "funding gap" of approximately \$1.2 billion. Ex. RP-55 (the Plan) at 87.

3. Under the Plan, the burden of reducing or eliminating the \$1.2 billion funding gap will rest on the 30,000 remaining SHIP policyholders who have not taken non-forfeiture options. Tr. 290-292; Ex. RP-55 at 102-103. The Plan seeks to reduce the funding gap by reducing policy benefits and increasing premiums. Ex. RP-55 at 10, 102-103.

4. The Plan requires policyholders to select among options, only one of which (Option 4) retains the policyholders' full benefits in Phase One. The other options (Options 1, 2, 2a, and 3) all reduce benefits in Phase One. Ex. RP-55 at 23-24; Tr. 113-117. Policyholders who choose Options 1 or 4 in Phase One face the possibility of additional substantial rate increases or benefit reductions in Phase Two. Ex. RP-55 at 15, 58.

5. In a liquidation, virtually all of SHIP's policies would be covered by one of the guaranty associations created by statute in each state, subject to the individual state statutory limits on guaranty association coverage. Ex. RP-55 at 93.

6. If SHIP were liquidated now so that guaranty associations are triggered, policyholders will absorb only approximately \$397 million of the funding gap, based on the Rehabilitator's comparison file. Ex. SIR 5-1, Table 1; Tr. 564. This is because guaranty associations would provide approximately \$837 million in additional support to benefit policyholders, also based on the Rehabilitator's comparison file. Ex. SIR 5-1, Table 2; Tr. 565-66. The Plan does not trigger the guaranty associations, Ex. RP-55 at 92, so these additional funds will not be available to benefit policyholders under the Plan.

7. The policyholder elections under the Plan will be permanent in that guaranty association coverage may be given up. If SHIP is placed in liquidation after the Plan is implemented, the policies to which guaranty association coverage will apply will be the policies as modified as a result of the elections. EX. RP-55 at 14, 92; Tr. 300-301, 313.

8. The Plan is highly unlikely to eliminate the funding gap and restore SHIP to solvency, even considering both Phase One and Phase Two. Tr. 80, 306. In all likelihood, the Plan will not eliminate the deficit, just reduce it materially. Tr. 189-190.

9. The Plan will not provide all policyholders with an option with a net present value (present value of future benefits less present value of future premiums) at least as great as the net present value in liquidation. Only 85% of policyholders will have at least one Phase One option with a net present value equal to or greater than liquidation. Ex. RP-7; Tr. 183, 185, 510, 512. This 85% rests principally on Option 4. Tr. 510, 512-513, 572; Ex. SIR 5-2. Option 4 has the least impact on the funding gap, and it is subject to further adjustment in Phase Two. Tr. 259, 513; Ex. RP-55 at 14.

10. Under state statutes, long term care insurance rates are reviewed and approved by the insurance regulatory official of the state in which the policy is issued. Tr. 155, 157. Each state has its own approach to reviewing rates. Tr. 413-414. The Plan does not follow this issue state rate approval process. Ex. RP-55 at 33-34, 96; Tr. 158-159. It removes state insurance regulators from their role in reviewing rates, which is “unprecedented.” Ex. RP-55 at 33-34; Tr. 82. Under the Plan, the Rehabilitator will not seek approval of rates from state regulators under their statutes but instead from the Commonwealth Court. Ex. RP-55 at 33-34, 96.

11. The Plan has an “issue state rate approval” section under which state regulators purportedly may “opt-out” of having the Commonwealth Court approve rates. Ex. RP-55 at 108. The section provides that, unless the “opt-out” state approves the Rehabilitator’s rate application, in full, within 60 days, it is deemed

denied. Ex. RP-55 at 111. In that case, the options available to policyholders in that state will be more limited than the options available in other states, and the state's policyholders will be disadvantaged. Ex. RP-55 at 109, 116; Tr. 169-170.

ARGUMENT

I. THE STATE INSURANCE REGULATORS HAVE A STRONG CASE ON APPEAL.

The State Insurance Regulators have substantial arguments that the Court's approval of the Plan should be reversed because the Plan is based on errors of law. To warrant approval under 40 P.S. § 221.16, the Plan must be free from any abuse of the Rehabilitator's discretion. *Foster v. Mutual Fire, Marine and Inland Ins. Co.*, 614 A.2d 1086, 1091 (Pa. 1992) ("*Mutual Fire II*"), *cert. denied* 506 U.S. 1080 and 1087 (1993). "It is a paradigmatic abuse of discretion for a court [or the Rehabilitator] to base its judgment upon an erroneous view of the law." *Commonwealth v. Taylor*, 230 A.3d 1050, 1072 (Pa. 2020).

A. The Court Erred In Holding That There Is No Feasibility Requirement And That The Plan Was Feasible Where It Is Highly Unlikely To Restore SHIP To Solvency.

The goal of the Plan as originally presented to the Court was to restore SHIP to solvency – "to restore SHIP to a financially self-sustaining long-term care insurance company." Rehabilitator's Application for Approval of the Plan of Rehabilitation ¶ 2 (April 22, 2020). At the hearing, however, the Special Deputy Rehabilitator conceded that "it is not likely that we will magically restore SHIP to

solvency.” Tr. 80. The Court seemed to acknowledge this (Mem. Op. 14, 24-25), but it later said that the Plan “will reduce or eliminate” the funding gap (Mem. Op. 78) as if elimination were a reasonable possibility. The Special Deputy Rehabilitator made clear it was not. He testified that: “In all likelihood [the Plan] will not eliminate [the deficit]. In all likelihood, it will just reduce it materially.”

Tr. 190. Further:

Q. . . . Yesterday you testified that it was unlikely, I think highly unlikely, that the plan could eliminate the funding gap. Did you mean Phase One or did you mean Phase One and Phase Two?

A. I meant Phase One and Phase Two. . . .

Tr. 306. The most that can be said is that the Plan will “materially reduce” the funding gap. Mem. Op. 67; Tr. 90. But if the Plan only materially reduces the funding gap, SHIP will still need to be liquidated.

The Court held that feasibility is not required, and that it is sufficient if the Plan reduces the funding gap because it also pursues other goals. This was error.

1. A Rehabilitation Plan Must Be Feasible.

To be approved, a rehabilitation plan for an insolvent insurer must be reasonably likely to restore the insurer to solvency. This commonsense requirement reflects the fact that if the insurer continues to be insolvent after the plan, it will still need to be liquidated. It is not enough that the “ultimate goal” of a plan is to restore the company to solvency if the plan is not likely to actually do so.

Feasibility is a well-recognized requirement. *See 1 Couch on Ins.* § 5:24 (3d ed. 2021) (“Above all, the rehabilitation plan must be feasible . . .”). Contrary to the opinion (Mem. Op. 65), feasibility has been recognized as a requirement in Pennsylvania decisions. For instance, in an earlier case in which the insurer opposed liquidation, the Supreme Court held that “[i]t is clear that [the company] has the burden of showing that rehabilitation is feasible.” *Sheppard v. Old Heritage Mut. Ins. Co.*, 425 A.2d 304, 310 (Pa. 1980) (citing *Comm. Ins. Dep’t v. Safeguard Ins. Co.*, 336 A.2d 674, 680) (Pa. Commw. 1975)). In *Mutual Fire II*, the Supreme Court detailed the history of the rehabilitator’s and trial court’s consideration of feasibility. 614 A.2d at 1090. While feasibility was not an issue on appeal, the discussion shows that a rehabilitation plan that is not feasible should not be approved. *See also Grode v. Mutual Fire, Marine & Inland Ins. Co.*, 688 A.2d 233, 234 (Pa. Commw. 1996) (noting that court had required the rehabilitator to report on feasibility and that the initial plan did not proceed because it was not feasible). The feasibility requirement also rests on the statutory standard for conversion to a liquidation. Tr. 90. Where rehabilitation is “futile,” it should not proceed. *See* 40 P.S. § 221.18.

Feasibility is particularly important here because the Plan is expressly intended to permanently reduce policyholders’ benefits and increase their premiums. Ex. RP-55 at 14, 92. If SHIP is liquidated after the Plan is

implemented, the guaranty associations and liquidation estate will only cover contractual obligations as reduced under the Plan. The amount by which SHIP's liabilities are reduced will not be covered in a subsequent liquidation.

2. The Court's Redefinition of Feasibility is Unlikely to be Upheld.

The Court refashioned the concept of feasibility, holding that it just means "properly conserving and equitably administering the assets of the involved insurer." Mem. Op. 66. This deprives feasibility of any meaning. That language from *Mutual Fire II* did not describe the purpose of rehabilitation but only that a plan need not restore the company "to its exact original condition." 614 A.2d at 1094.

"The goal of rehabilitation is to manage the affairs of an insolvent insurer with the intended result of restoring the entity to sound fiscal status." *Mutual Fire II* at 1096 (emphasis added). See *Kueckelhan v. Fed. Old Line Ins. Co.*, 444 P.2d 667, 674 (Wash. 1968) (*en banc*) (rehabilitation aims to "restore the company to a viable status for the benefit of the policyholders"). The Plan's feasibility must be measured against the goal of restoring SHIP to solvency.²

² The State Insurance Regulators have not contended that feasibility requires SHIP to resume operation as an insurer writing insurance in the market, only that the Plan (assuming it were otherwise proper) must be reasonably likely to restore SHIP to solvency so that it can run off its obligations paying them in accordance with the options selected pursuant to the Plan.

Where the insurer is insolvent, measuring feasibility against goals other than financial viability is improper. Whatever the merits of the other goals, liquidation will follow if the insurer remains insolvent. Rehabilitation must be reasonably likely to avoid liquidation, and not – as here – just serve as a means to reduce policyholders’ contract rights on the way to inevitable liquidation.

B. The Plan Constitutes An Abuse Of Discretion, Exceeds The Rehabilitator’s Authority And Is Contrary To Law By Disregarding The Financial Interest Of Policyholders And The Guaranty Association System.

The Court’s approval of the Plan is an unprecedented departure from the fundamental goal of insurer rehabilitations – to protect to the maximum extent possible the contractual rights of policyholders. Instead of seeking to protect those contract rights, the Court approved reductions in those rights on the unprecedented theory that the policies were historically “underpriced.” Mem. Op. 43, 51, 63-64. The Court explicitly rejected triggering the insurance guaranty associations established to protect policyholders’ contract rights because that would impose a burden on the association’s insurer members and, ultimately, upon taxpayers. Mem. Op. 45, 63, 81. The Court also relied on its view that the state-based rate approval system has resulted in “discriminatory” rates contrary to the public good. Mem. Op. 45, 68-69, 80-81.

The Court’s approval of the Plan on these policy grounds (*see* Tr. 295) is contrary to the purpose of the rehabilitation statute to protect policyholders to the

maximum extent possible and frustrates the legislative judgment that the policyholders of insolvent insurers warrant guaranty association coverage. “[T]he power of courts to formulate pronouncements of public policy is sharply restricted. . . . Generally speaking, the Legislature is the body to declare the public policy of a state and to ordain changes therein.” *Conway v. Cutler Grp., Inc.*, 99 A.3d 67, 72 (Pa. 2014) (quoting *Mamlin v. Genoe (City of Phila. Police Beneficiary Ass’n)*, 17 A.2d 407, 409 (Pa. 1941)). The Court’s disregard of the statutory mandates to advance its policy views, at the expense of policyholders, is impermissible.

1. The Plan Is Adverse to the Best Financial Interest of Policyholders.

SHIP is massively insolvent, with a deficit of \$1.2 billion. Accordingly, it could be placed in liquidation on grounds of insolvency, *see* 40 P.S. § 221.19, § 221.14(1), which would trigger guaranty association coverage. The undisputed evidence, based on the Rehabilitator’s own Comparison File, is that in a liquidation the guaranty associations would provide over \$800 million in additional support, so that in liquidation the policyholders would bear a loss of only \$397 million from SHIP’s insolvency. While the Court acknowledges this (Mem. Op. 31-32), its decision disregards this undisputed adverse financial impact on policyholders.

Under the Plan, the entire \$1.2 billion burden of SHIP’s insolvency rests on SHIP’s 30,000 remaining non-NFO policyholders through benefit cuts and premium increases – even though those policyholders only contributed to part of

the Funding Gap. The benefits foregone under the Plan will be given up permanently, and they cannot form the basis for a claim to guaranty association benefits or a liquidation dividend in any subsequent liquidation. In a present liquidation, by contrast, the policyholders stand to receive the benefit of guaranty association coverage based on their original policies plus potentially a liquidation dividend on the excess. The Rehabilitator and Court thus chose to place the entire burden of the insolvency on the remaining policyholders and to forgo over \$800 million in guaranty association support that in a liquidation would fill much of the funding gap, spread the loss, and reduce the burden of insolvency on policyholders.

2. Placing the Burden of Insolvency on Policyholders is Contrary to the Purpose of the Rehabilitation Statute.

This disregards the fundamental purpose of the rehabilitation statute – to protect policyholders by preserving their contract rights to the maximum extent possible. A rehabilitator’s “first duty [is] to the ‘grave and important public interest’ in not depriving the . . . policyholders of the protection of their policies.” *In re Exec. Life Ins. Co.*, 38 Cal. Rptr. 2d 453, 465 (Cal. Ct. App. 1995) (emphasis added) (quoting *Carpenter v. Pacific Mut. Life Ins. Co. of Cal.*, 74 P.2d 761, 775 (Cal. 1937) (“*Carpenter*”), *aff’d sub nom. Neblett v. Carpenter*, 305 U.S. 297 (1938) (brackets omitted)). The goal of rehabilitation is not just to restore the company to solvency, but to do so in a way that benefits policyholders. *See*

Kueckelhan, 444 P.2d at 674 (rehabilitation aims to “restore the company to a viable status for the benefit of the policyholders”) (emphasis added). A rehabilitation plan must minimize harm to policyholders, as the statutes aim to protect them. *See* 40 P.S. § 221.16.

To support its efforts to “correct” historical underpricing and rates and avoid burdening those who fund the guaranty associations, the Court relied on general statements in *Mutual Fire II* that rehabilitation is intended to protect “the public good.” *See* Mem. Op. 42-43 (quoting *Mutual Fire II*, 614 A.2d at 1094 & n. 4). *See* 40 P.S. § 221.1. Those generalized statements, however, do not address the question here: whether a plan can advantage other persons to the detriment of policyholders. That issue was not presented in *Mutual Fire II*. Indeed, the Supreme Court recognized the primacy of policyholder interests elsewhere in the decision. *See Mutual Fire II*, 614 A.2d at 1100 (“If, after all, insurance is to perform its function of risk assumption and distribution of loss, then those statutes which govern it must first protect the insuring public.”) (quoting *Mutual Fire I*, 572 A.2d at 807) (emphasis added); *id.* at 1102 (referring to “the ultimate goal of this process, the overall good of the general public and the insurer’s policyholders”) (emphasis added); *id.* at 1104 (referring to “the statutorily charged duty of the Rehabilitator to protect the interests of Mutual Fire insureds”) (emphasis added). The Supreme Court’s initial, general statements do not provide

the Rehabilitator with a roving commission to adjust contract rights and refuse guaranty association support as she chooses.

The rehabilitation statute is limited. It provides for a rehabilitator to “correct” the conditions that constituted the ground for the rehabilitation order (here, insolvency), not to require the policyholders to exclusively bear the consequences. 40 P.S. § 221.16(b), (d). A rehabilitator is to honor policies to the extent possible and treat policyholders equally. *See* 40 P.S. § 221.15(d) (rehabilitation order “shall not constitute an anticipatory breach of any contracts of the insurer”); 40 P.S. § 221.44 (preferring policy obligations by giving them priority and prohibiting subclasses within a priority class). The statutes do not contemplate that a rehabilitator will decide that policyholders have been “underpaying” for “Cadillac” policies and should have their benefits cut. Tr. 78, 102. This may leave SHIP as an entity in “better shape” (Mem. Op. 25), but its policyholders are worse off. A plan that only attempts to materially reduce the size of the insolvency at the sole expense of policyholders, but still leaves the company insolvent, is not a proper rehabilitation plan.

3. The Court Improperly Rejected Guaranty Association Protection for Policyholders.

The Court approved the Plan because, in its view, SHIP’s policyholders should have paid more for their coverage so that it is “unjustified” to seek to trigger the guaranty associations because that would burden others through the

assessment mechanism. Mem. Op. 43, 45, 63, 81. This rationale is legally erroneous. The Court’s view that it “serves the public good” (Mem. Op. 43) to avoid triggering guaranty associations is contrary to the very purpose of having such associations. The legislatures in Pennsylvania and other states have chosen to protect policyholders of insolvent insurers by establishing guaranty associations to provide coverage (subject to certain limits), and they have chosen how to spread the burden of those protections through the assessment mechanism. It is not within the Rehabilitator’s or Court’s discretion to reject these statutory protections because they deem the policyholders unworthy of guaranty association support. *See Weaver v. Harpster*, 975 A.2d 555, 563 (Pa. 2009) (“[I]t is for the legislature to formulate the public policies of the Commonwealth.”)

Guaranty associations were established to protect policyholders by fulfilling the insolvent insurer’s contractual obligations (subject to statutory limits). For instance, the Pennsylvania statute provides:

The purpose of this article is to protect, subject to certain limitations, [policyholders] against failure in the performance of contractual obligations, under life, health and annuity policies, plans or contracts . . . because of the impairment or insolvency of the member insurer that issued the policies, plans or contracts.

40 P.S. § 991.1701. The statutes do not limit guaranty association coverage based upon the insufficiency of premiums that the policyholders paid in the past. They

seek to honor the insurer's contractual obligations, subject to specific limits. *E.g.*, 40 P.S. § 991.1703, § 991.1706(b).

The legislatures also chose how to allocate the burden of honoring the insurer's contractual obligations. The guaranty association statutes generally fund the associations through assessments on member insurers. *See, e.g.*, 40 P.S. § 991.1707. They typically permit the member insurers to offset the assessments against their premium tax obligations or to recoup assessments by a surcharge on premiums. *See, e.g.*, 40 P.S. § 991.1711. The legislatures chose to spread the burden of an insurer's insolvency broadly, including on taxpayers, not to focus it exclusively on the insurer's policyholders.

The Court improperly overrode these legislative judgments.

C. The Court Misapplied *Neblett v. Carpenter*.

The State Insurance Regulators also have substantial arguments that the Plan fails to satisfy the requirement of *Neblett v. Carpenter*, 305 U.S. 297 (1938), that the Plan must place policyholders in no worse off a position than they would face in a liquidation of SHIP. Contrary to the decision (Mem. Op. 62), this fundamental standard was recognized by the Supreme Court in *Mutual Fire II*. *See Mutual Fire II*, 614 A.2d at 1093-94 (“Under *Neblett*, creditors must fare at least as well under a rehabilitation plan as they would under a liquidation . . .”), at 1096 (plan provision “ensures that the creditors herein, at a minimum, will fare at least

as well under the rehabilitation as they would in a liquidation proceeding as mandated by the holding of *Neblett*”), and at 1096 n. 6 (noting “the fundamental right of the creditors to be treated, at a minimum, as well under the rehabilitation as they would in a liquidation”).³

Under this standard, the Plan must provide policyholders with an option that provides at least the value of the policyholder’s policy in liquidation. *See Neblett*, 305 U.S. at 305 (policyholders were not forced to accept policy modifications “but are given the option of a liquidation which on this record appears as favorable to them as that which would result from the sale of the assets and pro rata distribution in solution of all resulting claims for breach of outstanding policies.”). The Supreme Court in *Mutual Fire II* did not replace the *Neblett* standard with the three-part test of *Energy Reserves Grp., Inc. v. Kan. Power and Light*, 459 U.S. 400 (1983). It treated them as two separate issues.

Neblett established a floor of liquidation value that each policyholder should be able to obtain if desired. It is undisputed that the Plan fails to provide every

³ The Commonwealth Court has previously shared this understanding of *Neblett*. In the decision leading to *Mutual Fire II*, the Commonwealth Court said “[T]he Rehabilitator agrees that *Neblett* requires claimants be treated the same or better than in liquidation. We shall not belabor this point except to agree with the parties that the Plan must also be viewed in the light of this principle.” *Mutual Fire I*, 572 A.2d at 804. *See also Koken v. Fidelity Mut. Life Ins. Co.*, 907 A.2d 1149, 1155 (Pa. Commw. Ct. 2006) (“Under the Plan, [creditors] have received or will receive at least as much as they would receive in a forced liquidation, as is required if a rehabilitation plan is to be deemed fair and equitable,” citing *Mutual Fire II*).

policyholder with such an option based on the “Carpenter value” of net present value (present value of benefits less present value of premiums). Based on the Rehabilitator’s own Comparison File, only 85% of policyholders have such an option in Phase One. Mem. Op. 65. Moreover, this percentage falls sharply if Phase Two is considered. The Court cited evidence showing that the 85% figure principally reflects the availability of Option 4 in Phase One, that Option 4 is subject to benefit reductions and premium increases, and that premium increases alone can bring the percentage of policyholders with net present value in excess of liquidation value below 50%. Mem. Op. 31-32. However, the Court did not address the significance of these points.

The Court instead rejected the net present value Carpenter value relied on by the State Insurance Regulators (and, initially, by the Rehabilitator) in favor of the Rehabilitator’s new “maximum policy value” approach. Mem. Op. 64-65. This does not comport with *Neblett*. The Supreme Court set the constitutional floor as the value that would result “from the sale of the assets and pro rata distribution in solution of all resulting claims for breach of outstanding policies.” *Neblett*, 305 U.S. at 305. That is the net present value. *See 1 Couch on Ins. 3d* § 6:1 (2021). The “maximum policy value” of a policy is not the value of a claim for breach of the policy. It is just the maximum amount that a policy could pay. *See* Ex. RP-55 at 126 (defining “Maximum Policy Value” as the Maximum Daily Benefit times

the Maximum Benefit Period). It is an “outer boundary” (Tr. 468) that does not consider the likely amount (projected value) of a claim or the cost (projected premiums) of the policy. RP-55 at 126. Maximum policy value is not economic value, and it is not a proper measure for the constitutional standard under *Neblett*.

**D. The Court Erred In Overriding The States’
Regulatory Authority Over Rates.**

The State Insurance Regulators also have strong grounds to contend that the Court’s approval of the Plan should be overturned because the Plan’s rate provisions exceed the authority granted to the Rehabilitator by the Pennsylvania statutes and violate the Full Faith & Credit Clause. Rate regulation has long been committed to the individual States. See 1 *Couch on Ins.* 3d § 2:31 (2021); *German All. Ins. Co. v. Lewis*, 233 U.S. 389 (1914); *Ins. Dep’t v. City of Phila.*, 173 A.2d 811, 813 (Pa. Super. Ct. 1961). The states regulate rates for long-term care insurance by providing for review by the insurance regulator of the State in which the policyholder resided when the policy was issued and judicial review in the courts of that State. See, e.g., 24-A Me. Rev. Stat. § 2736; Mass. Gen. Laws ch. 175, § 108; Wash. Rev. Code § 48.19.010(2), §§ 48.83, 48.84, § 48.18.110. The Court improperly overrode these statutes.

**1. The Rehabilitation Statute Does Not Authorize
Displacement of State Regulatory Authority.**

The Court’s expansive view of the Rehabilitator’s powers (Mem. Op. 49-50) is not consistent with the statutory language. “A creature of statute, such as the

Insurance Commissioner acting as rehabilitator, can only exercise those powers which have been conferred by the Legislature in clear and unmistakable language.” *Koken v. Legion Ins. Co.*, 831 A.2d 1196, 1227 (Pa. Commw. Ct. 2003). The statutes do not authorize the Rehabilitator and Court to impose rates in disregard of the long-standing state-based system for review and approval of insurance rates. The rehabilitation statutes provide the Rehabilitator with control over assets and the business of the insurer. They do not oust state regulation of the insurer.

An order to rehabilitate an insurer “shall appoint the commissioner . . . rehabilitator and shall direct the rehabilitator forthwith to take possession of the assets of the insurer . . . and to administer them under the orders of the court.” 40 P.S. § 221.15(c). Subject to court approval, a rehabilitator “may take such action as he deems necessary or expedient to correct the condition or conditions which constituted the grounds for the order of the court to rehabilitate the insurer.” 40 P.S. § 221.16(b). Nothing in this language provides the rehabilitator with authority beyond the insurer itself. Its limited scope is confirmed by the sentences that follow, which specify that the rehabilitator “shall have all the powers of the directors, officers and managers” and “full power to direct and manage, to hire and discharge employees subject to any contract rights they may have, and to deal with the property and business of the insurer.” *Id.* (emphasis added). The statutes

authorize the Rehabilitator to manage SHIP. *See Koken*, 831 A.2d at 1227-1228.

They do not authorize her to disregard State regulation.⁴

Nor does the provision for rehabilitation plans exempt insurers in rehabilitation from State regulation. A rehabilitator may “prepare a plan for the reorganization, consolidation, conversion, reinsurance, merger or other transformation of the insurer.” 40 P.S. § 221.16(d). This does not authorize a rehabilitator to change contracts and rates without required regulatory approvals. Nothing in the text allows the Rehabilitator or Court to supplant otherwise applicable regulatory authority over the business of the insurer in other States.

A domiciliary state has an interest in rehabilitation, but it is not “overriding” (Mem. Op. 52). The rehabilitation statutes recognize that a rehabilitator must seek relief from courts in other jurisdictions as to litigation in other states. 40 P.S. § 221.5(b) (“The receiver may apply to any court outside of the Commonwealth for the relief described in subsection (a) or suspension of any insurance licenses issued by the commissioner.”); 40 P.S. § 221.17(a). Article V also specifies that it “shall not be interpreted to limit the powers granted the commissioner by other provisions of the law.” 40 P.S. § 221.1(a). Where the Article expressly does not

⁴ The language describing Article V’s purpose further demonstrates the intent to authorize displacement of private, not public actors: “The purpose of this article is the protection of the interests of insureds, creditors, and the public generally, with minimum interference with the normal prerogatives of the owners and managers of insurers” 40 P.S. § 221.1(c) (emphasis added). *See also* 40 P.S. § 221.6 (requiring cooperation by officers and employees).

limit the Pennsylvania Commissioner's regulatory authority, it cannot reasonably be interpreted to limit the regulatory authority of other States.

The purpose of rehabilitation is “to rehabilitate the business of an insurer,” 40 P.S. § 221.15(b), not to supersede regulation of the insurer. *Cf. Koken v. Fidelity Mut. Life Ins. Co.*, 803 A.2d 807, 826-827 (Pa. Commw. 2002). (rehabilitation plan provided that “FLIC obtain all necessary regulatory approvals to do business in the respective states”). The Plan's displacement of other states' regulatory authority exceeds statutory authority and is likely to be reversed.

2. The Full Faith & Credit Clause Protects Other State's Regulation Over Rates Within Their Boundaries.

Finally, the State Insurance Regulators have compelling arguments that the Court's ruling concerning the Full Faith and Credit Clause is erroneous. The purpose of the clause “was to alter the status of the several states as independent foreign sovereignties, each free to ignore obligations created under the laws or by the judicial proceedings of the others.” *Baker ex rel. Thomas v. General Motors Corp.*, 522 U.S. 222, 232 (1998) (quoting *Milwaukee Cnty. v. M.E. White Co.*, 296 U.S. 268, 277 (1935)). The Court's view that it can set rates in other states and supersede their statutes requiring review by their own regulatory officials violates this command.

Insurance rates are a matter of particularly local concern and regulation, and the States have placed responsibility for rates on their own insurance officials. The cases cited by the Court do not support extraterritorial jurisdiction to set rates in other states. The Plan works more than a “change[] in forum” (Mem. Op. 58), and the Court’s assertion that the rate setting statutes are all essentially alike (Mem. Opp. 57) ignores the evidence that rates have historically varied across states, and that state rate setting practices differ. See Ex. RP-55 at 88; Tr. 413-414. See Mem. Op. 14, 28. A Pennsylvania court cannot dictate to other States what rates are to be applied to policies issued in their jurisdictions, nor can it require that they “surrender[]” (Tr. 169) their authority and unilaterally substitute itself (or the Pennsylvania Commissioner) for the officials designated to review rates.

The Court’s decision plainly reflects hostility to state-based rate setting and the different rates that may result from it. See Mem. Op. 14-15 (describing rate structure resulting from different responses of state regulators to SHIP’s requested rate increases as “discriminatory” and “inequitable”), 43, 60, 80. Indeed, the Court expressly states an intent to use the Full Faith and Credit Clause as a sword to compel other states to respect its judgment to disregard their statutes and arrogate to itself the power to set rates. Mem. Op. 61. It thus seeks to “require a State to substitute for its own statute, applicable to persons and events within it, the statute of another State reflecting a conflicting and opposed policy.” See

Franchise Tax Bd. Of Cal. v. Hyatt, 136 S. Ct. 1277, 1281 (2016) (quoting *Carroll v. Lanza*, 349 U.S. 408, 412 (1955)).

The Court also erred in holding that the Plan’s “issue state rate approval” section cured the constitutional violation by allowing state insurance regulators to “opt-out” of the Plan’s rate-setting mechanism. That provision does not allow state regulators to apply their statutes and meaningfully review rates. The undisputed evidence is that it imposes requirements as to timing and methodology for the various states to follow, and penalties if they do not. Ex. RP-55 at 111; Tr. 410-414. It requires that “opt-out” states approve the Rehabilitator’s *seriatim* rate application in full within 60 days, absent which their policyholders will face different options from policyholders in other states. The Court downplays the differences by allowing only that the options under the provision “are not exactly the same” (Mem. Op. 58). This disregards the evidence. The Plan itself acknowledges that the options are likely to be worse, Ex. RP-55 at 109, and the Special Deputy Rehabilitator testified that “[i]n terms of policyholders, we think that [states opting out] will be harmful.” Tr. 170. Indeed, the Rehabilitator has recently advised regulators that in her view opting out “may not be in the best interest of the affected policyholders.” *See* Rehabilitator’s Letter to Commissioners dated August 26, 2021 at 1 (attached as Exhibit B hereto). This is coercive. The Plan seeks to present the appearance of deference to State rate

review while in fact requiring the States to approve the Rehabilitator's rates, in full, on pain of punishing policyholders in the State.

II. Absent A Stay, Policyholders And Regulators Will Suffer Irreparable Injury.

The Rehabilitator is moving to implement the Plan. *See* Praecipe to Substitute Approved Plan, Ex. A at 19 (September 30, 2021); Rehabilitator's Email (Exhibit A hereto). This is likely to irreparably harm both policyholders and regulators because both will be forced to make decisions that may not be reversible even if the Court's decision is reversed on appeal. SHIP's policyholders will be required to select options under the Plan that will permanently reduce their contract benefits. *See* Ex. RP-55 at 14, 92. This will reduce their rights as against SHIP and against guaranty associations in the liquidation that will inevitably follow, potentially by hundreds of millions of dollars. *Id.* The State Insurance Regulators and other regulators across the country will be required to decide whether or not to "opt-out" of the Plan. A regulator can only "opt-out" before the opt-out deadline; otherwise he or she is deemed to have "opted" into the Plan. Ex. RP-55 at 109-110. As noted above, if a regulator does anything other than approve the Rehabilitator's rate proposal in full within 60 days, the policyholders in the State will be left with options that are worse than those available in other states.

Thus, absent a stay, the Plan will impair the contract rights of the 30,000 affected policyholders and require regulators to take steps that may be detrimental

to policyholders in their states. The required elections and “opt-outs” under the Plan will fix contractual rights, and they are intended to be permanent. They will also occur relatively quickly. Regulators will be required to make opt-out decisions that will determine the options available in their States around mid-November 2021. *See* Exhibit A hereto. Around year-end, policyholders will be presented with election packages requiring them to make decisions by around mid-March 2022. Most critically, sometime around April 2022, the elections will be “effective,” and the policyholders will begin paying revised premiums and receiving reduced benefits in accordance with the Plan. *See* Praeceptum to Substitute Approved Plan, Ex. A at 19. These steps could potentially be undone by deeming the policyholder elections and regulator opt-outs nullities in the event the Court’s approval is reversed. However, it will be administratively difficult and confusing to policyholders and regulators to undo those steps. A stay preserving the *status quo* would prevent such problems.

Not granting a stay could result in policyholders and regulators being deprived of the benefit of appeal. The practical realities suggest that at some point the Rehabilitator may contend that the Plan has been “substantially consummated” so that the appeal should be dismissed under the doctrine of equitable mootness. *See, e.g., In re Tribune Media Co.*, 799 F.3d 272, 277 (3d Cir. 2015) (equitable mootness is “a narrow doctrine by which an appellate court deems it prudent for

practical reasons to forbear deciding an appeal when to grant the relief requested will undermine the finality and reliability of consummated plans of reorganization.”).

The State Insurance Regulators believe that the equitable mootness doctrine should not apply. There is a “strong presumption that appeals from confirmation orders of reorganization plans . . . need to be decided,” *Tribune Media*, 799 F.3d at 278. Further, “third parties with interests protected by equitable mootness generally rely on the emergence of a reorganized entity from court supervision,” *Id.* at 280, and that will not happen here for a long time if ever. The implementation of the Plan is subject to the continuing jurisdiction of the Court. However, given the significant contractual interests at stake for the policyholders and the important regulatory interests at stake for the regulators, the possibility that review could be denied if the Plan goes forward warrants a stay.

III. Issuance Of A Stay Will Not Harm Other Interested Persons.

Issuance of a stay pending appeal will not harm other interested persons. It will preserve the *status quo*. SHIP’s policyholders have paid the lawfully approved rates for their coverage, and they will continue to do so. Policyholders who are on claim will continue to receive claim payments as they have during the pendency of the Rehabilitator’s application for approval of the Plan. The

intervenor agents and brokers have settled. The intervenor health insurers will not need to pay guaranty association assessments.

The Rehabilitator may contend that the size of SHIP's insolvency will increase during the appeal, and that over time this will reduce amounts that can be paid to policyholders. However, this reflects the intended working of the Plan, which places the entire burden of SHIP's insolvency on policyholders through benefits cuts and premiums increases and specifically avoids triggering guaranty associations. *See* Mem. Op. 45, 63. The State Insurance Regulators' appeal, by contrast, seeks to protect policyholders by triggering guaranty associations. If the State Insurance Regulators are correct and guaranty associations must be triggered, then an additional \$800 million in support for policyholders will be available. *See* Mem. Op. 31-32. The balance of a somewhat deeper insolvency against the benefit of reversal weighs in favor of a stay. Under the Plan, the policyholders will bear the full existing \$1.2 billion deficit, while a successful appeal will bring \$800 million in guaranty association support and reduce the burden of insolvency on policyholders to approximately \$400 million.

IV. Issuance Of A Stay Will Not Harm The Public Interest.

Nor will a stay adversely affect the public interest. The State Insurance Regulators pursue this appeal to protect the financial interests of policyholders that are intended to be protected by the rehabilitation statutes and the guaranty

association system, and also the interests of regulators in their statutory role in reviewing the rates charged for policies issued in their states.

The Rehabilitator may contend that delaying benefit cuts and premium increases under the Plan will increase SHIP's insolvency and the burden on the guaranty associations, their member insurers and, in many States, on taxpayers when SHIP is liquidated. That is not cognizable "harm" to the public interest. As described above, the guaranty associations were created specifically to protect policyholders in the event of an insolvency (*see, e.g.*, 40 P.S. § 991.1701) by honoring the insurer's contractual obligations, subject to specific limits. *E.g.*, 40 P.S. § 991.1703, § 991.1706(b). The legislatures determined how to allocate the burden of that protection. *See, e.g.*, 40 P.S. § 991.1707, § 991.1711. Where the legislatures have chosen to provide protection to policyholders and how to fund that protection, allowing that process to work is not contrary to the public interest. Similarly, the legislatures have chosen to place rate review with their regulatory officials, and protecting that statutory choice and the application of the States' rate approval statutes is not contrary to the public interest.

Conclusion

For the above reasons, the State Insurance Regulators request that the Court stay its Orders approving the Plan pending appeal.

Dated: October 1, 2021

Respectfully submitted,

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PUBLIC ACCESS POLICY CERTIFICATE OF COMPLIANCE

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

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PROOF OF SERVICE

I, Stephen G. Harvey, hereby certify that on October 1, 2021, I served the foregoing document on all parties appearing on the Master Service List via PACFile, except the following, who have been served by U.S. Mail:

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IN THE COMMONWEALTH COURT OF PENNSYLVANIA

In re: Senior Health Insurance Company : No. 1 SHP 2020
of Pennsylvania in Rehabilitation :
:

ORDER

AND NOW, THIS _____ day of _____, 2021, upon consideration of the Intervenor State Insurance Regulators' Application for Stay Pending Appeal, and the Rehabilitator's response thereto, IT IS ORDERED that the Application is DENIED.

MARY HANNAH LEAVITT
PRESIDENT JUDGE EMERITA

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

In re: Senior Health Insurance Company : No. 1 SHP 2020
of Pennsylvania in Rehabilitation :
:

REHABILITATOR’S ANSWER AND BRIEF IN OPPOSITION TO
THE INTERVENOR STATE INSURANCE REGULATORS’
APPLICATION FOR STAY PENDING APPEAL

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INTRODUCTION

Jessica K. Altman, Insurance Commissioner of the Commonwealth of Pennsylvania, in her capacity as the Statutory Rehabilitator (“Rehabilitator”) of Senior Health Insurance Company of Pennsylvania (“SHIP”), hereby submits this Answer and Brief in Opposition to the Intervenor State Insurance Regulators’ (“Intervening Regulators”) Application for Stay Pending Appeal (“Stay Application”). This Court should deny the Stay Application because it fails to meet every criterion necessary for a stay. The Intervening Regulators fail entirely to show irreparable harm to themselves in the absence of a stay; they fail entirely to negate harm to the Rehabilitator and policyholders if a stay is imposed; they fail entirely to show a strong likelihood of success on the merits of their appeal; and they fail entirely to show that public policy supports a stay.¹

¹ The Stay Application does not comply with Pa. R.A.P. 123 and Pa. R.A.P. 1732, because an application must stand alone even if accompanied by a brief. The rules require an application to “state with particularity the grounds on which it is based, and . . . set forth the order or relief sought.” Pa. R.A.P. 123. The Stay Application includes an introduction, eleven numbered paragraphs stating the “essential facts” but without an assertion of authority or request for relief, and the text of a brief. The Intervening Regulators also suggest that “most of the basic facts” necessary to the Stay Application were referenced in the Court’s Approval Opinion approving the Plan but others were “omitted, understated or only noted in passing.” (Stay Application at 7.) There is no explanation of which facts fall into these latter categories, and there is no verification attached to the Stay Application despite the Intervening Regulators’ admission that it relies on facts outside of the record and the inclusion of two documents that post-date the hearing and are not authenticated by any party. These defects are procedural, yet they implicate substantive problems with the Stay Application which this Court should consider in ruling on its merits.

ANSWER TO STAY APPLICATION

APPLICATION:

1. SHIP's policies are enforceable contracts, and the premiums charged on the policies historically and on the rehabilitation date were lawfully approved rates. Tr. 227-229, 282.

RESPONSE:

Denied. The statements in Paragraph 1 are legal conclusions to which no response is required. To the extent a response is required, the statements are denied, as they are immaterial to the merits of the Stay Application. Moreover, the record cited by the Intervening Regulators does not affirmatively support these statements. The cited testimony from Mr. Cantilo states only that he has no reason to believe that the policies are not enforceable contracts and no reason to believe that the policies were not approved. Mr. Cantilo further explained in the cited testimony that he is not contending that the policies are unlawful and he assumes the rates were lawfully approved.

APPLICATION:

2. SHIP is insolvent, with a deficit or "funding gap" of approximately \$1.2 billion. Ex. RP-55 (the Plan) at 87.

RESPONSE:

Admitted in part, denied in part. It is admitted that SHIP had a funding gap of approximately \$1.2 billion at the time of the rehabilitation proceedings. The

statement in Paragraph 2 that SHIP is insolvent is a legal conclusion to which no response is required. To the extent a response is required, neither the Second Amended Plan cited by the Intervening Regulators nor the Approved Plan filed October 3, 2021 state that SHIP is insolvent. No finding of insolvency has been made by any court.

APPLICATION:

3. Under the Plan, the burden of reducing or eliminating the \$1.2 billion funding gap will rest on the 30,000 remaining SHIP policyholders who have not taken non-forfeiture options. Tr. 290-292; Ex. RP-55 at 102-103. The Plan seeks to reduce the funding gap by reducing policy benefits and increasing premiums. Ex. RP-55 at 10, 102-103.

RESPONSE:

Denied as stated. The statements in Paragraph 3 are characterizations of the Approved Plan, which is in writing, and thus the characterizations in this paragraph are denied. The Plan attempts to reduce the funding gap using a variety of mechanisms, including by offering policyholders options through which they can decide for themselves how to allocate the relationship between premiums and benefits under their SHIP policies.

APPLICATION:

4. The Plan requires policyholders to select among options, only one of which (Option 4) retains the policyholders' full benefits in Phase One. The other options (Options 1, 2, 2a, and 3) all reduce benefits in Phase One. Ex. RP-55 at 23-24; Tr. 113-117. Policyholders who choose Options 1 or 4 in Phase One face the possibility of additional substantial rate increases or benefit reductions in Phase Two. Ex. RP-55 at 15, 58.

RESPONSE:

Admitted in part, denied in part. It is admitted that the Plan requires policyholders to elect one of the offered options; any remaining characterization of the Plan options is denied. Option 1 will retain a policyholder's full benefits if that policyholder is currently paying the If Knew premium. Depending on a policyholder's election, Options 2 and 2a involve a reduction of benefits to match the future premiums, and Option 3 will provide a set amount of benefits without requiring any future premiums. Not all policyholders electing Option 1 or Option 4 in Phase One will face additional rate increases or benefit reductions in Phase Two; the scope and impact of Phase Two has not yet been decided, and, as explained in the Plan, no adjustments will be made to Option 1 or Option 4 policies unless those policies exceed guaranty association limits and are not already at a self-sustaining premium level.

APPLICATION:

5. In a liquidation, virtually all of SHIP's policies would be covered by one of the guaranty associations created by statute in each state, subject to the individual state statutory limits on guaranty association coverage. Ex. RP-55 at 93.

RESPONSE:

Admitted.

APPLICATION:

6. If SHIP were liquidated now so that guaranty associations are triggered, policyholders will absorb only approximately \$397 million of the funding gap, based on the Rehabilitator's comparison file. Ex. SIR 5-1, Table 1; Tr. 564. This is because guaranty associations would provide approximately \$837 million in additional support to benefit policyholders, also based on the Rehabilitator's comparison file. Ex. SIR 5-1, Table 2; Tr. 565-66. The Plan does not trigger the guaranty associations, Ex. RP-55 at 92, so these additional funds will not be available to benefit policyholders under the Plan.

RESPONSE:

Admitted in part, denied in part. The first phrase in the third sentence of Paragraph 6 is admitted, and the remaining statements in Paragraph 6 are legal conclusions and characterizations of evidence, all of which are denied. To the extent a response is required, the first and second sentences cite to documents prepared by the Intervening Regulators' expert which were not accepted by the Court. The

second phrase of the third sentence is denied because, while guaranty association funds are not available in rehabilitation, they remain available to policyholders in the event liquidation is later ordered.

APPLICATION:

7. The policyholder elections under the Plan will be permanent in that guaranty association coverage may be given up. If SHIP is placed in liquidation after the Plan is implemented, the policies to which guaranty association coverage will apply will be the policies as modified as a result of the elections. Ex. RP-55 at 14, 92; Tr. 300-301, 313.

RESPONSE:

Admitted in part, denied in part. It is admitted that the Plan calls for permanent changes to policies based on the elections made during the process and that policies may be modified based on those elections. The remaining statements in Paragraph 7 are denied. Policyholder elections will not cause any policyholders to give up guaranty association coverage because state guaranty associations have not yet been triggered. Instead, the options offered to policyholders will allow them to retain their existing policies by paying the appropriate premium or voluntarily give up their benefit-rich policies in favor of a more affordable option that better suits their needs. Whether policies modified as a result of elections in Phase One

will remain effective and in force at the time of any potential liquidation order will not be known until a liquidation order is entered, assuming one is entered at all.

APPLICATION:

8. The Plan is highly unlikely to eliminate the funding gap and restore SHIP to solvency, even considering both Phase One and Phase Two. Tr. 80, 306. In all likelihood, the Plan will not eliminate the deficit, just reduce it materially. Tr. 189-190.

RESPONSE:

Denied as stated. The statements in the first sentence of Paragraph 8 mischaracterize the cited record. The Special Deputy Rehabilitator testified that “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.” (Tr. 80:6-12.) Later, the Special Deputy Rehabilitator testified that Phase Two would seek to eliminate any remaining funding gap, and while it “would be ideal” if the funding gap was eliminated after Phase Two, the Rehabilitator could not “guarantee that will be the result.” (Tr. 306:6-19.) The Intervening Regulators’ counsel, not the Special Deputy Rehabilitator, used the term “highly unlikely.” (Tr. 306:11-14.) The second sentence of Paragraph 8 accurately characterizes the cited portion of the Special Deputy Rehabilitator’s testimony, but it is not the only testimony on this issue.

APPLICATION:

9. The Plan will not provide all policyholders with an option with a net present value (present value of future benefits less present value of future premiums) at least as great as the net present value in liquidation. Only 85% of policyholders will have at least one Phase One option with a net present value equal to or greater than liquidation. Ex. RP-7; Tr. 183, 185, 510, 512. This 85% rests principally on Option 4. Tr. 510, 512-513, 572; Ex. SIR 5-2. Option 4 has the least impact on the funding gap, and it is subject to further adjustment in Phase Two. Tr. 259, 513; Ex. RP-55 at 14.

RESPONSE:

Admitted in part, denied in part. The Rehabilitator denies that any of the statements in Paragraph 9 are material to the Stay Application, and she further denies that any of the statements in Paragraph 9 are decisive on the question of whether Plan approval was properly entered. As the Rehabilitator established during the hearing, net present value is only one possible metric, and it is one that has no meaning for policyholders—making it very unlikely or perhaps impossible that an individual policyholder would care whether the policies offered have an equal, greater, or lower net present value than the policy that might be offered in liquidation. (See Ex. RP-43 through Ex. RP-47 (multiple metrics); Tr. 347:1-348:12 (Cantilo), 437:13-438:9 (Bodnar).) The Rehabilitator showed that 100% of

policyholders have the option to elect a policy which matches their existing maximum policy value, and Option 1 allows policyholders to elect a policy which matches their existing premiums even if a benefit reduction is applied. (See Ex. RP-47 (MPV analysis); Ex. RP-56, Cantilo Slides at 109, 110; Tr. 184:12-15 (Cantilo Testimony).) These are the data points on which policyholders will assess the options. Moreover, even if net present value were the only test, an 85% equivalence rate would be more than enough to pass any required comparison to liquidation. Notwithstanding these denials, it is admitted that approximately 85% of policyholders will be presented with a Phase One option carrying a net present value equal to or greater than the net present value of their theoretical liquidation policy. It is also admitted that Option 4 is, in most cases, the option through which policyholders would obtain a policy with net present value equal to their theoretical liquidation policy, and that an Option 4 election, standing alone, has the least impact on the funding gap. It is denied that Option 4 elections are subject to further adjustment in Phase 2; rather, Option 4 elections are eligible for further adjustment in Phase 2, but only if the policy as elected exceeds guaranty association limits and the policy as elected is not self-sustaining with respect to premiums and benefits. Additionally, policyholders electing Option 4 in Phase One are not necessarily subject to further adjustment in Phase Two even if they meet the eligibility criteria, because such policyholders will have the opportunity to elect a different policy.

APPLICATION:

10. Under state statutes, long term care insurance rates are reviewed and approved by the insurance regulatory official of the state in which the policy is issued. Tr. 155, 157. Each state has its own approach to reviewing rates. Tr. 413-414. The Plan does not follow this issue state rate approval process. Ex. RP-55 at 33-34, 96; Tr. 158-159. It removes state insurance regulators from their role in reviewing rates, which is “unprecedented.” Ex. RP-55 at 33-34; Tr. 82. Under the Plan, the Rehabilitator will not seek approval of rates from state regulators under their statutes but instead from the Commonwealth Court. Ex. RP-55 at 33-34, 96.

RESPONSE:

Denied as stated. The first sentence of Paragraph 10 is not supported by the record, because it cites to testimony of the Special Deputy Rehabilitator and not any specific state statute. Moreover, the first sentence of Paragraph 10 overstates the meaning of the Special Deputy Rehabilitator’s cited testimony, in which the Special Deputy Rehabilitator was describing and summarizing the Intervening Regulators’ arguments, including that they arise out of “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.” (Tr. 155:11-158:24.) The second sentence of Paragraph 10 accurately summarizes the cited testimony of the Rehabilitator’s actuarial expert Vincent Bodnar, but it is incomplete and thus inaccurate, as Mr. Bodnar also testified that a lifetime loss ratio of at least 60%—*i.e.*, the ratio resulting

from the Rehabilitator’s proposed use of If Knew premium—is generally used across the country and is treated as a benchmark by regulators in determining what is actuarially justified. (Tr. 455:5-22.) It is true that, as stated in the third sentence of Paragraph 10, the Plan rightfully does not follow exactly the standard approval process, but the Plan has not removed regulators from their role in reviewing rates, as the Intervening Regulators and other state regulators have the opportunity to assert their authority over the rate review process by opting-out. The fourth sentence of Paragraph 10 is incomplete; the Rehabilitator will obtain approval for rates within the Plan pursuant to the procedure described in the Memorandum Opinion and Order, but, as described in the Issue-State Rate Approval Option, the Rehabilitator also intends to seek rate approval from the regulators of states opting-out of the Plan.

APPLICATION:

11. The Plan has an “issue state rate approval” section under which state regulators purportedly may “opt-out” of having the Commonwealth Court approve rates. Ex. RP-55 at 108. The section provides that, unless the “opt-out” state approves the Rehabilitator’s rate application, in full, within 60 days, it is deemed denied. Ex. RP-55 at 111. In that case, the options available to policyholders in that state will be more limited than the options available in other states, and the state’s policyholders will be disadvantaged. Ex. RP-55 at 109, 116; Tr. 169-170.

RESPONSE:

Admitted in part, denied in part. It is admitted that the Plan provides state regulators with an opportunity to opt-out of the Plan and review rates for policies issued in their state, but it is denied that such option is “purported[()],” because regulators—including the Intervening Regulators—will have the actual opportunity to opt-out. Indeed, the Intervening Regulators rely on the opt-out process as proof that the Rehabilitator is implementing the Plan and as (a misguided attempt at) proof of the potential harm of implementation. It is admitted that a regulator who elects to opt-out has sixty days to approve or deny the application, but Paragraph 11 mischaracterizes the impact of that decision. A regulator who approves in full the requested rate increases shall be treated as if his or her state did not opt-out, while a regulator who does not approve in full the requested rate increases shall be treated as having opted-out, exactly as requested. Policyholders in an opt-out state are not disadvantaged by the decision to opt-out. Consistent with the state-based system for which the Intervening Regulators advocated, residents of an opt-out state that own policies issued in a state that did not opt-out will have the full range of options available. Policyholders who own policies issued in an opt-out state that does not approve the Rehabilitator’s rate application are likely to have rates set on a group basis and receive fewer options than under the Plan, outcomes which may be disadvantageous to some of those policyholders regardless of where they reside.

BRIEF IN OPPOSITION TO THE STAY APPLICATION

A. INTRODUCTION

SHIP is currently in dire financial condition requiring immediate action. On August 25, 2021, this Court filed herein its Memorandum Opinion and Order (“Approval Opinion”) approving the Rehabilitation Plan proposed by the Rehabilitator (“Approved Rehabilitation Plan” or “Approved Plan”). As this Court recognized, it is imperative that the Rehabilitator move expeditiously and take the necessary steps to begin to implement SHIP’s Approved Plan to address the causes of SHIP’s financial distress and adequately preserve its assets. Notwithstanding, the Intervening Regulators now request that the Court stay implementation of the Approved Plan pending appeal, completely ignoring the significant harm this delay will cause to SHIP, its policyholders and creditors, and the public.

At the outset, the Intervening Regulators’ Stay Application is fundamentally flawed and should be rejected. The vast majority of the Intervening Regulators’ contentions are focused on purported policyholders’ interests. This is true with respect to both the underlying merits of the appeal (*e.g.*, Stay Application at 5 (contending that the Plan “does not serve the best financial interest of policyholders”)), as well as the purported harm that will occur absent a stay (*id.* at 29). But the Intervening Regulators do not speak for or represent *any* of SHIP’s policyholders. Indeed, the Intervening Regulators have expressly disavowed that

they are acting in a representative capacity for *even the policyholders in their own respective states*, which in any event comprise only a small fraction of SHIP's overall policyholders. (Tr. 543:9-18.) Thus, the Stay Application's entire discussion of purported harm to interests the Intervening Regulators do not represent is irrelevant. Notably absent from the Stay Application is any discussion of some actual harm to the Intervening Regulators themselves that would result from not staying implementation of the Approved Plan. This alone is fatal to the Intervening Regulators' Stay Application.

Even setting aside this critical defect, the Intervening Regulators utterly fail to satisfy their burden for a stay. *First*, the Intervening Regulators fail to show that they are likely to prevail on the merits—let alone make a *strong* showing that they are likely to prevail, as required for a stay. The parties extensively briefed all of the issues raised on appeal, in both pre-hearing and post-hearing submissions. The Court carefully considered—and rejected—the Intervening Regulators' arguments on three separate occasions: first, on a motion for a directed verdict on the Issue-State Rate Approval Option; then, in denying the Intervening Regulators' application for reconsideration; and finally, in a detailed eighty-one page memorandum opinion addressing each and every one of the contentions they now raise on appeal. Nor was this a close call. As the Court recognized, the Intervening Regulators failed to present any evidence supporting their challenge to the Issue-

State Rate Approval Option, failed to offer any evidence disputing any material fact that the Rehabilitator set forth in support of the Plan, and lacked standing to assert claims on behalf of policyholders. (Opinion at 68, 77, 79.) Moreover, the Intervening Regulators’ legal arguments essentially boiled down to the proposition that they would have exercised their discretion differently—hardly a basis for finding that the Rehabilitator abused her broad discretion in formulating a plan that balances the competing interests of policyholders, general creditors, other stakeholders, and public policy. The Stay Application’s rehashing of the very same arguments that the Court has already thoroughly rejected fails to make a strong showing that the Intervening Regulators are likely to prevail on appeal.

Second, the Intervening Regulators fail to demonstrate that they will suffer any harm, let alone irreparable injury, without a stay. As noted above, the Stay Application does not identify how the Intervening Regulators themselves will be harmed in any way. Instead, they point to supposed harm to policyholders and others. Of course, they do not, and cannot, speak for policyholders or other state regulators not a party to these proceedings. But even setting that aside, their argument that policyholders will suffer if the Plan is implemented and the policies “right-sized” is similarly without merit. There is no irreparable harm in SHIP’s policyholders paying actuarially justified rates for their insurance coverage during the pendency of this action or in discontinuing the involuntary subsidies of some

policyholders by others. Nor is there irreparable harm based on the mere possibility of policyholder “confusion” should the process be reversed after appeal. In short, implementation of the Approved Plan will not cause irreparable harm to the Intervening Regulators or to any other interested party.

Moreover, even the purported harm to policyholders (not the Intervening Regulators themselves) of which the Stay Application complains is speculative on its face and factually unsupported. At its core, the supposed harm arises from taking away from some policyholders the ability to continue buying long-term care coverage at inadequate premium rates at the expense of other policyholders. The Intervening Regulators, however, have introduced no evidence or authority in this proceeding supporting the proposition that any policyholders have an inviolate right to subsidization of their long-term care insurance. Neither is any supporting evidence or authority identified in the Stay Application, because there is no such right. In the absence of any record on this issue, this baseless argument cannot now constitute the requisite showing of irreparable injury.

Finally, a stay will significantly harm SHIP, its policyholders, creditors, and the public. Tellingly, the Stay Application hardly discusses these factors (Stay Application at 31–33) because any delay obviously causes significant harm to SHIP’s financial health. Delay in implementation of the Plan will allow for one of the primary conditions that led to SHIP’s poor financial condition to continue

unabated—that is, underpriced policies that are far from actuarially justified. It is critical that the Rehabilitator move quickly to implement the Plan, and a stay pending appeal imperils the prospects for a successful rehabilitation of SHIP.

Perhaps inadvertently signaling the little confidence they have in their Stay Application, the Intervening Regulators also fail entirely to address the issue of a supersedeas bond. Even if the Court were inclined to consider granting a stay (for which the Rehabilitator submits there is no basis), it would also have to consider what bond to require of the Intervening Regulators to insulate the Rehabilitator and SHIP's policyholders and creditors from the harm resulting from delay in implementation of the Plan. The Rehabilitator believes that even a conservative estimate of the cost of a one-year delay is in the range of \$55 to \$70 million. The Rehabilitator does not seek here to make the case for a specific bond amount, as the Court can address the amount of a bond in a subsequent hearing in the event it is inclined to permit a stay. Instead, the Rehabilitator's argument seeks only to highlight that this critical element of an application for stay has been wholly ignored as well, and the Stay Application should be denied for this additional reason.

B. THE STAY APPLICATION IS PREMISED ON PURPORTED POLICYHOLDER INTERESTS THAT THE INTERVENING REGULATORS LACK STANDING TO ASSERT.

The Intervening Regulators implicitly concede that they cannot satisfy the requisite showing for a stay based on any alleged harm to them or any other interest that they have in SHIP's rehabilitation. Instead, the Intervening Regulators attempt

to substitute the purported interests of SHIP’s policyholders nationwide for their own, when they do not speak for or represent *any* of SHIP’s policyholders in these proceedings—not even with respect to the relatively small fraction of policies issued in their own respective states. The Intervening Regulators’ misguided attempt to shift the focus of the Stay Application to the merits of arguments that they lack standing to assert and purported harms to parties they do not represent is defective on its face. The Stay Application may be denied on that basis alone.

This Court should not impose the requested stay unless the Intervening Regulators can demonstrate a strong likelihood of success on appeal. Insofar as their asserted harm is what they allege will be adverse effects for policyholders, their complete failure to adduce supporting evidence of such harm in the underlying proceeding vitiates entirely any likelihood of success, let alone a strong likelihood, on appeal.

The Intervening Regulators’ position in SHIP’s rehabilitation proceedings is uncontroverted: they do not—and cannot—speak on behalf of any policyholders, *including* any policyholders in their own respective states. The Court granted the Intervening Regulators’ request for limited intervention in these rehabilitation proceedings based on their own purported interests as regulators, and not in any *parens patriae* or other representative capacity for policyholders. Indeed, the Intervening Regulators have expressly disavowed that they are acting in any “sort of

parens patriae capacity on behalf of . . . policyholders [from their respective states] who have chosen not to intervene.” (Tr. 543:9-18; *accord* Intervening Regulators’ Pre-hearing Memorandum at 50 (conceding that the Intervening Regulators are not acting “as some sort of agent for the policyholders in their States”).) As a result, the Court held that the Intervening Regulators lacked standing to assert claims on behalf of policyholders that they do not purport to represent. (Opinion at 68.)

Notwithstanding, the Stay Application is focused almost *exclusively* on the interests of policyholders. That is, the Intervening Regulators’ arguments regarding the merits of the appeal are focused on purported financial interests of and burdens on policyholders through rehabilitation. (*E.g.*, Stay Application at 5 (arguing that the Plan “does not serve the best interests of policyholders” and “fails to place policyholders in at least as good a position as in liquidation”) and at 14–22.) Similarly, the Stay Application focuses on purported harm to policyholders absent a stay. (*Id.* at 29–30 (arguing that the Plan will affect “the contractual rights of the 30,000 affected policyholders”); (*id.* at 30 (policyholder “confusion”); *id.* (asserting benefit of appeal to policyholders).)

To be clear, the Intervening Regulators do not have standing to assert any alleged harm to policyholders or any basis to argue what is in the best interests of policyholders. Again, they do not represent the interests of any policyholders—unlike the Rehabilitator, who by statute is expressly charged with protecting the

interests of SHIP's policyholders. *See* 40 Pa. Stat. § 221.1(c).² The Intervening Regulators have no basis for requesting a stay based on their own interests, and cannot mask that deficiency by now invoking the interests of others whom they do not represent. *See Dep't of Env'tl. Res. v. Jubelirer*, 614 A.2d 199, 203 (Pa. 1989) (party failed to demonstrate a substantial case on the merits where it "had a serious standing problem"). The Intervening Regulators lack of standing to raise policyholders' interests is fatal to the Stay Application.

C. THE STAY APPLICATION FAILS TO MAKE A STRONG SHOWING THAT THE INTERVENING REGULATORS ARE LIKELY TO SUCCEED ON THE MERITS.

The Court's eighty-one page Memorandum Opinion addresses at length—and rejects—each of the Intervening Regulators' arguments that they repeat in their Stay Application. Regurgitating the same flawed arguments that this Court has already

² The Intervening Regulators' attempt to assert the interests of SHIP's policyholders against the Rehabilitator is particularly egregious here because collectively, fewer than 6% of SHIP's remaining 39,000 policies were issued in the Intervening Regulators' respective states. (*See* Joint Application for Intervention of Maine and Massachusetts (July 31, 2020) at ¶¶ 8, 13 (identifying 388 Maine policies and 345 Massachusetts policies subject to the Rehabilitation Plan as of November 30, 2019) and Joinder of Washington in the Joint Application for Intervention (Sep. 15, 2020) at ¶ 8 (identifying 1,509 Washington policies subject to the Rehabilitation Plan as of November 30, 2019).) Importantly, the Intervening Regulators do not speak for or represent even that limited number of SHIP's policyholders in their own states. Notwithstanding the Intervening Regulators' small share of the total policies, the Stay Application improperly attempts to focus on the alleged interests of SHIP's policyholders *nationwide*.

rejected does not satisfy the Intervening Regulators’ burden of making a strong showing of likelihood of success on the merits.

The Intervening Regulators’ arguments should be rejected on their face for several reasons. *First*, as explained above, the Intervening Regulators lack standing to assert claims on behalf of policyholders, and thus necessarily cannot prevail on the merits of those flawed arguments. Moreover, there is no evidence in the record supporting the Intervening Regulators’ contentions whatsoever. The Stay Application overlooks that the Intervening Regulators failed to present *any* evidence supporting their challenge to the Issue-State Rate Approval Option (Opinion at 77)—which necessitated the Court’s directed verdict on this issue—and failed to submit evidence disputing any material fact that the Rehabilitator set forth in support of the Plan (*id.* at 79). There is simply no evidentiary basis which would support allowing the Intervening Regulators to assert the harms purportedly suffered by policyholders or which would demonstrate that such harm exists in the first place.

Certainly, both in the underlying proceeding and now with the Stay Application, the Intervening Regulators have failed entirely to identify, let alone support with evidence and legal authority, any harm that they would suffer *as regulators* upon the Plan’s implementation and in the absence of a stay.

Moreover, the substance of the Intervening Regulators’ arguments regarding plan approval lack merit for the reasons this Court has already addressed in its

Approval Opinion. *First*, the Stay Application continues to assert that the Plan is not “feasible.” (Stay Application at 10–14.) But as the Court explained, “Article V does not require [the approved] Plan be ‘feasible’ in order to be approved.” (Opinion at 67.) In any event, the Court also held that the Plan *is* feasible to the extent such a requirement exists, because the Plan will materially reduce the Funding Gap, significantly improve SHIP’s financial condition, and if successful, will restore SHIP to its pre-receivership condition of an insurer winding down its long-term care insurance business. (*Id.* at 65–66.) The Intervening Regulators have not offered any evidence in support of a different conclusion, nor have they shown any likelihood of success as to their attack on the public policy findings reached by the Court or on the feasibility of the Plan in satisfying the Rehabilitator’s goals.

Second, the Stay Application broadly asserts (again without evidence) that the Plan is not in the best financial interests of policyholders. (Stay Application at 14–20.) Setting aside that the Intervening Regulators lack standing to assert whether the Plan is in the best financial interests of policyholders, the Intervening Regulators argument amounts to little more than suggesting that “they would have exercised their discretion differently,” which the Court correctly held “is not a basis for the Court to disapprove the Plan.” (Opinion at 79.) Nothing in the Stay Application or in any other filing offers a reason to believe the Intervening Regulators will succeed on appeal in convincing the Supreme Court that their judgment is entitled to the same

degree of deference—indeed, more—than that of the Statutory Rehabilitator. The Stay Application also ignores that the Plan is designed around “the core principle of policyholder choice,” and the Intervening Regulators completely and wrongfully discount the value of that choice simply because they disagree with the Rehabilitator’s exercise of her discretion in making that determination. (*See id.* at 9, 43, 47–48.)³ Instead, what the Stay Application again argues is that liquidation should be favored over rehabilitation because of the availability of guaranty association coverage. As the Court recognized, however, the Intervening Regulators’ views on this issue are contrary to Pennsylvania public policy favoring rehabilitation of an insurer where possible. (*Id.* at 67.) And independent of the existing Pennsylvania law favoring rehabilitation, there were numerous reasons for the Rehabilitator to exercise her discretion in choosing rehabilitation over liquidation. (*Id.* at 44–47.) The Intervening Regulators cannot make a strong showing that they are likely to prevail on the merits simply because they disagree with Pennsylvania public policy and disagree with how the Rehabilitator exercised her discretion.

³ On this point, the Intervening Regulators cannot avoid contradicting themselves, asserting that policyholder choice is unimportant while at the same time claiming that policyholders governed by opt-out state regulators will be injured if those policyholders receive fewer choices in rehabilitation than policyholders whose premiums and benefits are set by the Plan, an implicit acknowledgement that even the Intervening Regulators believe in the value of choice.

Third, the Stay Application continues to misconstrue *Neblett v. Carpenter*, 305 U.S. 297 (1938). (Stay Application at 20–23.) As the Court found, the Intervening Regulators’ interpretation of *Carpenter*—on which they double down in the Stay Application—is flawed. (Opinion at 64–65.) But even under the Intervening Regulators’ flawed metric, 85% of SHIP’s policyholders will be offered at least one option with a value equal to or higher than the value of the policy that they might have in liquidation. (*Id.* at 65.) As such, the Court correctly explained that even if the Plan substantially impairs policies, it meets any test created by *Carpenter* because “it serves a legitimate and significant public purpose, and the policy modifications are reasonable and appropriate to that purpose.” (*Id.* at 63.) The Stay Application offers no basis for overturning the Court’s findings.

Finally, as with the Intervening Regulators prior filings, the Stay Application baldly asserts that the Plan “exceed[s] the authority granted to the Rehabilitator by the Pennsylvania statutes and violate[s] the Full Faith & Credit Clause.” (Stay Application at 23.) Tellingly, the Stay Application cannot identify any specific statutory provision that the Plan would purport to violate—just as the Intervening Regulators failed to identify such a provision prior to the Court’s approval of the Plan.

As this Court explained, the Plan’s provisions fully comport with Pennsylvania law. (Opinion at 48–53.) Moreover, “[t]he Full Faith and Credit

Clause does not require the Rehabilitator to submit these premium rates to 46 states, the District of Columbia, and the U.S. Virgin Islands for their review and approval.” (*Id.* at 60.) To the contrary, such a requirement “would fracture Pennsylvania’s ‘own legitimate public policy’ in the rehabilitation of SHIP,” in contravention of the Full Faith and Credit Clause. (*Id.*) The Intervening Regulators cannot satisfy their burden on the Stay Application by simply repeating these failed arguments.

D. THE INTERVENING REGULATORS FAIL TO PROVE THEY WOULD SUFFER IRREPARABLE HARM ABSENT A STAY.

This Court can deny the Stay Application solely because the Intervening Regulators cannot show a substantial likelihood of success on the merits. *See Maritrans G.P., Inc. v. Pepper, Hamilton & Scheetz*, 573 A.2d 1001, 1004 (Pa. 1990) (“In view of [the] failure [to show a substantial likelihood of success on the merits, the court] need not scrutinize compliance with the remaining three criteria.”). Should the Court proceed to analyze the remaining elements, however, the Court will reach the same conclusion: the Stay Application should be denied.

Under the standard set forth in *Pennsylvania Public Utility Commission v. Process Gas Consumers Group*, 467 A.2d 805 (Pa. 1983), a stay cannot be entered unless the Intervening Regulators establish that “without the requested relief, [they] will suffer irreparable injury.” 467 A.2d at 809; *see also* Pa. R.A.P. 1732 (rule governing application for stay noting that *Process Gas* determines “the criteria for the issuance of a stay pending appeal.”) Irreparable injury is present only when the

movant demonstrates some imminent harm which cannot be avoided, unwound, or redressed. *See, e.g., Maritrans*, 573 A.2d at 1004-05 (no irreparable harm related to disclosure of confidential information where there was no evidence of any actual or imminent disclosure); *Commonwealth Bd. of Fin. v. Rosetta Oil, Inc.*, 635 A.2d 139, 142 (Pa. 1993) (irreparable injury would arise if a lien was imposed during appeal because the lien would likely place the moving party in default with its lender, driving the moving party out of business); *Process Gas*, 467 A.2d at 809-10 (irreparable harm where plaintiff-consumers would lose benefit of lower gas rates and state agency was barred by law from using mechanisms to make up the difference in the future).

The Intervening Regulators cannot carry their burden on this issue. As set forth herein, the Intervening Regulators have no direct interest in the Plan; they gain no benefit and suffer no burden from its implementation, and the policy modifications proposed by the Plan have no impact on the Intervening Regulators. In ruling on the directed verdict and on the Rehabilitator's application for approval, this Court rightfully recognized that the Intervening Regulators lacked an interest in the proceedings sufficient to warrant disapproval of the Plan. (*See Opinion at 74.*) Absent any record evidence of any harm to the Intervening Regulators arising out of or related to the Plan as proposed, the Intervening Regulators cannot now assert an irreparable harm arising out of implementation of that same Plan once approved.

The Stay Application also fails to identify any irreparable harm warranting a stay independent of this fatal lack of interest in the Plan. The Intervening Regulators allege that a stay is necessary to prevent “harm [to] both policyholders and regulators because both will be forced to make decisions that may not be reversible even if the Court’s decision is reversed on appeal.” (Stay Application at 29.) This argument fails for three reasons.

First, the Intervening Regulators have no right to seek a stay based on potential irreparable harm to third parties—here, policyholders and “other regulators across the country.” (Stay Application at 29.) To satisfy the second *Process Gas* factor, Pennsylvania law clearly requires a showing of irreparable harm to the movant—*i.e.*, the Intervening Regulators—rather than any other party or non-party. In *Process Gas*, adopting the existing federal law on supersedeas, the Supreme Court of Pennsylvania defined the second factor as requiring “the petitioner [to] show[] that without the requested relief, **he** will suffer irreparable injury.” *Process Gas*, 467 A.2d at 808-809 (quoting *Virginia Petroleum Jobbers Ass’n v. Fed. Power Comm’n*, 259 F.2d 921 (D.C. Cir. 1958)) (emphasis added). In granting the stay, the Court found a “sufficient showing of irreparable harm **likely to result to the [movants]**,” a group of industrial gas consumers directly impacted by the surcharge allocation at issue. *Process Gas*, 467 A.2d at 809. Thus, a stay can only be entered upon a showing of irreparable harm to the Intervening Regulators—not anyone else.

To the extent the Intervening Regulators invoke injuries allegedly suffered by other regulators or policyholders, those harms are simply immaterial to the irreparable injury analysis. The Intervening Regulators cannot speak for the regulators of more than forty other states, each of whom rejected the opportunity to intervene in these proceedings, and who may in fact support the Plan. With respect to policyholders, the Intervening Regulators explicitly disclaimed that they participated in the proceedings in a representative capacity such as *parens patriae*, and instead affirmed that they appeared on their own behalf to challenge the Plan based on their judgment as regulators. (Tr. at 541-547.)⁴ Even if the Intervening Regulators could speak in a representative capacity, however, their judgment as to whether policyholders or others are harmed absent a stay is merely one opinion among many possible opinions—including the Rehabilitator’s—and is not entitled to any weight. *See Jubilerer*, 614 A.2d at 204 (no irreparable harm to appellant state environmental agency claiming it could not act for protection of that state’s citizens where, *inter alia*, the agency’s “judgment” was not “the sole indication of the public

⁴ The Stay Application also confusingly references the impact of the Plan on policyholders “in” the opt-out state—*i.e.*, residents of the opt-out state. This is incorrect. A state insurance regulator who opts out of the Plan retains his or her authority to approve or reject rates for policies issued in that state, regardless of where that policyholder lives now. During the hearing, the Rehabilitator showed that 207 of the residents of the Intervening Regulators’ states had policies issued in other states, placing these policyholders beyond the regulatory authority of the Intervening Regulators. (Tr. 157:17-158-24.)

interest when there are other agencies equally responsible for protecting this interest”).

Second, the single alleged harm to the Intervening Regulators is no harm at all, and certainly not an irreparable harm. According to the Stay Application, the Intervening Regulators will be injured if they are required to decide now whether to allow the Rehabilitator and the Court to set rates and benefits or to opt-out of the Plan and exercise their regulatory authority over policies issued in their states. Indeed, the Intervening Regulators argued in these proceedings that the Plan harmed them by pre-empting their rate review process. Notably, they failed then and fail again now to explain *how* this injured them in any way. Their presentation appears limited to dubious legal argument that they—and only they—can approve premium rates in their states. Even if that legal proposition were accepted (though the Rehabilitator has shown that there is little reason to do so in this rehabilitation), the Intervening Regulators have never identified even a scintilla of harm to them from its purported violation despite intervening in these proceedings more than a year ago. Furthermore, early on, the Rehabilitator included in the Plan the Issue-State Rate Approval Option, thus giving the Intervening Regulators the ability to opt-out of the Plan in favor of their own review and approval processes. Nowhere do the Intervening Regulators show that any hypothetical harm is not wholly avoided by this provision. And, in addition, the Stay Application fails to establish any difference

between making that rate decision now and making that decision following an appeal, let alone any harm to the Intervening Regulators.

The Intervening Regulators have complained that opting-out deprives policyholders whose policies were issued in Maine, Massachusetts, and Washington of the full range of Plan options. This alleged “harm” belongs to policyholders if it exists at all; the Intervening Regulators themselves suffer no injury if policyholders whose policies were issued in their states have fewer options in rehabilitation than policyholders of policies issued in other states. Moreover, the Intervening Regulators have disagreed from the beginning with the Rehabilitator’s effort to level the playing field by eliminating subsidies and right-sizing the policies in receivership because it presents a fundamentally different set of circumstances than business in the ordinary course. Any state-to-state variation in premiums and benefits during receivership is the natural consequence of the checker-board state-based process for which the Intervening Regulators have advocated—just as it would be if SHIP were not in receivership. The Intervening Regulators should not be allowed to demand the right to ensure that policies issued in different states are treated differently even in receivership, then turn around and complain that treating policies differently negatively impacts those policyholders.

Third, even ignoring these critical defects in the Stay Application, the harms cited by the Intervening Regulators are not irreparable or imminent. The only

alleged injury to the Intervening Regulators themselves—the decision to participate in the Plan or opt-out—is plainly reparable because if Plan approval is reversed then the decision to participate or opt-out is rendered moot because there is no plan being implemented. The same is true of other regulators and policyholders, assuming *arguendo* this Court permits the Intervening Regulators to rely on the alleged harms of others in satisfying the second *Process Gas* factor. In fact, after describing the opt-out and election processes, the Intervening Regulators make a revealing and fatal admission: “[t]hese steps could potentially be undone by deeming the policyholder elections and regulator opt-outs nullities in the event the Court’s approval is reversed.” (Stay Application at 30.) Thus, accepting the Intervening Regulators’ arguments as true, their proposed stay would not prevent *irreparable* harm, only the unidentified “problems” that could arise because it could be “administratively difficult and confusing . . . to undo” implementation. (*Id.*) Assuming these claims are true—and the Intervening Regulators have not shown that they are—“difficult and confusing” is not the test under *Process Gas*.

The Intervening Regulators also argue that a stay should be entered because the Rehabilitator “may contend” that the “the appeal should be dismissed under the doctrine of equitable mootness,” citing *In re Tribune Media Co.*, 799 F.3d 272 (3d Cir. 2015). (See Stay Application at 30.) But the Rehabilitator notes that the question of mootness is not before the Court at this time, and the mere possibility that the

Rehabilitator may raise an argument in the future is not an imminent harm. Even if the Rehabilitator were certain to make such an argument, however, “[t]he possibility that an appeal may become moot does not alone constitute irreparable harm for purposes of obtaining a stay.” *In re Nuverra Env'tl. Solutions, Inc.*, No. 17-10949, 2017 WL 3326453, at *4 (D. Del. Aug. 3, 2017). In contrast, a stay has been entered on equitable mootness grounds where, for example, a party has consistently and convincingly argued that “equitable mootness was a near certainty” if a stay was not entered. *See, e.g., In re Adelphia Commc'ns Corp.*, 367 B.R. 84 (S.D.N.Y. 2007) (finding appellant was judicially estopped from arguing against equitable mootness after affirmatively using equitable mootness to seek stay). Here, the Intervening Regulators take no position as to whether Plan implementation will render the appeal moot.⁵ The Intervening Regulators cannot rely on equitable mootness as an imminent and irreparable harm while refusing to say affirmatively that it will occur in this case absent a stay.

E. THE INTERVENING REGULATORS IGNORE THE HARM CAUSED BY A STAY AND THE CLEAR PUBLIC INTEREST IN MOVING QUICKLY TO IMPLEMENT THE PLAN.

The Intervening Regulators are the *only* party in these proceedings without a financial, equitable, or legal interest impacted by the Plan, and yet they are also the

⁵ As its name implies, equitable mootness involves a weighing of numerous factors, many of which cannot be known at this time. The Intervening Regulators do not even attempt to address any of these factors, and neither the Court nor the Rehabilitator can or should address such a theoretical and incomplete argument.

only party insisting on a stay of implementation, with no regard for the impact of that stay on other parties. Having failed to prove the first two *Process Gas* requirements, the Intervening Regulators are again unconvincing in their arguments addressed to the final two factors: harm to other parties and the public interest. With respect to other parties before the Court, the Intervening Regulators assert that a stay will not cause injury to other interested persons because it retains the *status quo*—policyholders continue to receive coverage, the agents and brokers have settled, and the guaranty associations have not been triggered. With respect to the public interest, the Intervening Regulators claim their appeal is designed to benefit policyholders and other regulators, and that the requested stay supports that mission.

Both arguments are plainly without merit. The record before this Court is clear in showing that delay itself is damaging to the rehabilitation and thus to policyholders. As the Court found, rehabilitation is preferable to liquidation in part because it avoids delay: “a plan can be implemented quickly, thereby addressing the causes of SHIP’s financial distress, preserving assets, and reserving flexibility.” (Opinion at 47.) In reaching that conclusion, the Court noted that the Rehabilitator could learn the impact of Phase One and the potential scope of Phase Two within a year of approval—a favorable timeline over liquidation, where rate approvals could take as long as two years, and in which there would be little certainty as to the impact on policyholders for some time. (*Id.*) Unlike the opt-out and election processes

acknowledged by the Intervening Regulators to be reversible, delay in implementation is absolutely irreparable. In fact, if there were a hearing on the amount of a bond, the Rehabilitator would be prepared to demonstrate that the irreparable damage from a one-year delay, even using a conservative measure, would be at least \$55 to \$70 million. The Rehabilitator would demonstrate as well that such damage equates to a year of the most costly long-term care services for approximately 500 policyholders. The Rehabilitator cannot ever recover those assets through other means, and those policyholders will be left unable to make up the difference.

The Intervening Regulators first blame the Rehabilitator for any deepening of the deficit during delay, saying it “reflects the intended working of the Plan, which places the entire burden of SHIP’s insolvency on policyholders through benefit cuts and premium increases.” (Stay Application at 32.) But the Plan is designed to be implemented as quickly as possible, not after a delay, so that policyholders can minimize any potential loss or burden from SHIP’s receivership by allocating the premiums and coverages available to best suit their individual needs. It is disappointing that the Intervening Regulators continue to misunderstand the Plan and the benefit provided to policyholders in making these elections. The Intervening Regulators also claim that any deepening of SHIP’s deficit is immaterial because \$800 million will be available in liquidation if the Intervening Regulators succeed.

But even assuming as the Intervening Regulators do that liquidation is inevitable, the alleged \$800 million will be available independent of the stay. In contrast, if a stay is not entered and the Court’s order is upheld, policyholders will benefit by having made the prompt election of policy options and through the accompanying use of SHIP’s assets to pay claims during the rehabilitation.

The Intervening Regulators make similarly unpersuasive arguments with respect to the public interest. The Intervening Regulators point to the various state legislatures’ allocation of the burden of policyholder losses through the guaranty association system, claiming that a deeper deficit cannot harm the public because using guaranty association funds to cover SHIP’s deficit—however big or small—is simply the system functioning as intended. But SHIP is not yet in liquidation, and the Pennsylvania legislature, like that of many other states, also enacted laws reflecting a public policy favoring meaningful efforts at rehabilitation over immediate liquidation. As this Court found, “[t]he legislatively stated purpose of Article V is the protection of the interests of insureds, creditors, and the public generally [as well as] the equitable apportionment of any unavoidable loss through, *inter alia*, improved methods for rehabilitating insurers. . . .” (Opinion at 41 (citation and internal quotation marks omitted).) Similarly, “[t]he benefits of rehabilitation—its flexibility and avoidance of inherent delays—are preferable to the static and cumbersome procedures of statutory liquidation.” *Grode v. Mutual Fire, Marine*

and Inland Ins. Co., 572 A.2d 798, 803 (Pa. Commw. Ct. 1990). Thus, recognizing the legislative interest in effective and meaningful efforts at rehabilitation, allowing estate assets to be depleted during an appeal can only harm the public interest by making the rehabilitation process more difficult.

F. THE INTERVENING REGULATORS FAIL TO ADDRESS THE NECESSITY OF A BOND.

The Intervening Regulators cannot make out a case on the merits for a stay, and thus the Court need not consider now whether a bond is appropriate to maintain the *status quo* as requested in the Stay Application. See Pa. R.A.P. 1732, 1733 (related to appeals and security). The Intervening Regulators’ decision to omit any argument on the question of whether a bond is needed—and if so, in what amount—offers an additional reason to deny the motion. If the Court is inclined to grant a stay despite the numerous defects in the Stay Application, however, the Court will be required to address the bond issue at some point. Given that the Intervening Regulators made no reference at all to a bond, they have arguably waived the right to oppose the imposition of security here, and indeed the Court could find that a bond representing the Intervening Regulators’ own projection of the outcome in rehabilitation—a deficit reduction exceeding \$300 million—is appropriate. Alternatively, the Court may conclude that a bond representing the \$55 million or more of deepening deficit during an appeal is sufficient. These are difficult fact-based questions, and thus the Rehabilitator submits that the question of appropriate

security—whether required and in what amount if so—should be considered in a separate hearing during which the parties can present evidence and argument on this specific issue.

G. CONCLUSION

For the reasons set forth herein, and for the reasons addressed in this Court’s Memorandum Opinion and Order, the Rehabilitator respectfully asks that this Court deny the Application for Stay.

Dated: October 15, 2021

Respectfully submitted,

/s/ Michael J. Broadbent

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CERTIFICATE OF SERVICE

I, Michael J. Broadbent, hereby certify that on October 15, 2021, I caused to be served the foregoing REHABILITATOR'S ANSWER AND BRIEF IN OPPOSITION TO THE INTERVENOR STATE INSURANCE REGULATORS' APPLICATION FOR STAY PENDING APPEAL through the Court's PACFile system and on all parties listed on the Master Service List. In addition, I hereby certify that an electronic copy of the foregoing document will be posted on SHIP's website at <https://www.shipltc.com/court-documents>.

/s/ Michael J. Broadbent

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

In re: Senior Health Insurance
Company of Pennsylvania (In
Rehabilitation)

No. 1 SHP 2020

**THE HEALTH INSURERS' RESPONSE TO THE INTERVENING
REGULATORS' APPLICATION FOR STAY PENDING APPEAL**

The Intervenor Anthem, Inc., Health Care Service Corporation, Horizon Healthcare Services, Inc. d/b/a Horizon Blue Cross Blue Shield of New Jersey, and UnitedHealthcare Insurance Company (collectively, the “Health Insurers”), through their undersigned counsel, hereby submit this Response to the application filed by the Intervenor Superintendent of Insurance of the State of Maine, Commissioner of Insurance of the Commonwealth of Massachusetts, and Insurance Commissioner of the State of Washington (collectively, the “Intervening Regulators”) for a stay pending appeal of the August 24, 2021 Order (the “Confirmation Order”) granting the application of the Insurance Commissioner of the Commonwealth of Pennsylvania as Rehabilitator (the “Rehabilitator”) of Senior Health Insurance Company of Pennsylvania (“SHIP”) for approval of the Second Amended Plan of Rehabilitation (the “Plan”), the May 21, 2021 ruling granting the Rehabilitator’s motion in the nature of a directed verdict regarding issue state rate approval and the

August 25, 2021 Order denying reconsideration (the “Application”).¹ For the reasons set forth below, the Application should be denied because the Intervening Regulators have failed to meet the requirements for a stay pending appeal.

ARGUMENT

I. The Standards for the Issuance of a Stay Pending Appeal

The criteria for issuing a stay or supersedeas pending appeal are derived from the Pennsylvania Supreme Court’s decision in *Penn. Public Util. Comm’n v. Process Gas Consumers Group*, 467 A.2d 805 (Pa. 1983). *See also* Pa.R.A.P. 1732, Official Note (citing *Process Gas* for the criteria for the issuance of a stay). Under that case, a stay or supersedeas is warranted if:

(1) The petitioner makes a strong showing that he is likely to prevail on the merits. (2) The petitioner has shown that without the requested relief, he will suffer irreparable injury. (3) The issuance of a stay will not substantially harm other interested parties in the proceedings. (4) The issuance of a stay will not adversely affect the public interest.

Process Gas, 467 A.2d at 808–09. “[I]t is essential that the unsuccessful party, who seeks a stay of a final order pending appellate review, make a strong showing under the[se] criteria in order to justify the issuance of a stay.” *Id.* at 809.

In establishing the criteria for the grant of a stay or supersedeas pending appeal, the Pennsylvania Supreme Court expressly adopted the standards set forth in *Virginia Petroleum Jobbers Ass’n v. Federal Power Comm’n*, 259 F.2d 921 (D.C.

¹ Capitalized terms used but not defined herein have the meanings ascribed to them in the Plan.

Cir. 1958), as refined in *Washington Metro. Area Transit Comm'n v. Holiday Tours, Inc.*, 559 F.2d 841 (D.C. Cir. 1977). The Court in *Virginia Petroleum* elaborated on the stay criteria as follows:

(1) Has the petitioner made a strong showing that it is likely to prevail on the merits of the appeal? **Without such a substantial indication of probable success, there would be no justification for the court's intrusion into the ordinary processes of administrative and judicial review.**

(2) Has the petitioner shown that without such relief, it will be irreparably injured? **The key word in this consideration is irreparable.** Mere injuries, however substantial, in terms of money, time and energy necessarily expended in the absence of a stay, are not enough. **The possibility that adequate compensatory or other corrective action will be available at a later date, in the ordinary course of litigation, weighs heavily against a claim of irreparable harm.** But injury held insufficient to justify a stay in one case may be sufficient to justify it in another, where the applicant has demonstrated a higher probability of success on the merits.

(3) Would the issuance of a stay substantially harm other parties interested in the proceedings? **On this side of the coin, we must determine whether,** despite showings of probable success and irreparable injury on the part of the petitioner, **the issuance of a stay would have a serious adverse effect on other interested persons.** Relief saving one claimant from irreparable injury, at the expense of similar harm caused another, might not qualify as the equitable judgment that a stay represents.

(4) Where lies the public interest? **In litigation involving the administration of regulatory statutes designed to promote the public interest, this factor necessarily becomes crucial.** The interest of private litigants must give way to the realization of public purposes. The public interest may, of course, have many faces—favoring at once both the rapid expansion of utilities and the prevention of wasteful and repetitive proceedings at the taxpayer's or consumer's expense; both fostering competition and preserving the economic viability of existing

public services; both expediting administrative or judicial action and preserving orderly procedure. We must determine, these many facets considered, how the court's action serves the public interest.

Virginia Petroleum, 259 F.2d at 925 (emphasis added). *Washington Metro. Area Transit Comm'n* clarified that the necessary level of “possibility of success” to warrant a stay or supersedeas “will vary according to the court’s assessment of the other factors.” 559 F.2d at 843. “In essence, *Process Gas* requires that a court balance the equities without necessarily giving any one element more weight than another.” G. Ronald Darlington et al., 20A West’s Pa. Prac., Appellate Practice § 1732:6. *See also Reading Anthracite Co. v. Rich*, 577 A.2d 881, 884 (Pa. 1990) (“As a rule, we assume that a party will establish the existence of each criterion and that a court will assess the movant’s chances for success on appeal and weigh the equities as they affect the parties and the public and, thereby, exercise its discretion to grant or deny a stay so that injustice will not follow from the court’s decision.”).

The Intervening Regulators have not made a strong showing on any of these elements, and the issuance of a stay in this case will cause significant harm to the interests of the Rehabilitator, SHIP’s estate and other interested parties. As a result, the Application should be denied. Each element is considered below as well as the need for a bond as security in the event a stay were to be issued (a requirement the Intervening Regulators failed to address at all in the Application).

II. The Intervening Regulators Have Failed to Demonstrate a Strong Showing that They Are Likely to Prevail on the Merits of the Appeal

The Plan involves nothing more than the application of doctrines already well established under Pennsylvania Supreme Court authority. Its building blocks are these:

- The Pennsylvania Insurance Commissioner as rehabilitator has broad discretion to structure a plan of rehabilitation for an insurer. *Vickodil v. Commw. of Pa. Ins. Dep't*, 559 A.2d 1010, 1013 (Pa. Commw. Ct. 1989). The Rehabilitator is granted the authority under Article V to “take such action as [she] deems necessary or expedient to correct the condition or conditions which constituted the grounds for the order of the court to rehabilitate [SHIP].” 40 P.S. § 221.16(b). The Court reviews those decisions for an abuse of discretion only. *Grode v. Mutual Fire, Marine and Inland Ins. Co.*, 572 A.2d 798, 803 (Pa. Commw. 1990) (“*Mutual Fire I*”); *Foster v. Mutual Fire, Marine and Inland Ins. Co.*, 614 A.2d 1086, 1091 (Pa. 1992) (“*Mutual Fire II*”); *see also Koken v. Fidelity Mutual Life Ins. Co.*, 803 A.2d 807, 826 (Pa. Commw. Ct. 2002) (“The decision to rehabilitate the business of an insurer is within the sound discretion of a rehabilitator and should not be rejected by the reviewing court unless the rehabilitator has abused that discretion.”) (citing *Mutual Fire II*, 614 A.2d at 1092).

- A rehabilitation plan can modify the rights and obligations of policyholders under policy contracts. *Mutual Fire II*, 614 A.2d at 1094; *Consendine v. Penn Treaty Network Am. Ins. Co.*, 63 A.3d 368, 452 (Pa. Commw. 2012) (“*Penn Treaty*”).
- A rehabilitation plan does not have to restore the company to its exact original condition as long as it “properly conserves and equitably administers the assets of the involved corporation in the interests of investors, the public and others, with the main purpose being the public good....” *Mutual Fire II*, 614 A.2d at 1094 (internal quotations, citations omitted).
- The *Carpenter* test (set forth in *Neblett v. Carpenter*, 305 U.S. 297 (1938) (“*Carpenter*”)) does not require that every single policyholder get at least what he or she would get in a liquidation, if the plan meets a compelling public purpose. *Mutual Fire II*, 614 A.2d at 1094; *Penn Treaty*, 63 A.3d at 453.

The Intervening Regulators state that they have “substantial arguments that the Court’s approval of the Plan should be reversed because the Plan is based on errors of law.” Application at 10. Yet, as discussed below, the Application cites virtually no factual basis or legal authority in support of the propositions it advances. What the Intervening Regulators would really like to do is substitute their judgement for the judgment of the Rehabilitator. But the fact that they would choose a different

path (liquidation) does not mean the Rehabilitator has abused her discretion in pursuing the Plan.

A. Feasibility.

The Intervening Regulators challenge the Plan on the basis that is not “feasible.” Application at 10-14. They cite testimony from the Special Deputy Rehabilitator to the effect that the Plan will not restore SHIP to solvency. Fairly characterized, the testimony of the Special Deputy Rehabilitator was that Phase One of the Plan was unlikely to return SHIP to solvency, but that Phase Two of the Plan could do so, depending on the results of 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 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.

Tr. at 306. The Plan contemplates the restoration of SHIP to solvency through at least two phases, the second of which could restore SHIP to solvency, though such restoration is uncertain. The Intervening Regulators do not cite a single case for the proposition that a plan of rehabilitation must be “feasible” or that a plan cannot proceed in phases. Nor do they cite any authority for the proposition that rehabilitation plans must be certain to succeed in order to be undertaken.

To the contrary, in the Confirmation Order, the Court observed that neither Article V nor the case law sets “feasibility” as an independent requirement of a plan, but only requires a plan to properly conserve and administer the assets of the insurer in the interest of investors, the public and others. Confirmation Order at 66. Under this standard, proper stewardship in the service of the stakeholders is required. A definite return to solvency is not. Again, the Intervening Regulators cite no contrary authority. In addition, there is precedent for rehabilitation plans in Pennsylvania to proceed in phases. *See Mutual Fire II* at 635-36 (amending the plan of rehabilitation after implementation to achieve its rehabilitative purpose).

The Plan does not impair Guaranty Association coverage, and all policyholders have the option to retain their existing policies with only a requirement to pay an actuarially justified premium, as required by the terms of the policy itself. *See, e.g.*, Tr. at 102-03, 188, 331-32. Benefit modifications are entirely voluntary, and the evidence establishes many reasons why policyholders may want to modify

their benefits when presented with the opportunity. *See, e.g.*, Tr. at 85-86 (estimating that SHIP’s “indemnity” policies provide \$400 million in benefits in excess of what is needed for the costs of care, and that policyholders may not want to pay for such excess benefits); Tr. at 86-87 (noting that there are likely many policyholders who no longer need a lengthy or unlimited benefit period, either because of their attained age or current health circumstances.)

The evidence shows that a return to solvency is contemplated by the Special Deputy Rehabilitator at the end of the Phase Two of the Plan. The Intervening Regulators cite no authority that feasibility must be shown under Pennsylvania law, that a plan implemented in phases is *per se* not feasible, or that a plan must be certain to restore solvency. Thus, it is unlikely that the Intervening Regulators have substantial prospects for reversal of the Confirmation Order on this basis.

B. Best Interest of Policyholders

The Intervening Regulators’ appear to contend that the only means by which the burden of an insolvency can be distributed is by triggering the Guaranty Associations in a liquidation and invoking the assessment mechanisms. “The legislatures in Pennsylvania and other states have chosen to protect policyholders of insolvent insurers by establishing guaranty associations to provide coverage (subject to certain limits), and they have chosen how to spread the burden of those protections through the assessment mechanism.” Application at 19. The Intervening Regulators

claim that “[t]he Court improperly overrode these legislative judgments.” *Id.* at 20. First, and fatally to this argument, the Intervening Regulators fail to recognize that those same legislatures chose *not* to mandatorily trigger the Guaranty Associations upon “insolvency.” *See, e.g.*, 40 P.S. § 991.1706(b) (providing for mandatory trigger only if the insurer is placed under an order of liquidation with a finding of insolvency); National Association of Insurance Commissioners Life and Health Insurance Guaranty Association Model Act at § 8(b) (same). Second, if this were the only means by which insurance company insolvencies could be addressed under Pennsylvania law, then Article V and case law in Pennsylvania should bar the modification of policies in a rehabilitation proceeding. But, of course, the contrary is true. Pennsylvania precedent clearly contemplates that policies can be modified. *Mutual Fire II*, 614 A.2d at 1094; *Penn Treaty*, 63 A.3d at 452.

Moreover, the Intervening Regulators mischaracterize the operation of the Plan in making their arguments. They imply that the Plan involuntarily modifies the contractual rights of the policyholders, which it does not. The Plan imposes rate increases on policyholders under the If Knew Premium methodology in Phase One and the Self-Sustaining Premium methodology in Phase Two. Plan at 23. The policies by their terms allow for rate increases.² Tr. at 331-32. The undisputed

² The question of whether the policyholders – or the Intervening Regulators – have a contractual or other right to have rates determined by the regulator in the state that issued the policy is dealt with in Section D below.

testimony is that the actuarial methods applied to both phases are legitimate and recognized methods of setting premium rates. Tr. at 107-08; 399-400. The Plan provides policyholders options other than accepting the rate increase, but these are entirely voluntary.

The Intervening Regulators are also wrong in asserting that the Rehabilitator and the Court cannot consider the interests of other stakeholders. Indeed, *Mutual Fire II* establishes that a main purpose of a plan of rehabilitation is the public good. *Mutual Fire II*, 614 A.2d at 1094. *See also id.* at 1094 n.4 (determining that the state’s interest in “regulat[ing] the fiscal affairs of its insurers for the welfare of the public” is a legitimate and significant public purpose). Under the three-part test established in *Mutual Fire II*, the Court should confirm a plan of rehabilitation so long as the Rehabilitator has acted for a legitimate and significant public purpose and the adjustment of contractual rights is reasonable and of a nature appropriate to that public purpose. *Penn Treaty*, 63 A.3d at 453 (discussing the three-part test established in *Mutual Fire II*). As part of that analysis, “the Court **must** consider the greater good, including the consequences to the larger class of policyholders **and the taxpaying public.**” *Id.* (citing *Vickodil*, 559 A.2d at 1013) (emphasis added); *see also* Confirmation Order at 62-63 (discussing same). The Court expressly determined that the Plan—even assuming, *arguendo*, that it substantially impairs policies—serves a legitimate and significant public purpose, and the policy

modifications are reasonable and appropriate to that purpose. Confirmation Order at 63.

The Plan achieves its objectives by requiring all policyholders to pay an actuarially justified premium consistent with the terms of their policies, or choose another option that reduces both benefits and premiums. In all cases their Guaranty Association protections remain intact. On these facts, found by the Court (and not challenged by the Intervening Regulators), it seems highly unlikely that the Intervening Regulators would prevail on these issues on appeal.

C. The *Carpenter* test

The Intervening Regulators argue that *Carpenter* “established a floor of liquidation value that each policyholder should be able to obtain if desired.” Application at 21. The Pennsylvania Supreme Court disagrees with this interpretation of *Carpenter*. *Mutual Fire II*, 614 A.2d at 1094; *Penn Treaty*, 63 A.3d at 453. As the Court stated in the Confirmation Order:

if a particular policyholder is found to be worse off under a rehabilitation plan than in liquidation, and the impairment is ‘substantial,’ the Court should confirm the plan so long as the Rehabilitator has acted for a legitimate and significant public purpose and the contractual modification is reasonable and appropriate to that public purpose.

Confirmation Order at 63. The Court went on to find that 85% of policyholders would receive an option under the Plan with a value equal or greater than what they would receive in a current liquidation based on the Intervening Regulators’ own

metrics. But more importantly, the Court found that the Plan serves a “legitimate and significant public purpose” by requiring policyholders to pay a fair premium for their policies on an ongoing basis (as required by their policies) instead of shifting the burden of historical rate suppression to the Guaranty Associations and the taxpayers. *Id.* at 63-64.

In reaching this conclusion, the Court’s decision fell squarely within the four corners of *Mutual Fire II*. It is highly unlikely that the Pennsylvania Supreme Court would reverse the Confirmation Order given the Supreme Court’s specific pronouncements on the interpretation of the *Carpenter* test.

D. State authority over the regulation of rates

As observed by the Court, Pennsylvania authority clearly interprets the rehabilitation statute to allow a rehabilitator to impair policies by reducing benefits under them pursuant to a rehabilitation plan. *Mutual Fire I*, 572 A.2d at 804, *affirmed Mutual Fire II*, 614 A. 2d at 1086; Confirmation Order at 50. The Court reasoned that increasing premiums would be authorized by the same statutes and is conceptually no different from a reduction in benefits. Confirmation Order at 51. This contention goes unanswered in the Intervening Regulators’ Application. They argue that Article V does not give authority to the Rehabilitator to either modify policies or rates. Application at 25. But this is clearly not the law in Pennsylvania.

The Intervening Regulators also reject the Court’s explanation of why the Full Faith and Credit clause of the U.S. Constitution does not require ceding control over rate-making to numerous state regulators, who have refused to set adequate rates in the past. But they do nothing to distinguish the cases cited by the Court or refute the contention that the statutory rate provisions in the three objecting states are substantially similar to those in Pennsylvania, and implicate the same public policies. The wide acceptance of the Plan’s rate-making methodologies by insurance regulators across the country, including Maine, Massachusetts and Washington, was established during the hearing on the Plan through undisputed expert testimony. Tr. at 107-08; 399-400; 442-43; 456-57. *See also* Confirmation Order at 61 (finding that “the interests of Maine, Massachusetts, and Washington in ensuring that long-term care insurance premium rates are not excessive, unfairly discriminatory, or unreasonable to the benefits provided will be advanced, rather than impaired, by the Plan.”). The Intervening Regulators could not refute that testimony then, nor can they now.³

Finally, the Intervening Regulators reject the “opt-out” provisions of the Plan as a measure designed to allow them to exercise rate-making authority within the

³ The Health Insurers’ Pre-hearing Memorandum discussed at length the reasons why the Plan’s provisions governing the approval of premium rates are authorized by Article V and are not violative of the U.S. Constitution. Health Insurers’ Pre-hearing Memorandum at 4-22. The Health Insurers incorporate that analysis by reference, and note that the Intervening Regulators’ Application does not raise any arguments that were not already addressed in the Health Insurers’ Pre-hearing Memorandum or by the Court in the Confirmation Order.

framework of the Plan. They contend that the Plan does not give them enough time to perform a review and creates disincentives for them to do so. Application at 28. But as the Special Deputy Rehabilitator testified, providing the states with an unlimited review period would bring the progress of the Plan to a halt. Tr. at 162-63. The disincentives are slight. Policyholders will still have option to keep their policy at the rate prescribed by the opt-out regulator, though with reduced benefits if the premium is below the If Knew Premium. They can also keep the full benefit of their policy at the If Knew Premium rate or they can elect policy modifications similar to those available to policyholders in opt-in states. Plan at 108-14 (Phase One); 114-16 (Phase Two). These provisions of the Plan strike a reasonable balance between the overall goals of the Plan, which require speed and uniformity, with the desire of the Intervening Regulators to exercise authority over rate review.

It is highly unlikely that the Pennsylvania Supreme Court will find that the Plan deprives policyholders of a meaningful contract right, that the Full Faith and Credit clause invests the Intervening Regulators with the right to set rates in the context of this rehabilitation case or that the Plan has not made reasonable accommodation for the Intervening Regulators to exercise their rate-making authority if they choose to do so.

III. The Intervening Regulators Will Not Suffer Irreparable Injury Without a Stay

Perhaps the most glaring element missing from the Application is any showing by the Intervening Regulators that the implementation of the Plan harms them in their capacity as regulators in any way. The sole allegation of harm is that if the Plan is implemented, the Rehabilitator might someday make an argument that an appeal would be equitably moot. They speculate that:

The practical realities suggest that at some point the Rehabilitator may contend that the Plan has been “substantially consummated” so that the appeal should be dismissed under the doctrine of equitable mootness.

Application at 31. This potential, speculative “harm” falls well short of the harm a party must demonstrate to justify the drastic remedy of a stay. On the other hand, as discussed below, a stay would work concrete, quantifiable harm to the interests of the Rehabilitator, as established by evidence in the record.

The doctrine of equitable mootness has not been developed in the Pennsylvania case law. It is largely a creature of Federal Bankruptcy law. Under those cases, the possibility of equitable mootness is not, without more, justification for a stay. *See, e.g., BDC Cap., Inc. v. Thoburn Ltd. P’ship*, 508 B.R. 633, 640 (E.D. Va. 2014) (“the fact that an appeal may become moot without a stay does not alone constitute irreparable harm”); *In re DJK Residential, LLC*, No. 08-10375, 2008 WL 650389, at *3 (S.D.N.Y. Mar. 7, 2008) (“a ‘majority of courts have held that a risk of mootness, standing alone, does not constitute irreparable harm’”); *N.L.R.B. v. 710*

Long Ridge Rd. Operating Co. II, LLC, No. CIV.A. 14-832 CCC, 2014 WL 906128, at *1 (D.N.J. Mar. 6, 2014) (“Even if the Court were to accept the NLRB’s proposition that the denial of a stay would render its appeal equitably moot, a risk of equitable mootness by itself is insufficient to justify a stay pending appeal.”); *In re Baker*, CV05–3487, 2005 WL 2105802, at *9 (E.D.N.Y. Aug. 31, 2005) (“As other courts have noted, the possibility that an appeal will be rendered moot by a denial of stay does not, in and of itself, constitute irreparable harm.”); *In re Windstream Holdings, Inc.*, No. 20 CV 4276, 2020 WL 4481933, at *3 (S.D.N.Y. Aug. 3, 2020) (“But equitable mootness is a risk present in any post-confirmation appeal of a Chapter 11 plan; merely invoking that risk in a demand for expedition is not enough to show irreparable harm.”).

Even the few cases concluding that the possibility of equitable mootness could constitute irreparable injury have only done so where the appellant has made a strong showing that it is likely to prevail on the merits. *See, e.g., In re Los Angeles Dodgers LLC*, 465 B.R. 18, 30-1 (D.C. Del. 2011) (“Appellant has shown a strong likelihood of success on the merits of its appeal.”); *In re Cujas*, 376 B.R. 480, 491 (Bankr. E.D. Penn. 2007) (“In this sense, GJR does not have a reasonable likelihood of success. It is only a question of whether the likely outcome happens sooner or later.”).

As set forth in Section II, the Intervening Regulators do not have substantial claims of error or a strong possibility of success on appeal, given the prior decisions

of the Pennsylvania Supreme Court. Their prospects for success are even further limited by the relief that they seek, which is sweeping in its scope. They want the consummation of the Plan “undone by deeming the policyholder elections and regulator opt-outs nullities in the event the Court’s approval is reversed.” Application at 30. Even they recognize that this would “be administratively difficult and confusing to policyholders and regulators to undo those steps.” Application at 30. The prospects for obtaining this relief are remote even if their appeal succeeded. First, this relief is premised on a complete reversal of all elements of the Plan. The Intervening Regulators do not, by their own express admission, represent policyholders, and the Court has ruled that they “lack standing to assert the claim that the Plan treats ‘policyholders in different States differently.’ They expressly disavowed that they were appearing in a *parens patriae* or other representative capacity for policyholders in their states.” Confirmation Order at 68 (citing Tr. at 541-47). This means that they only have standing to raise issues that involve their rights as regulators rather than the rights of the policyholders. Therefore, the relief that they could obtain on appeal could only relate to the opt-out provisions of the Plan, not the policy modifications.

Second, even if the Intervening Regulators were entitled to represent the interest of policyholders (contrary to their own concession), they would surely only represent the interests of policyholders of policies issued in their states, which

comprise only 1,405 of the 33,261 policyholders of SHIP – approximately 4%. Exhibit RP-30 (figures as of Jan. 21, 2021, excluding policyholders who have taken NFOs and are thus not eligible to make elections under the Plan). Thus, even in the unlikely event that the Pennsylvania Supreme Court were inclined to recognize the standing of the Intervening Regulators to represent the interests of some policyholders, it is a very small subset of SHIP’s total policyholder population. Reversing the effects of the Plan for *all* policyholders and *all* regulators would vastly exceed any possible harm to the Intervening Regulators resulting from the Plan’s rate-making provisions for the 1,405 policies issued in their states. *See* Tr. at 155-59 (discussing the ordinary course process in which the regulator in the state where a policy was issued will set the rate and why the application of that procedure in receivership is infeasible).

In sum, the mere possibility of equitable mootness raised by the Intervening Regulators has widely been rejected by courts as a basis for establishing irreparable injury. Even the courts that have accepted it have only done so when the moving party has made a strong showing of likelihood of success on the merits. As set forth in Section II, the Confirmation Order is supported by undisputed facts in the evidentiary record and well-established Pennsylvania Supreme Court authority. The relief sought by the Intervening Regulators is well beyond the scope of any injury that they may sustain either as regulators (which is the only capacity in which they

appear) or even as representatives of holders of policies issued in their states (if the Court were to permit them to assert such interests).

IV. SHIP and Other Interested Parties Will be Substantially Harmed By a Stay

Unlike the speculative harm asserted by the Intervening Regulators that might someday result from implementing the Plan, the issuance of the stay sought by the Intervening Regulators will result in immediate harm to the Rehabilitator's interests, and the interests of the SHIP estate and other interested parties. Currently, appeals from rulings of the Commonwealth Court have taken nearly a year to resolve. (See Exhibit A, which sets forth information about the timing of recent appeals from filing to decision.⁴) The passage of a year without implementation of the Plan will significantly diminish SHIP's assets, further delay the implementation of necessary rate increases and jeopardize the prospects for accomplishing the rehabilitative purpose set out in the Plan. The Intervening Regulators admit the harm to the estate and the fact that it will "reduce amounts that can be paid to policyholders." Application at 32.

The Intervening Regulators did not dispute the testimony and exhibits of the Rehabilitator establishing that SHIP continues to hemorrhage money year after year. The disparity between claims paid and premiums plus investment income continues

⁴ This material is compiled from public records. Accordingly, this Court may take judicial notice of it. Pa. R. Evid. 201.

to average approximately \$200 million per year.⁵ This is quantifiable and significant harm to the SHIP receivership estate, and ultimately to policyholders if the Plan is upheld.

The fundamental problem caused by delay was stated succinctly by the Special Deputy Rehabilitator as follows:

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.

Tr. at 67-68 (emphasis added). Each year of delay in implementing the Plan decreases the runway. Not only does SHIP lose the benefit of a year of increased, actuarially justified premium (as to those who elect to keep their policies at the If Knew Premium), but SHIP also loses the benefit of decreased policy obligations from elected policy modifications. The benefits of increased premium and reduced policy obligations cannot be regained other than by imposing further burdens on the policyholders. The Special Deputy Rehabilitator made a similar observation in connection with the potential delay caused by submitting to the ordinary rate making process advocated by the Intervening Regulators:

⁵ Exhibit RP-12 at 1 (calculated as follows: FY 2019 benefits paid of \$369,626,000 less premiums received of \$80,672,000 less net investment income of \$66,717,000 equals \$222,237,000; FY 2020 Benefits paid of \$333,201,000 less premiums received of \$66,982,000 less net investment income of \$69,368,000 equals \$196,851,000).

But we concluded pretty early on that that approach [46 state regulatory approval] 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.

Tr. at 82-83 (emphasis added); *see also* Plan at 34 (“Moreover, the delay and expense of ‘traditional’ state-by-state rate or benefit approval would make the Plan unfeasible.”). Even under the most conservative scenario (81% of policyholders elect to keep the policy at If Knew Premium), the Plan will close the Funding Gap by \$525 million. Tr. at 113. Losing a year on a short premium runway is bound to cut into this amount. This harm is concrete and supported by the evidentiary record in this case. It clearly outweighs the Intervening Regulators’ conjectured harm from the possible application of equitable mootness.

Conspicuously absent from the Application is any offer to provide security as a condition to the granting of a stay. Pa.R.A.P. 1733(a) provides that an appeal from an order that is not solely for the payment of money “shall, unless otherwise prescribed in or ordered pursuant to this chapter, operate as a supersedeas **only** upon the filing with the clerk of the court below of appropriate security as prescribed in this rule.” (Emphasis added.) In any such appeal, the Court “may, upon its own motion or application of any party in interest, impose such terms and conditions as it deems just and will maintain the res or status quo pending final judgment or will facilitate the performance of the order if sustained.” Pa.R.A.P. 1733(a). “The trial

court, in the first instance, and thereafter the appellate court, are afforded broad discretion to fix security in such amount as the trial court or the appellate court deems appropriate under the circumstances.” G. Ronald Darlington et al., 20A West’s Pa. Prac., Appellate Practice § 1733:3. In this case, if the Court is willing to entertain a stay pending appeal, it should be conditioned on a bond in an appropriate amount, and the Court should conduct a hearing to determine the amount.⁶

A recent Third Circuit decision in a bankruptcy appeal is instructive. *See In re Tribune Media Co.*, 799 F.3d 272 (3d Cir. 2015). In approving the trial court’s reasoning in setting the bond amount, the Third Circuit explained that such a bond was required “to indemnify the party prevailing in the original action against loss caused by an unsuccessful attempt to reverse the holding of the bankruptcy court.” *Id.* at 281-82.

It then described the lower court’s process and reasoning when setting the bond amount at issue:

The Bankruptcy Court held a hearing on the motion at which it considered whether to issue a stay and, if so, whether to condition it on a bond. Aurelius opposed posting a bond in any amount. The Court stayed its confirmation order, but it also considered **how much an unsuccessful appeal by Aurelius would cost Tribune [the debtor]**. As a result of this valuation, the Court conditioned its stay on Aurelius’s posting a \$1.5 billion bond to indemnify Tribune against the estimated costs associated with staying the order for the likely time to appeal.

⁶ There are a variety of methodologies that could be used to calculate the bond. While it would be premature to explore them at this stage, it is very likely that the harm to the estate as a result of the stay will be approaching or greater than \$100 million.

...

In this case, the Bankruptcy Court carefully calculated **the likely damage to the estate of a stay pending an appeal from its confirmation order**. In particular, it analyzed the following costs to Tribune and its creditors that a stay would cause: **additional professional fees, opportunity costs to creditors who would receive delayed distributions from the DCL Plan or delayed interest and principal payments from reorganized Tribune, and a loss in market value to equity investors caused by the delayed emergence**. We need not go through the opinion in detail, as Aurelius does not squarely argue that the bond requirement was an abuse of discretion, but **we note that the valuation was well-considered and as convincing as the alchemy of valuation in bankruptcy can be**.

In re Tribune Media Co., 799 F.3d 272, 276, 281-82 (3d Cir. 2015) (emphasis added) (discussing *In re Tribune Co.*, 477 B.R. 465, 482 (Bankr. D. Del. 2012)).

The Court should deny the Application on the basis that the harm to the estate and other parties substantially outweighs any potential harm to the Intervening Regulators, particularly in light of their low likelihood of success on the merits. If the Court is willing to entertain such a stay, a bond should be required to protect the estate and the parties from the loss inherent in delay. If such a bond will be required, a hearing on the amount of that bond should be held in order to permit the type of expert testimony and determinations as were made in the *Tribune* case on a fully developed record.

V. The Issuance of a Stay Would Adversely Affect the Public Interest

The Intervening Regulators and the Rehabilitator both claim to be custodians of the public interest as state appointed officials. The Intervening Regulators argue

that a stay of Plan implementation would promote the public interest because they are seeking to invoke the Guaranty Associations and vindicate their role and the role of other regulators in setting premium rates. However, the Intervening Regulators seem to forget that they only represent themselves. They certainly do not represent all other regulators, and the Court has found that they do not even represent the interests of the policyholders in their states.

By contrast, the Rehabilitator is charged with promoting the state's "significant interest...[in] regulat[ing] the fiscal affairs of its insurers for the welfare of the public." *Mutual Fire II*, 614 A.2d at 1094, n.4. (emphasis added). The Rehabilitator has undertaken this obligation by proposing the Plan which has two goals:

First, we reduce or eliminate the funding [gap] or the deficit.
Second, eliminate the inequitable and discriminatory rate structure that's currently in place and eliminate the subsidies across policyholders...prospectively.

Tr. at 105.

The Court summarized the public policy arguments supporting the Rehabilitator's position as follows:

A liquidation will place the burden of an actuarially justified premium upon the policyholders of member insurers of the applicable guaranty associations and, ultimately, upon the taxpayers in those states. No one has provided the Court with an explanation as to why, as a matter of policy, the premium burden of SHIP's policyholders should be borne by others.

Confirmation Order at 81. The stay sought by the Intervening Regulators would undermine the Plan and the advancement of the policies it embodies. For that reason, the Application should be denied.

CONCLUSION

The Application does not satisfy the four factors required for the entry of a stay pending appeal under Pennsylvania law. The Intervening Regulators are not likely to succeed on the merits of their appeal. It is undisputed that a stay would injure the interests of the Rehabilitator, SHIP's estate and other parties. The possibility of equitable mootness is not recognized in the vast majority of the case law as an injury to the appellant, and even in the minority of cases (none of which is a Pennsylvania receivership case), it is only an injury if there is a strong showing of likelihood of success on the merits. Finally, the Plan serves the public interest by reducing the Funding Gap and more equitably distributing the burden of premiums. For these reasons, the Application should be denied.

Respectfully submitted,

Dated: October 15, 2021 MORGAN, LEWIS & BOCKIUS LLP

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EXHIBIT A

Docket No.	Days from Allocatur to Argument	Days from Argument to Decision	Days from Allocatur to Decision
59 MAP 2020	168 days	212 days	380 days
58 MAP 2020	168 days	212 days	380 days
36 EAP 2020	133 days	173 days	306 days
3 MAP 2021	118 days	127 days	245 days
74 MAP 2020	140 days	127 days	267 days
71 MAP 2020	126 days	161 days	287 days
4 EAP 2021	127 days	127 days	254 days
20 WAP 2020	N/A	N/A	371 days
22 WAP 2020	182 days	162 days	344 days
9 WAP 2020	205 days	279 days	484 days
Average	152 days	176 days	332 days

PROOF OF SERVICE

I, John P. Lavelle, Jr., hereby certify that on October 15, 2021, the foregoing document was served via the PACFile system as well as via e-mail upon the following counsel:

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Dated: October 15, 2021

/s/ John P. Lavelle, Jr.
John P. Lavelle, Jr.

**In Re: Senior Health Insurance :
Company of Pennsylvania (in : No. 1 SHP 2020
Rehabilitation) :**

Pursuant to Pa. R.A.P. 123 and 1732(a), the Intervenor Superintendent of Insurance of the State of Maine, Commissioner of Insurance of the Commonwealth of Massachusetts, and Insurance Commissioner of the State of Washington (“State Insurance Regulators”), request that the Court expedite its consideration and ruling on the State Insurance Regulators’ Application for Stay Pending Appeal (the “Application for Stay”) of the Orders approving the Second Amended Plan of Rehabilitation (“Plan”) for Senior Health Insurance Company of Pennsylvania (“SHIP”). As reasons therefor, the State Insurance Regulators state as follows:

1. On September 21, 2021, the State Insurance Regulators appealed from the Court’s August 24, 2021 Order granting the application of the Insurance Commissioner of the Commonwealth of Pennsylvania as Rehabilitator (“Rehabilitator”) of SHIP for approval of the Plan, as well as the May 21, 2021 ruling granting the Rehabilitator’s motion in the nature of a directed verdict

regarding issue state rate approval and the August 25, 2021 Order denying reconsideration.

2. On October 1, 2021, the State Insurance Regulators filed their Application for Stay with the Court pursuant Pa. R.A.P. 123 and 1732(a).

3. On October 15, 2021, the Rehabilitator filed her Answer and Brief in Opposition to the Intervenor State Insurance Regulators' Application for Stay Pending Appeal. That same day, the Intervenor Health Insurers filed their Response to the Intervening Regulators' Application for Stay Pending Appeal.

4. An expedited ruling on the Application for Stay is necessary because the Rehabilitator has set a November 15, 2021 deadline for state insurance regulators to "opt-out" of the Plan. The imminence of an approximate November 15, 2021 "opt-out" deadline was noted in the State Insurance Regulators' Application (see pages 4, 29-30 and Exhibit A to the Application). The Rehabilitator has firmly set the November 15, 2021 deadline in a letter received by counsel after the Application was filed. *See* the Special Deputy Rehabilitator's letter dated September 30, 2021 attached as Exhibit 1 hereto.

5. In the absence of a stay, state insurance regulators around the country will be required to make an "opt-out" decision on or before November 15, 2021. This places regulators in the position of either implicitly acquiescing to what the State Insurance Regulators maintain is the Plan's usurpation of state regulatory

authority or “opting-out” and then either approving the Rehabilitator’s rate submission or placing policyholders in their state in a worse position than policyholders in other states.¹

6. The imminence of the November 15, 2021 deadline requires the State Insurance Regulators to make this request for expedited ruling. In the event that the Court were to deny the Application for Stay, the State Insurance Regulators intend to apply to the Supreme Court for a stay pending appeal pursuant to Pa. R.A.P. 1732. To allow any reasonable opportunity for the Supreme Court to make a decision on the application for stay in advance of the November 15, 2021 deadline, the State Insurance Regulators will need to file the application with the Supreme Court on or about November 5, 2021. The State Insurance Regulators will want to advise the Supreme Court of the Court’s reasons for denying a stay (if it were to do so) in accordance with Pa. R.A.P. 1732(b).

7. The absence of a ruling on the Application for Stay as the November 15, 2021 “opt-out” deadline approaches effectively constitutes a denial of the Application for Stay as to state regulators. In such circumstances, the State Insurance Regulators would need to consider applying to the Supreme Court for a

¹ A stay pending appeal is also necessary because of the harm to policyholders that will result from the implementation of the policyholder election process. However, the Rehabilitator has advised that the policyholder election packages will be mailed around year-end, so they do not implicate this application for expedited ruling.

stay on the ground that the trial court had failed to afford the relief which the applicant requested under Pa. R.A.P. 1732(b). The State Insurance Regulators would strongly prefer, however, to determine how to proceed based on a ruling of the Court regarding the Application for Stay.

Conclusion

For the above reasons, the State Insurance Regulators request that the Court expedite its ruling on their Application for Stay Pending Appeal.

November 2, 2021

Respectfully submitted,

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IN THE COMMONWEALTH COURT OF PENNSYLVANIA

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

BEFORE: HONORABLE MARY HANNAH LEAVITT, Judge

OPINION NOT REPORTED

MEMORANDUM OPINION
BY JUDGE LEAVITT

FILED: November 4, 2021

Before the Court is an application for a stay pending appeal (Stay Application) filed by Intervenors Superintendent of Insurance of the State of Maine, Commissioner of Insurance of the Commonwealth of Massachusetts and Insurance Commissioner of the State of Washington (collectively, Intervening Regulators). The Intervening Regulators seek a stay of this Court's August 24, 2021, order granting the application of Jessica K. Altman, Insurance Commissioner of Pennsylvania, in her capacity as the Statutory Rehabilitator (Rehabilitator) of Senior Health Insurance Company of Pennsylvania (SHIP), for approval of the Second Amended Plan of Rehabilitation for SHIP. The Intervening Regulators also seek a stay of the Court's May 21, 2021, ruling granting the Rehabilitator's motion in the nature of a directed verdict regarding issue state rate approval and the Court's August 25, 2021, order denying reconsideration of that ruling. Because the Intervening Regulators fail to meet the requirements for a stay pending appeal, the Court denies the Stay Application.

On August 24, 2021, this Court approved the Rehabilitator's Second Amended Plan of Rehabilitation (Plan)¹ for SHIP, a long-term care insurer that currently has an operating deficit of approximately \$1.2 billion. In broad terms, the Plan seeks to reduce or eliminate SHIP's deficit by increasing premium revenue and modifying the existing terms of most of the approximately 39,000 policies in force. The multi-phased Plan does so by offering policyholders an array of options to either maintain their coverages and pay an actuarially justified premium or reduce their coverages to avoid or temper a premium increase. The Plan also seeks to correct SHIP's discriminatory premium rate structure, whereby policyholders whose state of issue has approved requested rate increases over the years are paying more for the same coverages than policyholders whose state of issue has disapproved requested rate increases. The Plan contains an Issue State Rate Approval Option, by which a state may opt out of the rate approval section of the Plan.²

The Intervening Regulators objected to the Plan in its totality. One of their principal objections to the Plan was that, in their view, it unlawfully allows premium rates to be set by the Rehabilitator and this Court rather than by state-of-issue regulators. The Intervening Regulators asserted that the Plan's deviation from the ordinary state-by-state rate review process violated the Full Faith and Credit

¹ The Second Amended Plan of Rehabilitation is now known as the "Approved Plan." *See* Praecepte to Substitute Approved Plan of Rehabilitation, filed September 30, 2021, and the Court's order filed October 28, 2021, approving the substitution.

² If a state opts out, the Rehabilitator will file an application to increase rates for policies issued in that state to an actuarially justified 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. The Rehabilitator's unrefuted evidence established that policyholders in an opt-out state will, like their counterparts in opt-in states, have four options for adjusting their coverages and premium rate. Their choices will not, however, be exactly the same as those offered in the Plan.

Clause of the United States Constitution³ and was inconsistent with the principle of comity. They argued that the Plan's Issue State Rate Approval Option did not cure these infirmities because it is coercive and provides them with no meaningful review of the rate filings.

At the close of the hearing on the Plan on May 21, 2021, the Rehabilitator made an oral motion for judgment in the nature of a directed verdict on the claim of the Intervening Regulators that the Issue State Rate Approval Option was unlawful. In support, the Rehabilitator argued that the Intervening Regulators had not presented any evidence that their interests would be harmed by the Issue State Rate Approval Option, and as such, their objection to that aspect of the Plan could not serve as a basis for the Court to disapprove the Plan. The Court granted the Rehabilitator's motion from the bench. The Intervening Regulators sought reconsideration of the Court's ruling, which the Court denied by order dated August 25, 2021. In doing so, the Court reasoned, *inter alia*, that the Intervening Regulators had not presented any evidence to support their challenge to the opt-out provision.

The Intervening Regulators have appealed the Court's orders approving the Plan, granting the directed verdict and denying reconsideration of that verdict. Pursuant to Pa. R.A.P. 1732,⁴ they seek a stay of those orders pending a decision by the Pennsylvania Supreme Court. Under Pennsylvania law,

³ It states:

Full Faith and Credit shall be given in each State to the public Acts, Records, and judicial Proceedings of every other State. And the Congress may by general Laws prescribe the Manner in which such Acts, Records and Proceedings shall be proved, and the Effect thereof.

U.S. CONST. art. IV, §1.

⁴ Rule of Appellate Procedure 1732(a) provides, in relevant part, that an "[a]pplication for a stay of an order of a trial court pending appeal ... must ordinarily be made in the first instance to the trial court. Pa. R.A.P. 1732(a).

on an application for a stay pending appeal the movant is required to make a substantial case on the merits and to show that without the stay, irreparable injury will be suffered. Additionally, before granting a request for a stay, the court must be satisfied the issuance of the stay will not substantially harm other interested parties in the proceedings and will not adversely affect the public interest.

Maritrans G.P., Inc. v. Pepper, Hamilton & Scheetz, 573 A.2d 1001, 1003 (Pa. 1990) (citing *Pennsylvania Public Utility Commission v. Process Gas Consumers Group*, 467 A.2d 805, 808-09 (Pa. 1983)).

Under the first prong of the *Process Gas* standard, the Intervening Regulators must establish a substantial case on the merits of their appeal. In summary, the Intervening Regulators argue on appeal that the Plan is not feasible as required by law; constitutes an abuse of discretion because it does not serve the best financial interests of policyholders; fails to place policyholders in at least as good a position as in a liquidation, as required under *Neblett v. Carpenter*, 305 U.S. 297 (1938); exceeds the Rehabilitator's authority under Article V of the Insurance Department Act of 1921 (Article V);⁵ and violates the Full Faith and Credit Clause of the United States Constitution by superseding the regulatory authority of other states over premium rates.

The first impediment to the Intervening Regulators' case on appeal is their lack of standing to assert claims on behalf of policyholders. The Intervening Regulators' position in SHIP's rehabilitation proceedings is uncontroverted: they do not represent any policyholders, even those with policies issued in their own

⁵ Act of May 17, 1921, P.L. 789, added by Section 2 of the Act of December 14, 1977, P.L. 280, as amended, 40 P.S. §§221.1 – 221.63.

respective states.⁶ The Court granted the Intervening Regulators’ request for limited intervention in the hearing on the Plan based on their purported interests as regulators, and not in any *parens patriae* or other representative capacity for policyholders. Indeed, at the hearing, counsel for the Intervening Regulators expressly disavowed that they are acting in any “sort of a *parens patriae* capacity on behalf of . . . policyholders [from their respective states] who have chosen not to intervene.” Notes of Testimony (N.T.), 5/19/2021, at 543. As a result, the Court held that the Intervening Regulators lacked standing to assert claims on behalf of policyholders that they do not purport to represent.

The Court’s opinion in this matter addressed at length the substance of the Intervening Regulators’ arguments. *See generally In Re: Senior Health Insurance Company In Rehabilitation* (Pa. Cmwlth., No. 1 SHP 2020, filed August 24, 2021) (*In Re: SHIP*). For purposes of the *Process Gas* analysis, the Court will summarize the portions of its analysis relevant to the Intervening Regulators’ likelihood of success on the merits.

First, the Intervening Regulators continue to assert that the Plan is not “feasible.” They are not likely to prevail on this argument, however, because, as the Court explained, Article V does not require that the Plan be “feasible” in order to be approved. *Id.* at 68. In any event, the Court also held that the Plan is feasible to the extent such a requirement exists, because the Plan will materially reduce the Funding Gap, significantly improve SHIP’s financial condition, and if successful, will restore SHIP to its pre-receivership condition of an insurer winding down its long-term care insurance business. The Intervening Regulators have not offered any evidence in support of a different conclusion.

⁶ Notably, the number of policies issued in Maine, Massachusetts and Washington, 1,405, is approximately 4% of the policies in force as of January 21, 2021. *See* Exhibit RP-30.

Second, the Intervening Regulators contend that the Plan is not in the best financial interests of policyholders. Setting aside that the Intervening Regulators lack standing to assert such an argument, their position reflects only that “they would have exercised their discretion differently” than the Rehabilitator, which the Court held “is not a basis for the Court to disapprove the Plan.” *Id.* at 80. The Intervening Regulators favor an immediate liquidation of SHIP because that will trigger guaranty association coverage. The Intervening Regulators cannot establish that they are likely to prevail on the merits simply because they disagree with the Rehabilitator’s exercise of her discretion in deciding that a rehabilitation is to be preferred for several sound policy reasons. Moreover, they do not address the Court’s finding that in a liquidation, some policyholders will pay less than the actuarially justified premium for their coverage and other policyholders will, as a result, pay more for identical coverage. Nor do the Intervening Regulators address the fact that in a liquidation, policyholders will have little or no choice over their coverage once their policies are terminated, as is required by a liquidation order. Their replacement policy from the guaranty association will cap the limits of coverage.

Third, the Intervening Regulators continue to misconstrue *Neblett v. Carpenter*, 305 U.S. 297 (1938). Even accepting their interpretation, however, 85% of SHIP’s policyholders will be offered at least one option with a value equal to or higher than the value of the policy that they might have in liquidation. Accordingly, the Court held that even if the Plan substantially impairs policies, under any measure created by *Carpenter* “it serves a legitimate and significant public purpose, and the policy modifications are reasonable and appropriate to that purpose.” *In Re: SHIP* at 63. The Stay Application offers no basis for overturning the Court’s findings.

Finally, the Intervening Regulators argue that the Plan exceeds the Rehabilitator's authority under Article V and violates the Full Faith and Credit Clause. The Stay Application does not identify any specific statutory provision that the Plan violates, and this Court's opinion approving the Plan explained at length how the Plan's provisions fully comport with Pennsylvania law. The Court also explained why the Full Faith and Credit Clause does not require the Rehabilitator to submit premium rate increase requests to 46 states, the District of Columbia, and the U.S. Virgin Islands for their review and approval. To the contrary, such a requirement "would fracture Pennsylvania's 'own legitimate public policy' in the rehabilitation of SHIP," in contravention of the Full Faith and Credit Clause. *Id.* at 61. The Intervening Regulators cannot satisfy their burden under *Process Gas* by simply repeating these failed arguments.

Having determined that the Intervening Regulators cannot make a substantial case on the merits of their appeal, the Court could deny the Stay Application without considering the remaining three *Process Gas* factors. *See Maritrans*, 573 A.2d at 1004 ("In view of that failure [to show a substantial case on the merits, the court] need not scrutinize compliance with the remaining three criteria."). Even so, the Intervening Regulators cannot satisfy the remaining factors.

Under the second *Process Gas* factor, the Intervening Regulators must establish that without the stay, they will suffer irreparable injury. They allege here that a stay is necessary to prevent "harm [to] both policyholders and regulators because both will be forced to make decisions that may not be reversible even if the Court's decision is reversed on appeal." Stay Application at 29. This argument fails for several reasons.

First, the Intervening Regulators cannot request a stay based on hypothetical harm to third parties, *i.e.*, policyholders and other state regulators. When our Supreme Court adopted the federal law on supersedeas, it defined the second factor as requiring “the petitioner [to] show[] that without the requested relief, *he* will suffer irreparable injury.” *Process Gas*, 467 A.2d at 808 (emphasis added). In granting the stay in that case, the Supreme Court found a “sufficient showing of irreparable harm likely to result to the [movants],” a group of industrial gas consumers directly impacted by the surcharge allocation at issue. *Id.* at 809. Thus, a stay can only be entered upon a showing of irreparable harm to the moving party. To the extent the Intervening Regulators allege that other regulators or policyholders will be harmed absent a stay, such allegations are immaterial to the *Process Gas* analysis.

Second, to the extent the Intervening Regulators argue they will themselves be harmed absent a stay, the Court notes that their asserted right to regulatory authority over policies issued in their states and the rate review process is preserved by the Issue State Rate Approval Option. To date, the Intervening Regulators have offered no evidence to support their challenge to the legality of this opt-out provision in the Plan. For this reason, the Court entered a directed verdict in favor of the Rehabilitator on that issue.

Third, the alleged harms cited by the Intervening Regulators are not irreparable or imminent. The only alleged injury to the Intervening Regulators themselves, *i.e.*, the decision to participate in the Plan or opt out, is reparable because if the Court’s approval of the Plan is reversed, then the decision to participate or opt out will be rendered moot. Even if the Intervening Regulators are correct that it may be “administratively difficult and confusing . . . to undo” implementation of the Plan,

Stay Application at 30, that situation would not constitute irreparable harm under *Process Gas*.⁷

Regarding the final two *Process Gas* factors, harm to other parties and harm to the public interest, the Intervening Regulators' arguments are unpersuasive. They assert that a stay will not cause injury to other parties before the Court because it will maintain the status quo, *i.e.*, policyholders will continue to receive coverage, the agents and brokers have settled, and the guaranty associations have not been triggered. With respect to the public interest, the Intervening Regulators claim their appeal is designed to benefit policyholders and other regulators, and that the requested stay supports that mission.

The record before this Court established that delay itself is damaging to the rehabilitation of SHIP and, thus, to policyholders. The Court emphasized that rehabilitation is preferable to liquidation in part because it avoids delay: "a plan can be implemented quickly, thereby addressing the causes of SHIP's financial distress, preserving assets, and reserving flexibility." *In Re: SHIP* at 47. In reaching that conclusion, the Court noted that the Rehabilitator could learn the impact of Phase One and the potential scope of Phase Two within a year of approval, which is a favorable timeline over liquidation, where rate approvals could take as long as two years, and in which there would be little certainty as to the impact on policyholders for some time. The Plan is designed to be implemented as quickly as possible so that policyholders can minimize any potential loss or burden from SHIP's receivership by allocating the premiums and coverages available to best suit their individual

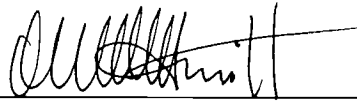
⁷ The Intervening Regulators also argue that a stay should be entered because, if the Plan is implemented before the appeal is heard and decided, the Rehabilitator may contend that the appeal should be dismissed under the doctrine of equitable mootness. *See In re Tribune Media Co.*, 799 F.3d 272 (3d Cir. 2015). The question of mootness is not before the Court at this time, and the mere possibility that the Rehabilitator may raise an argument in the future is not an imminent harm.

needs. The Court notes, further, that any harm to policyholder interests caused by a delay in implementing the Plan will be irreparable.⁸

The Intervening Regulators' arguments with respect to the public interest are similarly unpersuasive. They point to the various state legislatures' allocation of the burden of policyholder losses through the guaranty association system, claiming that a deeper deficit cannot harm the public because using guaranty association funds to cover SHIP's deficit, regardless of its size, is simply the system functioning as intended. But SHIP is not yet in liquidation, and the Pennsylvania legislature, like that of many other states, has enacted a law that favors meaningful efforts at rehabilitation over immediate liquidation. As this Court has previously observed, "[t]he legislatively stated purpose of Article V, to which the Court must give effect, is 'the protection of the interests of insureds, creditors, and the public generally' and the 'equitable apportionment of any unavoidable loss' through, *inter alia*, 'improved methods for rehabilitating insurers. . . .'" *Grode v. Mutual Fire, Marine and Inland Insurance Co.*, 572 A.2d 798, 803 (Pa. Cmwlth. 1990) (quoting Section 501 of Article V, 40 P.S. §221.1). Similarly, "[t]he benefits of rehabilitation—its flexibility and avoidance of inherent delays—are preferable to the static and cumbersome procedures of statutory liquidation." *Id.* Thus, recognizing the legislative interest in effective and meaningful efforts at rehabilitation, allowing estate assets to be depleted during an appeal can only harm the public interest by making the rehabilitation process more difficult.

⁸ In addressing the need for a bond in the event a stay is granted, the Rehabilitator estimates that the irreparable damage from a one-year delay would be between \$55 and \$70 million. The Rehabilitator posits that such damage equates to one year of the most costly long-term care services for approximately 500 policyholders.

For all of the above reasons, the Court denies the Intervening Regulators' application for a stay pending appeal.

A handwritten signature in black ink, appearing to read 'M. Leavitt', is written over a horizontal line.

MARY HANNAH LEAVITT, President Judge Emerita

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

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

ORDER

AND NOW, this 4th day of November, 2021, the Application for Stay Pending Appeal filed by Intervenors Superintendent of Insurance of the State of Maine, Commissioner of Insurance of the Commonwealth of Massachusetts and Insurance Commissioner of the State of Washington is DENIED. The Intervenors' Application for Expedited Ruling on Application of Stay Pending Appeal is DISMISSED as moot.



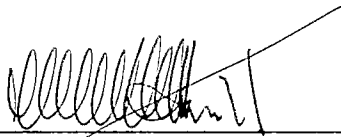
MARY HANNAH LEAVITT, President Judge Emerita

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

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

AMENDMENT ORDER

AND NOW, this 4th day of November, 2021, the opinion in the above matter, filed August 24, 2021, is amended as follows (see attached opinion).

A handwritten signature in black ink, appearing to read 'Mary Hannah Leavitt', is written over a horizontal line.

MARY HANNAH LEAVITT, President Judge Emerita

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

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

RE: Application for Approval of the Plan of Rehabilitation for Senior Health
Insurance Company of Pennsylvania

BEFORE: HONORABLE MARY HANNAH LEAVITT, Judge

FILED: August 24, 2021

OPINION AND ORDER

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I. Introduction

Before the Court is the application of Jessica K. Altman, Pennsylvania Insurance Commissioner, which she filed in her capacity as Statutory Rehabilitator of Senior Health Insurance Company of Pennsylvania (SHIP). By this application, the Rehabilitator seeks approval of her Second Amended Plan of Rehabilitation (Second Amended Plan or Plan) for SHIP pursuant to Section 516(d) of Article V of The Insurance Department Act of 1921 (Article V), Act of May 17, 1921, P.L. 789, *added by* the Act of December 14, 1977, P.L. 280, 40 P.S. §221.16(d). The Rehabilitator has the statutory responsibility to develop a plan to correct the conditions that caused SHIP's hazardous financial condition. Giving deference to the Rehabilitator's discretion in formulating this Plan, this Court must decide whether to approve the Plan, approve the Plan with modifications, or disapprove the Plan.

At present, SHIP has approximately \$1.4 billion in assets and \$2.6 billion in liabilities, producing a deficit of approximately \$1.2 billion (also referred to as the Funding Gap). The Second Amended Plan's ultimate goal is to eliminate the Funding Gap by increasing premium revenue and modifying the existing terms of most of the approximately 39,000 policies in force. The Plan is structured to maximize policyholder choice in several ways. Depending on his circumstances and preferences, a policyholder may choose to continue his policy with all benefits and terms unchanged by paying the actuarially justified annual premium for that policy. Alternatively, the policyholder may choose to reduce some policy coverages as more suitable to the policyholder's current circumstances in order to avoid or temper a premium increase. A policyholder who is 95, for example, may decide to reduce the

maximum coverage period from 10 to 5 years in lieu of paying the premium required for a policy with a 10-year period of coverage.

The Second Amended Plan also seeks to correct SHIP's discriminatory premium rate structure. At present, SHIP policyholders pay substantially different premiums for the same coverages. The difference in premiums is attributed to the decisions of different state regulators on SHIP's proposed rate increases. The state where the policy is issued retains authority for all rate increases, even after the policyholder moves to another state. Policyholders whose state of issue has approved the requested rate increase pay more for the same coverages than policyholders whose state of issue has disapproved the requested rate increase. As a result, the former group of policyholders pays more than its fair share of the costs of providing the coverages and the latter group pays less than its fair share. The Second Amended Plan seeks to eliminate these inequities.

The Court conducted a hearing on the Second Amended Plan from May 17, 2021, through May 21, 2021. The parties submitted post-hearing briefs on June 21, 2021, and June 28, 2021. On July 21, 2021, the Rehabilitator and Intervening Agents and Brokers filed an application for the Court's approval of a settlement agreement, which will amend Part VI.N of the Plan. The Rehabilitator's application for approval of the Second Amended Plan is ready for disposition, with the exception of Part VI.N, on which a decision will be deferred for 30 days to allow a hearing on the Rehabilitator's settlement agreement with the Intervening Agents and Brokers.

II. Findings of Fact

A. Business and History of SHIP

SHIP is a Pennsylvania life and health insurance company. Its origins date to 1887, when its corporate predecessor, the Home Beneficial Society,

commenced business. By the 1980s, the company was known as American Travelers Insurance Company and was primarily writing long-term care insurance. In 1996, the company was acquired by, and merged into, CIHC, Inc., a wholly-owned subsidiary of Consecro, Inc., and renamed Consecro Senior Health Insurance Company. In 2002, Consecro, Inc. filed a petition for reorganization under Chapter 11 of the United States Bankruptcy Code.¹ In 2003, Consecro, Inc. emerged from bankruptcy as CNO Financial Group. In 2003, Consecro Senior Health Insurance Company ceased writing long-term care insurance and limited its operations to the administration and servicing of existing policies. In October 2008, Consecro Senior Health Insurance Company changed its name to Senior Health Insurance Company of Pennsylvania (SHIP), and its ownership was transferred from CNO Financial Group to the newly-formed nonprofit Senior Health Care Oversight Trust, which has managed the run-off of SHIP's long-term care insurance business since 2008.

SHIP was licensed in 46 states (excluding Connecticut, New York, Rhode Island, and Vermont), the District of Columbia, and the U.S. Virgin Islands. Through its predecessors, SHIP issued approximately 645,000 long-term care policies; as of December 31, 2020, 39,148 policies remained in force. Exhibit (Ex.) RP-33 at 3.² SHIP's policies cover long-term care services provided in congregant settings, such as nursing homes and assisted living facilities, as well as home-based health care services and adult day care. The states with the greatest number of SHIP

¹ 11 U.S.C. §§101-1532.

² As of the date of the hearing on the Plan, SHIP had approximately 45,000 policies in force that are not long-term care policies. These policies are not material to the Second Amended Plan or the proposed rehabilitation of SHIP; they do not consume SHIP resources, either because they are reinsured or because claims under those policies are paid through a trust which is adequately funded.

long-term care policies in force as of December 31, 2020, are Texas with 4,960 policies; Florida with 4,040 policies; Pennsylvania with 3,862 policies; California with 3,183 policies; and Illinois with 1,753 policies. Ex. RP-22 at 2. By contrast, the three states represented by the intervening state regulators in this matter have comparatively fewer policies in force; as of year-end 2020, there were 316 policies in force in Maine, 296 in Massachusetts, and 1,287 in Washington. *Id.*

The average age of a SHIP long-term care policyholder is 86, and the average age of a policyholder on claim is 89. Only 53% of SHIP long-term care policyholders pay premium. This is because the remaining 47% of policyholders either are on premium waiver³ or have previously taken a non-forfeiture option, which allows the policyholder to discontinue paying premiums in exchange for a period of coverage equal to the premiums previously paid to the company less any benefits previously received. Approximately 13% of SHIP's long-term care policyholders are on claim, and the Rehabilitator expects that number to rise to 32% of all policyholders by 2050. Ex. RP-56 at 21. The Rehabilitator also expects the volume of SHIP's claims to continue outpacing its premium collections. Specifically, in the absence of the Rehabilitator's plan, SHIP will pay another \$3 billion in claims but collect only \$230 million in premiums. *Id.* at 20.

B. SHIP's Financial Condition

SHIP has approximately \$1.4 billion in assets and \$2.6 billion in liabilities, *i.e.*, a Funding Gap of \$1.2 billion. Ex. RP-31 at 1-2. The major causes

³ Approximately 99% of SHIP's long-term care policies provide that a policyholder who receives benefits under his policy for a specified period of time (such as 90 days) is no longer required to pay premiums for coverage after that time period as long as the policyholder remains eligible for benefits or receives a specified level of care. "Once the policyholder's eligibility for benefits ends, the policyholder is required to resume paying premiums." Ex. RP-55 at 86 (Second Amended Plan).

of SHIP's insolvency were the use of erroneous actuarial assumptions to develop initial premium rates, poor investment returns, high operating costs, and the inability to obtain the approval of actuarially justified rate increases from state insurance regulators. Two significant adverse events exacerbated SHIP's financial situation. In 2018, following the appointment of a Special Deputy Rehabilitator and a revision of SHIP's key actuarial assumptions, SHIP recorded a \$374 million premium deficiency reserve; a \$44 million increase in claim reserves; and a \$176 million investment loss from the so-called Beechwood investment program. These accounting entries increased SHIP's 2018 deficit by \$500 million. *See* Ex. RP-56 at 23. In 2019, revised actuarial assumptions required an increase in reserves, thereby adding another \$400 million to SHIP's deficit. *Id.* SHIP's annual premium revenue as of December 31, 2020, is \$58 million. *Id.* at 14.

C. Rehabilitation Plan

Given SHIP's negative capital and surplus, the Insurance Department applied to this Court for an order placing SHIP in rehabilitation, with the consent of the Senior Health Care Oversight Trust and SHIP's directors. On January 29, 2020, the Court granted the application and appointed the Pennsylvania Insurance Commissioner to serve as Rehabilitator of SHIP; to take steps to address SHIP's financial challenges; and to protect its policyholders and other creditors.

The Rehabilitator engaged a Special Deputy Rehabilitator, Patrick Cantilo, and actuarial consultants, including Oliver Wyman, to study SHIP's financial condition and to manage the company while they developed corrective measures. On April 22, 2020, the Rehabilitator filed a plan for the rehabilitation of SHIP. The Court issued a case management order which, *inter alia*, solicited formal

and informal comments from any interested person. Several intervened to offer comments on the rehabilitation plan and participate in any proceedings, including:⁴

- 1) The Maine Superintendent of Insurance, the Massachusetts Commissioner of Insurance, and the Washington Insurance Commissioner (Intervening Regulators);
- 2) The National Organization of Life and Health Guaranty Associations (NOLHGA);
- 3) ACSIA Long Term Care, Inc.; Global Commission Funding LLC; LifeCare Health Insurance Plans, Inc.; Senior Commission Funding LLC; Senior Health Care Insurance Services, Ltd., LLP; and United Insurance Group Agency, Inc. (Intervening Agents and Brokers);
- 4) Anthem, Inc.; Health Care Service Corporation; Horizon Health Care Services, Inc. d/b/a Horizon Blue Cross Blue Shield of New Jersey; and UnitedHealthcare Insurance Company (Intervening Health Insurers); and
- 5) James Lapinski, a policyholder and agent, and Georgianna Parisi, a policyholder.

After reviewing the formal and informal comments, the Rehabilitator filed an amended rehabilitation plan on October 21, 2020. Following a second comment period and a pre-hearing conference, the Rehabilitator filed the Second Amended Plan on May 3, 2021.

The Second Amended Plan is designed to be implemented in three phases. Phase One, beginning immediately upon Court approval, is the principal phase and seeks to reduce substantially or eliminate the Funding Gap. This phase identifies the SHIP policies that require modification because their current premium

⁴ The original intervening persons also included Transamerica Life Insurance Company and Primerica Life Insurance Company, both of which issued policies reinsured and administered by SHIP. These parties are no longer actively participating in the proceeding.

falls below the “If Knew Premium” for the benefits provided by the policies. Ex. RP-55 at 10. The If Knew Premium rate is the rate that, if charged from inception, would have produced an underwriting loss ratio of 60% for each policy form. *Id.* at 27. If Knew Premium rates are intended to price policies adequately on a lifetime basis, but not to recoup losses due to inadequate pricing in the past. Further, the policyholder’s age and current medical condition are not taken into account when setting the If Knew Premium rate. The If Knew Premium is an accepted methodology for setting premiums for long-term care insurance policies.

Policyholders whose current premium (including the premium they would be paying but for a premium waiver) falls below the If Knew Premium for the policy’s benefits will be required to elect one of four options:

Option 1: continue paying the current premium or maintain the premium waiver if one is in effect, but if the current or waived premium is less than the If Knew Premium, have the policy benefits reduced in accordance with Plan provisions so that the premium for the reduced benefits (including waived premium) is equal (on an If Knew Premium basis) to the current premium. The benefit reductions will be selected automatically by the Plan.

Option 2: select certain policy endorsements that provide essential benefits (sometimes greater than the benefits provided by Option 1) for an actuarially justified premium. The maximum benefit period is capped at four years, the maximum daily benefit is capped at \$300 and inflation protection is capped at 1.5%.

Option 2A: an enhanced alternative with a five-year benefit period and 2% inflation rider. Options 2 and 2A will not be subject to further rate increases or benefit reductions in Phase Two of the Plan. Options 2 and 2A are designed to provide reasonable coverage at reasonable premium rates.

Option 3: Non-forfeiture Option (NFO) through which the policyholder will receive a Reduced Paid-up (RPU) policy providing limited benefits but for which no future premiums will

be charged. Under the Plan, this option will include more generous benefits than the typical industry non-forfeiture option or reduced paid-up policy, most notably in that it will offer as much as a 30-month benefit period unless the current policy has a shorter benefit period. Moreover, policyholders who select this option will never have to pay additional premiums and this policy will never lapse.

Option 4: retain the current policy benefits and pay the corresponding If Knew Premium (unless equal to or lower than the policyholder's current premium). For many policyholders this may require a substantial increase in premium.

See Ex. RP-55 at 11-12. Policyholders who presently pay a premium at or above the If Knew Premium may elect Option 2 or Option 3 if preferable, given their present circumstances. Otherwise, these policyholders will not have their policies modified in any respect.

Before making an election, each policyholder will receive information detailing the premiums and benefits associated with each option. Special elections will apply to policyholders who are not currently paying premium due to a premium waiver provision in their or their spouses' policies. Most of these policyholders have a current premium (what they would be paying but for the waiver) that is lower than the If Knew Premium. These policyholders will be required to pay a differential premium, which represents the difference between (1) the premium they would be paying but for the premium waiver in effect (the current premium), and (2) the If Knew Premium appropriate for their policy coverages. Ex. RP-55 at 12. Should the premium waiver terminate, these policyholders will then be required to pay the full applicable If Knew Premium. Similar options will be offered to policyholders on claim.

For every policyholder there will be a default option that applies automatically if no election is made. For the policyholder whose current premium falls at or above the If Knew Premium, the default option leaves the policy unchanged. For the policyholder whose current premium falls below the If Knew Premium, the default option will be identified in the election materials. For policyholders on premium waiver, the default option will be Option 1 (the benefit downgrade). Where the nonforfeiture option would provide these policyholders better benefits than the downgrade, Option 3 will be the default option. For policyholders paying premium, Option 2 (basic policy endorsements) will be the default option.

In Phase Two of the Second Amended Plan, the results of Phase One will be evaluated to determine whether additional policy modifications may be necessary for certain policies that are still underpriced. It is expected that modifications in Phase Two will largely be based on achieving a self-sustaining premium for every policy. The goal of Phase Two will be to eliminate any Funding Gap not eliminated in Phase One. In Phase Three, the Rehabilitator will complete the run-off of SHIP's long-term care insurance business remaining in force.

The Second Amended Plan corrects the condition that caused SHIP's insolvency: the underpricing of policies. The Plan will address the Funding Gap by increasing premiums or modifying policy coverages. The Rehabilitator has concluded that a modification of coverages will do more to reduce the Funding Gap than premium increases. Further, many policyholders are paying for more coverage than they are likely to use.

The Rehabilitator designed the Plan around the core principle of policyholder choice. All policyholders will have at least one option for preserving

their current coverage (by paying an increased premium) and at least one option for preserving their current premium (by reducing policy benefits). The Plan's premium rate structure takes rate increase history and product differences into account, and it will develop premium rate increases based solely on the characteristics of each policy and not on the policyholder's state of residence or the state where the policy was issued.

The payment of commissions owed to agents under agreements made prior to the inception of rehabilitation proceedings will be suspended under the Second Amended Plan until policyholders' claims have been paid in full and adequate provision made for reasonably anticipated future claims. Accrual of commissions will also be suspended as of the effective date of the Plan, *i.e.*, the date the policyholder elections become effective. Claims for commissions owed to agents and brokers will be subordinated to policyholder claims. The Plan's treatment of agent and broker commissions reflects the Rehabilitator's belief that most policyholders do not maintain a close relationship with their agent after purchasing their policy. They typically contact SHIP or another trusted professional when they have questions about their policy.

D. Hearing on Second Amended Plan

At the hearing on the Second Amended Plan, the Rehabilitator offered testimony from the following witnesses: Special Deputy Rehabilitator Patrick Cantilo, who was admitted as an expert in insurer insolvency matters, specifically as to long-term care insurers; Marc Lambright, an actuarial consultant to the Rehabilitator, who testified as a fact witness; and Vincent Bodnar, an actuarial consultant to the Rehabilitator, who was admitted as an actuarial expert and as an expert on long-term care insurance, including product development and sales

practices, the rate setting and approval process for insurers, and the liquidation of financially troubled insurers.

i. Rehabilitator's Evidence

a. Patrick Cantilo

Special Deputy Rehabilitator Patrick Cantilo provided the history of the business of SHIP, summarized above, and his involvement in the rehabilitation since 2018.

He first discussed the effects of the COVID-19 pandemic on SHIP's business and financial condition. Cantilo testified that since the beginning of the pandemic in 2020, SHIP has experienced a moderate increase in mortality, *i.e.*, more of its insureds died than would normally be expected, which generated a moderate increase in policy lapses. There was a small increase in morbidity, *i.e.*, the expected incidence of disease. The pandemic adversely affected SHIP's expected yield on invested assets. Cantilo opined that the aggregate effects of the pandemic had a relatively moderate impact on SHIP's financial condition and are not material to the Second Amended Plan.

Cantilo focused his testimony on the approximately 39,000 long-term care policies of SHIP. Approximately 53% of SHIP's current policyholders are paying premium, generating \$58 million in revenue as of year-end 2020. The remaining 47% of policyholders are on claim, have previously selected a non-forfeiture option or are on premium waiver. *See* Ex. RP-56 at 14. Many policyholders have been paying less premium than is necessary to fund their coverages, and this premium deficiency has existed for years. SHIP policies that create the greatest liability have a 5% compounded inflation rider; unlimited lifetime benefits; and are non-tax qualified, meaning that they have lower benefit triggers

and shorter elimination periods. The effect of the inflation rider has been to increase the maximum daily benefit up to \$650, without regard to actual inflation levels or the actual cost of the policyholder's care. Cantilo testified that the inflation rider is a "big contributor" to SHIP's overall deficit. Notes of Testimony (N.T.), 5/17/2021, at 34.

Cantilo testified that the majority of policyholders pay an annual premium of less than \$2,500 per year. N.T., 5/17/2021, at 37-38. *See* Ex. RP-56 at 14. The group is 71% female, and the majority are in their 80s and 90s. Approximately 70% of the policies in force provide comprehensive coverage for both home health care and facility care in either an assisted living facility or nursing home. Inflation protection is a feature of 47% of these policies. The majority of policies, 54%, provide between one and four years of benefits; 27% provide lifetime benefits. Ex. RP-56 at 17.

Cantilo opined that SHIP's claims, when compared to premiums, do not present "a good picture." N.T., 5/17/2021, at 41. The number of policies in force has declined since SHIP began operating in 2009, and at present, the claim costs outpace the premium revenue. Of the total premium revenue that SHIP is expected to collect prior to the expiration of the policies in force, approximately \$7.4 billion, it has already collected \$7.1 billion. Stated otherwise, SHIP expects to collect only about \$300 million in additional premium. On the other hand, SHIP's expected claims during that same period total approximately \$11 billion; it has paid only \$7.7 billion so far. In short, SHIP can expect to pay another \$3 billion in claims but to collect only \$300 million in premium, unless its business is restructured in a rehabilitation.

Cantilo testified that SHIP is not atypical in the industry. Long-term care insurers collect more premium than needed in the early years of writing policies. They invest the excess, put it aside, and then tap into those invested assets to pay claims. When a company stops writing new business, as SHIP did 18 years ago, the premium curve begins to flatten and the claim curve begins to rise. Cantilo testified that the assets set aside for the purpose of paying claims did not earn the expected income that was needed to meet liabilities.

Cantilo discussed the reasons for SHIP's insolvency, beginning with the erroneous actuarial assumptions made when the policies were first issued. SHIP underestimated the number of people who would become ill and qualify for benefits. At the same time, SHIP overestimated how quickly people would recover and stop needing care, referred to in the industry as morbidity improvement. SHIP overstated mortality by assuming more people would die before submitting claims than actually did. Relatedly, SHIP overestimated the number of policies that would lapse by reason of death or non-payment of premium. Cantilo estimated that through 2040, when most of the block of business will have terminated, the aggregate effect of the erroneous actuarial assumptions approximately equals the total deficit of \$1.2 billion. *See* Ex. RP-56 at 29.

Another factor in SHIP's insolvency is its investment history. SHIP experienced lower market yields than it anticipated while it was selling and pricing its long-term care policies. To counter the effects of economic conditions, in 2009, SHIP invested in two programs, the Beechwood program and Roebbling Re. Instead, these programs produced investment losses between \$150 million and \$300 million (as reported in 2018).

Cantilo testified that a significant cause of SHIP's insolvency is its discriminatory premium rate structure. As SHIP management realized its premium rates were inadequate, it began seeking premium rate increases from state regulators across the country from 2009 to 2021. SHIP received wildly different rate approvals. *See* Ex. RP-56 at 45. Cantilo testified that from 2009 to 2019, SHIP lost \$312 million in cumulative premium due to rejected rate increase filings, or \$371 million using an assumed 3.5% interest rate of return on investments. N.T., 5/17/2021, at 63-64; Ex. RP-56 at 50-51. The different responses of state regulators to SHIP's requested rate increases have created a discriminatory rate structure, which has been the focus of criticism in the regulatory community. Policyholders whose state of issue has approved rate increases are effectively subsidizing policyholders whose state of issue has not approved rate increases. Similarly situated policyholders are paying vastly different premiums for the same coverage. Cantilo opined that this has created an unfortunate side effect: states inclined to approve actuarially justified rate increase requests become hesitant to do so because of the failure of other states to act in kind.

The Rehabilitator's team had to decide whether to pursue a rehabilitation or liquidation of SHIP. Cantilo testified that the team chose rehabilitation because SHIP is financially able to provide a reasonable package of coverages to the remaining 39,000 policyholders. The Rehabilitator also considered that, in a liquidation, guaranty association coverage will be triggered, resulting in taxpayers contributing hundreds of millions of dollars to pay claims of policyholders who have not paid an appropriate premium. Rather than shifting the burden of the inadequate premium to taxpayers, the team concluded that the better course was to right-size the existing policies to an actuarially justified premium. Acknowledging

that no rehabilitation plan will magically restore SHIP to solvency, Cantilo testified the Second Amended Plan will, at a minimum, substantially reduce the Funding Gap and correct SHIP's inequitable premium rate structure. He explained that the Plan must be implemented quickly because of the advanced age of the policyholders.

In preparing the Second Amended Plan, the Rehabilitator relied on the combined expertise of Cantilo; Vincent Bodnar and other actuarial analysts at Oliver Wyman; Robert Robinson, who was appointed Chief Rehabilitation Officer of SHIP and who served as Chief Rehabilitation Officer and Chief Liquidation Officer for Penn Treaty;⁵ Pennsylvania Insurance Department legal counsel and staff; and SHIP technical staff. The Rehabilitator also sought and considered the input of state insurance regulators, staff of the National Association of Insurance Commissioners, policyholders and other formal and informal commenters. The Rehabilitator's team prepared extensive analyses of SHIP's finances, its policyholders, the long-term care insurance market, and other matters relevant to SHIP's condition and prospects for rehabilitation. Key data and information have been made available to interested persons through a data site, which included actuarial files relating to assumptions and analyses, a seriatim actuarial file for every policy at issue, and tailored reports related to the Second Amended Plan.

Cantilo explained how the Second Amended Plan will operate. He described it as "completely scaleable," meaning that the elements of the Plan can

⁵ Penn Treaty Network America Insurance Company, a Pennsylvania insurer, and its subsidiary, American Network Insurance Company (collectively, Penn Treaty), provided long-term care insurance to over 126,000 policyholders in all 50 states and the District of Columbia. Penn Treaty became insolvent for many of the same reasons that SHIP is insolvent, *i.e.*, benefit-rich policies were underpriced at inception and the company's active live reserves became understated. Penn Treaty was placed into rehabilitation by the Pennsylvania Insurance Commissioner on January 6, 2009. Rehabilitation ultimately proved unsuccessful, and on March 1, 2017, this Court ordered the liquidation of Penn Treaty.

respond to changes in the amount of the Funding Gap as SHIP moves through Phase One and into Phase Two and Phase Three. N.T., 5/17/2021, at 97. In Phase One, the policyholder's options are based on the If Knew Premium, and in Phase Two the options will be developed to establish a self-sustaining premium structure.⁶ Cantilo testified that it was important to give each policyholder at least two options: (i) retain his current coverages by paying the actuarially justified premium (Option 4) or (ii) retain his current premium by adjusting coverages to match that premium (Option 1). Between those two options there is a non-forfeiture option (Option 3) that is more generous than a non-forfeiture option in liquidation and basic policy options (Options 2 and 2A), which provide a reasonable package of long-term care coverage at an affordable price.

Cantilo testified that the If Knew Premium was selected to establish the premium in Phase One because it is generally accepted by regulators across the country; it was the methodology used by guaranty associations to increase premium rates for policyholders in the Penn Treaty liquidation; it is an easy rate methodology to explain to policyholders; and it achieves the goal of putting policyholders on a level playing field when it is calculated on a seriatim basis.

Cantilo explained in detail each Phase One option in the Second Amended Plan. Option 1 is the downgrade option. It allows the policyholder to keep his current premium but reduces benefits until the premium is adequate, on an If Knew basis. The policyholder will not choose which benefits to downgrade, which was discovered to be too complicated in the Penn Treaty liquidation. The methodology for reducing benefits under Option 1 will proceed in the following

⁶ The scope of Phase Two can only be determined after the completion of Phase One and an assessment of the remaining Funding Gap. Cantilo anticipates that the Rehabilitator will return to the Court at that point in the rehabilitation process.

sequence: elimination of benefit restoration provisions; elimination of benefit extension provisions; adoption of tax-qualified benefit triggers; discontinuation of return of premium provisions; removal of inflation protection and locking of maximum daily benefit at current levels; conversion from indemnity to reimbursement of actual expenses up to the maximum daily benefit amount; reduction in the maximum daily benefit; extension of any elimination period to 90 days and applying it to each period of care; reduction in the policy's maximum benefit period; elimination of all premium waiver provisions; and conversion of the policy to a pool of money with a reduction of the maximum benefit period to the amount required to match the current premium. Ex. RP-55 at 45-46; Ex. RP-56 at 69. If the first revision is sufficient to match the policy's coverages to the existing premium, no further coverage modifications will be made.

Under Option 2, the policyholder selects basic policy coverages and a corresponding If Knew Premium. After extensive policyholder outreach, the Rehabilitator selected the key components of long-term care that most policyholders desire if they cannot afford the most expensive package of coverages. These include a maximum benefit period equal to the lesser of the current benefit period or four years; a maximum daily benefit equal to the lesser of 80% of the current daily benefit or \$300 for nursing facility care;⁷ and an annual inflation adjustment capped at 1.5%. Option 2A, which is an enhanced version of Option 2, provides a maximum benefit period of five years and an annual inflation adjustment of 2% for a higher premium. Policyholders who elect Option 2 or 2A will not be expected to participate in Phase Two of the Second Amended Plan.

⁷ The maximum daily benefit for facility care other than nursing home care is \$225. The maximum daily benefit for home health care is \$150.

Option 3 is the non-forfeiture option, which offers the policyholder a maximum benefit period of 2.5 years and a maximum daily benefit equal to the lesser of 80% of the current daily benefit or \$300 for nursing facility care.⁸ Cantilo contrasted Option 3 with the standard non-forfeiture option in the industry, which offers the policyholder the equivalent of accumulated premium less claims. Typically, this results in only several months of coverage, particularly where the policy is rich in benefits. By contrast, Option 3 provides a reasonable alternative to a “luxurious” policy. Policyholders who elect Option 3 will not be required to participate in Phase Two of the Plan.

Option 4 allows the policyholder to keep his current coverages by paying the If Knew Premium. Cantilo testified that this option is the least favored by the Rehabilitator because if the majority of policyholders choose this option the Funding Gap will only be reduced by half. N.T., 5/17/2021, at 191. This is because the If Knew Premium does not cover the prior years of premium inadequacy.

Cantilo explained that the options will vary depending on whether the policyholder is on claim or paying premium. A policyholder on premium waiver may choose to pay a differential premium, *i.e.*, the difference between the waived premium and the If Knew premium. The policyholder may choose not to pay the differential premium, but the benefits of his policy will be reduced in a commensurate amount. Cantilo testified that the rationale behind the differential premium is to apportion the burden of rehabilitation among all policyholders, not just the subset still paying premium. It would be unfair for the 13% of policyholders on premium waiver to be immunized from a premium adjustment at the expense of the other 87%.

⁸ The maximum daily benefit for facility care other than nursing home care is \$225. The maximum daily benefit for home health care is \$150.

Cantilo described the option election process, which will begin with the Rehabilitator sending every policyholder a packet of information containing three sections. The first section describes the policyholder's current policy, including the monthly premium, available benefits, maximum policy value and the applicable statutory guaranty association limit were SHIP to be liquidated. The second section provides information on each option and how it changes the key provisions of the policy, *e.g.*, duration of benefit period and maximum daily benefit amount. The amount of the maximum policy value not covered by the applicable guaranty association is also provided. The third section contains two key pieces of information: the policyholder's estimated annual premium should a liquidation be ordered and the policyholder's estimated self-sustaining premium in Phase Two of the rehabilitation. Cantilo explained that these two numbers will enable policyholders to better choose among the options, especially since Options 1 and 4 will subject them to Phase Two.

To create user-friendly policyholder election materials, the Rehabilitator has engaged consultants who specialize in preparing Medicare supplement materials. The election forms will use graphics and be intuitively easy to follow. The Rehabilitator also plans to post a video tutorial online to guide the policyholder through the election forms. Cantilo testified that the Rehabilitator's goal is 100% policyholder participation. If a policyholder whose current premium is below the If Knew Premium does not make an election by the deadline, there are default options. For policyholders on premium waiver, the default option is Option 1, the downgrade option, unless Option 3 will provide better coverage, in which case it will be the default. For policyholders paying premium, the default option is Option 2, the basic policy endorsements.

The Rehabilitator conducted considerable outreach about the rehabilitation of SHIP beginning in the early stages of the rehabilitation. The Rehabilitator participated in regular meetings of the National Association of Insurance Commissioners and organized numerous meetings and conference calls with state regulators. The goal was to design a rehabilitation plan to address all concerns, particularly those expressed about state-of-issue responsibility for premium rate review. The Rehabilitator set up a secure data site for interested persons that contains all of the exhibits to this proceeding, including the seriatim actuarial files for every policy. Individual reports were generated for each state explaining how resident policyholders of that state would fare under the plan.

To date, the Rehabilitator has received comments from approximately 100 policyholders. Cantilo testified that this was far fewer than the number of comments in Penn Treaty. As expected, most policyholder concerns related to reduction of benefits and rate increases. Cantilo was surprised how many policyholders were supportive of a rehabilitation and the plans submitted by the Rehabilitator.

The principal concerns raised by state insurance regulators related to the following areas: (1) treatment of reinsurance assumed; (2) setting of premium rates by the Rehabilitator and this Court rather than by state-of-issue regulators; (3) desirability of liquidation instead of rehabilitation; and (4) feasibility of the Second Amended Plan. Cantilo discussed each of these areas in turn.

On the first concern, Cantilo explained that SHIP's assumed reinsurance involved approximately 2,000 long-term care policies originally issued by American Health and Life, Primerica and TransAmerica, or the predecessors of those companies. SHIP's predecessors entered into agreements to reinsure 100% of

these policies and administer claims. In the case of TransAmerica, on December 29, 2020, this Court approved an agreement by which TransAmerica recaptured its policies from SHIP. Cantilo opined that the recapture was consistent with industry norms.

With regard to premium rates, Cantilo acknowledged the objections of the Intervening Regulators. They contend that the state where the policyholder resided when the policy was issued is solely responsible for the regulation of the policy's premium rate. Cantilo opined that this makes sense for solvent insurers, but when an insurer enters rehabilitation, the domiciliary state has sole responsibility for the insolvent insurer and the restructuring of its business. This responsibility includes the adjustment of premiums and policy coverages where necessary to correct the insurer's financial condition.

Cantilo testified that the Intervening Regulators' legal assertion that they have the right to review and approve premium rates for policies issued by SHIP in their states creates "some ironic consequences." N.T., 5/17/2021, at 157. For example, 34 policies issued in Maine, 84 policies issued in Massachusetts and 89 policies issued in Washington are held by policyholders who now reside in other states. Thus, the Intervening Regulators assert the right to set the rates for 207 policyholders who live outside of their states. Ex. RP-56 at 97. Further, 21 policyholders who reside in Maine, 83 policyholders who reside in Massachusetts and 87 policyholders who reside in Washington had their policies issued in other states. Under the Intervening Regulators' legal assertion, other state regulators would set the rates for 191 policyholders residing in the states represented by Intervening Regulators. *Id.* at 98. In short, their inflexible view of rate regulation results in approximately 400 policyholders residing in Maine, Massachusetts and

Washington having their rates set by states in which they do not reside. The better approach, in Cantilo's view, is for the domiciliary regulator of an insurer in rehabilitation to manage rate and contract modifications as part of a comprehensive rehabilitation plan.

Nevertheless, the Second Amended Plan contains an Issue State Rate Approval Option. As Cantilo explained, every state will be given the option of opting out of the rate approval section of the Second Amended Plan. If a state opts out, the Rehabilitator will file an application to increase premium rates for policies issued in that state to the If Knew Premium level. No rate increase will be sought for policies on premium waiver or which are already at or above the If Knew Premium. The Rehabilitator will file the application on a seriatim basis to eliminate subsidies and restore a level playing field. The regulator for the opt-out state will then render a decision on the application; if it is only partially approved, the Rehabilitator will downgrade the benefits for the affected policies.⁹ Cantilo testified that this is essential to eliminate the subsidies that exist between policyholders across states by virtue of uneven rate increase approvals over the years. Each opt-out state policyholder will still have four options, which are not exactly the same as those offered in the Second Amended Plan. They are: (1) pay the approved premium and have benefits reduced to match; (2) accept a downgrade of benefits to match the current premium; (3) accept an issue-state non-forfeiture option; or (4) keep the current benefits and pay the If Knew Premium. Cantilo pointed out that the non-forfeiture option available to opt-out policyholders will not be as generous as the enhanced non-forfeiture option in Option 3 of the Second Amended Plan. There will also be no "basic policy benefits" option, *i.e.*, Option 2 in the Plan.

⁹ If the state takes no action on the rate application within 60 days, it will be deemed denied.

Cantilo next addressed the Intervening Regulators’ argument that immediate liquidation of SHIP is preferable to rehabilitation. In this regard, the Intervening Regulators focus on the present value of future benefits less the present value of future premiums, also referred to as the “Carpenter value,” to support their view that policyholders would fare better in a liquidation. N.T., 5/17/2021, at 175.¹⁰ Cantilo criticized this measure because it does not give an accurate picture of a policyholder’s situation. He offered the example of an actual 92-year-old SHIP policyholder currently paying \$2,761 for a policy with unlimited benefits. Ex. RP-56 at 102. Using the Intervening Regulators’ preferred methodology, the “Carpenter value” of that policy is \$33,890, which is higher than the “Carpenter value” produced under any of the four Plan options. However, to receive this value of \$33,890, the policyholder would have to pay \$11,520 in annual premium. By contrast, this policyholder could choose Option 3, a paid-up policy with a slightly lower “Carpenter value” of \$33,550. With a paid-up policy, however, this policyholder would receive 2.5 years of coverage and never pay another premium. Cantilo offered other examples where Option 3 would be the best option for a policyholder, given the amount of premium the policyholder would be required to pay to the guaranty association in a liquidation. *See, e.g.*, Ex. RP-56 at 103. Cantilo opined that these are not exceptions; “[t]here are many cases where the raw projection of future benefits less future premium doesn’t really tell you what the real value of the policy is.” N.T., 5/17/2021, at 177.

Cantilo discussed several different ways to compare the value of the Plan options to what would be available in a liquidation. Using the Intervening

¹⁰ “Carpenter value” refers to the United States Supreme Court’s decision in *Neblett v. Carpenter*, 305 U.S. 297 (1938), which is often cited for the proposition that, in order for a rehabilitation plan to be constitutional, policyholders must fare as well in rehabilitation as they would in a liquidation.

Regulators' standard of present value of future benefits less present value of future premiums, 85% of policyholders will have at least one option as favorable as liquidation and 15% will not. Ex. RP-56 at 105. Using the present value of future benefits divided by annual premiums, those numbers are 79% and 21%. *Id.* at 106. Using the maximum policy value divided by annual premium, those numbers are 89% and 11%. *Id.* at 107. Using the maximum policy value less present value of future premiums, those numbers are 96% and 4%. *Id.* at 108. Finally, using the Rehabilitator's preferred standard of maximum policy value, also referred to as the "benefit account value" or "lifetime maximum benefit" in some policies, *id.* at 104, 100% of policyholders will have at least one option in the Plan that offers the same or a better value than in a liquidation. *Id.* at 109.

Cantilo acknowledged that these are actuarial techniques that rely on the exercise of professional judgment. He opined that the maximum policy value is what policyholders use when they purchase an insurance policy, *i.e.*, the maximum daily benefit and the maximum benefit period.

Cantilo offered additional reasons to explain why rehabilitation is preferable to liquidation. First and foremost is the value of policyholder choice. Second, the Second Amended Plan contains features that would not be available to policyholders in liquidation, such as an option to retain their current policy level of coverage, which may exceed the applicable guaranty association cap, by paying the If Knew Premium. Third, there is the enhanced non-forfeiture option that provides reasonable coverage for no additional premium. In a liquidation, the non-forfeiture option would be locked into the policy's present coverages and terms, which may result in a very short period of coverage. Fourth, the Plan reduces or eliminates the subsidies in the current rate structure, which cannot be done in a liquidation.

Finally, Cantilo testified about the likelihood of success of the Second Amended Plan. He opined that the Plan is designed to eliminate the Funding Gap over three phases. This is not likely to happen in Phase One, but Phase One will materially reduce the Funding Gap.

Cantilo offered an exhibit illustrating the amount of the Funding Gap reduction under 11 hypothetical policyholder election scenarios. In general, the more that policyholders elect to pay the If Knew Premium for their current benefits (Option 4), the worse the outcome for the Funding Gap. For example, in Scenario 1, where 7% elect Option 1, 8% elect Option 2 or 2A, 4% elect Option 3 and 81% elect Option 4, the Funding Gap is reduced by \$525 million. Ex. RP-56 at 113. At the other extreme, in Scenario 11, where a very small number of policyholders elect Option 4 and the rest split evenly among Options 1, 2, 2A and 3, the Funding Gap is completely eliminated. *Id.* This underscores how the policyholders will be the masters of the fate of SHIP. No matter how much of the Funding Gap is eliminated in Phase One, SHIP will be in better shape if it eventually has to be liquidated because the discriminatory subsidies in the premium rate structure will be eliminated, and the policies will be right-sized for the premium the policyholder is willing to pay.

On examination by the Intervening Health Insurers, Cantilo testified that the SHIP policies contain provisions that allow SHIP to modify the premium rate. Some policies provide that rate increases will require the approval of state regulators, while others specify that rate increases may be sought only where an increase is warranted given the claims experience of the cohort of policyholders covered by the same policy form. Cantilo stated that these provisions are standard in long-term care insurance policies. The Rehabilitator designed the If Knew

Premium methodology in the Second Amended Plan to be consistent with the standards for setting long-term care insurance premium rates, which are substantially the same in every state.

b. Marc Lambright

Marc Lambright, an accident and health insurance actuary with Oliver Wyman, testified for the Rehabilitator. Lambright testified that the Pennsylvania Insurance Department engaged Oliver Wyman in early 2017 to conduct a targeted examination of SHIP's reserves and the assumptions used by its actuarial firm, Milliman, to set the reserves. Following its examination, Oliver Wyman submitted a report making several observations: Milliman's cash flow testing assumptions were too optimistic; claim reserves for the preceding years were inadequate; and the Beechwood investment program was riskier than assumed in the 2016 cash flow test report. Ex. RP-56 at 53. Oliver Wyman made several recommendations for the ongoing financial monitoring of SHIP. They included using more recent experience to develop morbidity, lapse and termination assumptions. *Id.* Milliman largely rejected Oliver Wyman's recommendations.

In 2018, after SHIP was placed under the supervision of the Insurance Department, Cantilo asked SHIP to devise a corrective action plan.¹¹ Cantilo also asked Oliver Wyman to continue analyzing SHIP's financial condition. Lambright testified that much of 2018 was spent pressing SHIP to substantiate some of its actuarial assumptions. Lambright testified that the Beechwood investment losses (\$176 million) and the premium deficiency reserve booked in 2018 (\$347 million) had a significant impact on SHIP's financial picture. N.T., 5/18/2021, at 374. In

¹¹ Section 510(a) of Article V authorizes the Insurance Commissioner to "make and serve upon the insurer and any other persons involved, such orders ... as are reasonably necessary to correct, eliminate or remedy" the insurer's condition that required the supervision. 40 P.S. §221.10(a).

2019, Lambright assisted Vincent Bodnar as he built the corrective action plan that would become the rehabilitation plan.

c. Vincent Bodnar

Vincent Bodnar, an actuary at Oliver Wyman with a specialty in long-term care insurance, testified as an expert witness. Bodnar performed actuarial work for the Rehabilitator and was involved in developing the Second Amended Plan, including the Phase One options to be offered to the policyholders.

Bodnar described the seriatim model as the core of the Second Amended Plan. A seriatim model, which produces actuarial projections for each policy individually, has become the industry standard in the past five years. The input to the seriatim model consists of individual policyholder characteristics such as age, gender, issue age, benefit features of the policy, and the premium charged. Applied to the input file are actuarial assumptions, including morbidity and mortality rates, lapse rates, and exhaustion rates, which Oliver Wyman has developed using SHIP's historical experience. The seriatim model projects future premiums and future claims for each policy on a month-by-month basis. N.T., 5/18/2021, at 397.

Bodnar explained that the If Knew Premium methodology employed in Phase One determines the premium an insurer would charge had it known when the policy was issued what it knows today, *i.e.*, that it would experience lower returns on investments, lower mortality rates, lower lapse rates, and higher claim incidence rates. The If Knew Premium assumes a 60% lifetime loss ratio from inception of a policy, *i.e.*, the use of 60% of expected premium to pay benefits to policyholders. The other 40% of expected premium is used to pay salaries, administrative overhead, premium taxes, federal taxes and profit for the insurer. The goal of the lifetime loss ratio is to establish a premium level that is reasonable in relation to the benefits paid.

The 60% lifetime loss ratio is the benchmark required for a premium rate increase in most states. The If Knew Premium methodology employed in Phase One will be actuarially justified and will not recoup past underpricing losses, although several states allow such recoupment. In the Penn Treaty liquidation, guaranty associations sought premium rate increases from the states based on an If Knew Premium methodology similar to the one employed in Phase One.

Because the Second Amended Plan intends to set premium rates on a seriatim basis, each policyholder will receive an individual premium increase calculated on the benefit features of his policy and the policyholder's characteristics. The model does not consider individual claim experience but, rather, "all the various variants that make up a given assumption" for a risk class. N.T., 5/18/2021, at 412. By contrast, in a traditional rate application process, insurers request state approval of an aggregate premium rate increase, although their models might be developed on a seriatim basis.

Bodnar testified that it is common for an insurer to receive mixed responses to a premium rate increase request from state regulators because each state has its own approach to reviewing rates. Additionally, the rate review process typically takes between 90 days and 2 years. Protracted rate reviews with drastically different outcomes have resulted in some SHIP policyholders paying a premium rate that subsidizes the inadequate premium rates of other SHIP policyholders. The Second Amended Plan seeks to eliminate this inequitable discrimination in premium payments.

Based on his experience with insurance product development and consumer choices, Bodnar testified that, generally, policyholders look at maximum policy value, *i.e.*, the maximum daily benefits, elimination period and premium rate,

in choosing an insurance policy. Bodnar considered all these factors in developing the options in the Second Amended Plan. Option 1 allows policyholders to retain their current premium rates with reduced benefits. Options 2 and 2A provide policyholders with basic policy coverages at corresponding If Knew Premium rates. The basic policy retains the key components of long-term care insurance and reduces or eliminates some features, such as a 4.5% inflation rider, that are not so important to policyholders. The maximum daily benefit, although reduced, would continue to provide meaningful coverage to most policyholders. The policyholders who elect Option 2 or 2A would not be subject to a rate increase in Phase Two, which is an appealing feature. In the Penn Treaty liquidation, policyholders were offered a benefit reduction option similar, but not identical to, Options 1 and 2 or 2A, but Bodnar did not recall how that affected their premium level. N.T., 5/19/2021, at 517, 520. By contrast, the Second Amended Plan proposes to offer policyholders three options by which to reduce their coverages and save premiums.

Option 3 of the Second Amended Plan offers a non-forfeiture option, which allows policyholders to receive up to 2.5 years of coverage and stop paying any additional premium. This is more generous than the standard non-forfeiture option, which caps coverage to the amount of premiums the policyholder has paid from inception. Policyholders in the Penn Treaty liquidation who chose the standard non-forfeiture option received continued coverage for a shorter period of time, sometimes only months. *Id.* at 435.

Option 4 of the Second Amended Plan allows policyholders to keep their current policy benefits and pay the If Knew Premium rate to retain those benefits. The guaranty associations in the Penn Treaty liquidation did not offer an equivalent option to policyholders whose coverages exceeded the statutory limits.

Instead, they offered a rate increase option that retained the policy's coverages up to the statutory maximum amount allowed for each resident.

Bodnar explained how the different Phase One options relate to Phase Two of the Plan. Policyholders who elect Options 1 and 4 and have a policy providing coverage in excess of the guaranty association limits will be subject to a rate increase in Phase Two. Phase Two seeks to deploy a self-sustaining premium rate methodology, which will keep the lifetime loss ratio at 60% and thus be actuarially justified. Phase Two is not absolutely necessary under the Second Amended Plan because Phase One could close the Funding Gap, or the assumptions deployed in Phase One could play out differently than projected. Bodnar opined that any meaningful reduction in the Funding Gap during the rehabilitation would be a success.

Bodnar opined that a rehabilitation as proposed in the Second Amended Plan, as opposed to an immediate liquidation, presents policyholders with better options; sets the premium rates to equitable levels; and reduces SHIP's Funding Gap. There is no formulaic method to determine whether policyholders are better off in a rehabilitation or in a liquidation; the so-called "Carpenter test" is not an actuarial test. Policyholders who choose Option 4 will have a policy with a net present value greater than or equal to what they would have in liquidation because it will not be capped at the level set forth in the applicable guaranty association statute. However, Option 4 has the least effect on reducing the Funding Gap. N.T., 5/19/2021, at 512-513.

Bodnar opined that policyholders are likely to consider the maximum policy value/premiums analysis or the maximum policy value analysis in making determinations. The present value analysis, or "Carpenter test," is appropriate for

evaluating the impact of the Phase One options on SHIP's liabilities. However, he explained that policyholders do not use a present value analysis when they choose their long-term care insurance coverage. Nor would they rely solely on the present value analysis to select one of the options offered under the Second Amended Plan.

Upon approval of the Second Amended Plan, Bodnar and the actuarial team at Oliver Wyman will prepare an actuarial memorandum in support of the If Knew Premium rates, similar to what would be submitted to state regulators in a rate increase filing. In developing the Second Amended Plan, Oliver Wyman has prepared an actuarial report describing the If Knew Premium rating methodology and an assumption report, Ex. RP-16 and Ex. RP-17, and has gathered all the information needed for the actuarial memorandum. N.T., 5/19/2021, at 460.

ii. Intervening Regulators' Evidence

a. Frank Edwards

Frank Edwards, the vice president and chief life and health actuary of INS Consultants, testified as a fact witness on behalf of the Intervening Regulators. Edwards testified that under the Second Amended Plan, policyholders bear the responsibility for the \$1.2 billion Funding Gap through benefit reductions and premium increases. By contrast, in liquidation, policyholders would bear a burden of approximately \$397 million, and the guaranty associations would bear a burden of approximately \$837 million. This represents the difference between the net amount the guaranty associations would pay to policyholders and the distributions they would receive from the SHIP estate. Because a rehabilitation does not trigger the guaranty associations, these funds will not be available to benefit policyholders under the Second Amended Plan.

Edwards observed that among the four options in the Second Amended Plan for Phase One, Option 4 provides a net present value for approximately 83% of policyholders that is greater than they would receive in a liquidation. The other options provide policyholders with a net present value that is lower than they would receive in liquidation.

Oliver Wyman presented 10 scenarios to illustrate the potential results of the Second Amended Plan for SHIP's liabilities, each leaving a deficit that ranged from \$699 million to \$186 million. Ex. RP-16 at 11. Only Scenario 11, later added, eliminates the Funding Gap. Based on the information provided by Oliver Wyman, Edwards calculated a "Best Interest" scenario, which assumed that each policyholder will choose the option that provides the greatest net present value, or "Carpenter value." Ex. SIR 5-4. Option 4 would give 67.13% of the policyholders the greatest net present value and would reduce SHIP's Funding Gap by \$184 million. *Id.*

Edwards addressed a comparison of rehabilitation to liquidation under Phase Two. Edwards calculated the effects of hypothetical Phase Two premium increases on policyholders who selected Option 4 in Phase One. Assuming a premium increase of 50% in Phase Two, the percentage of policyholders receiving a net present value greater than in a liquidation under Option 4 drops to 33.89%. The percentage of policyholders in a rehabilitation, in the aggregate, that would receive a net present value greater than liquidation is 54.57%. Assuming a premium increase of 100% in Phase Two, the percentage of policyholders for whom Option 4 provides a net present value greater than in a liquidation drops to 22.92%. The percentage of all policyholders in a rehabilitation, in the aggregate, that would receive a net present value greater than in a liquidation is 47.21%. Even so, these

hypothetical premium increases of 50% and 100% would leave remaining a Funding Gap of approximately \$858 million and \$676 million, respectively. Ex. SIR 5-5.

Edwards observed that the information presented by Oliver Wyman indicated that the net present value of Option 2 for policies with benefits in excess of guaranty association limits is typically less than the net present value of the guaranty association limits. Ex. SIR 5-6.

Edwards did not evaluate Oliver Wyman's work. He compared the Second Amended Plan to liquidation using hypotheticals in which policyholders made elections based solely on maximizing the present value of future policy benefits minus the present value of future premiums, or the "Carpenter value."

iii. Intervenor NOLHGA's Evidence

a. Peter Gallanis

Peter Gallanis, the president of NOLHGA, testified as a fact witness. NOLHGA intervened in this proceeding to offer its suggestions on the Second Amended Plan; provide background information on the guaranty association system; and identify and request certain information material to its guaranty association members.

NOLHGA's members are life and health guaranty associations, one for each state and the District of Columbia, which are nonprofit entities created by state statutes to protect policyholders when a life or health insurance company is liquidated. In multi-state insurance insolvencies, the guaranty associations collaborate and coordinate through NOLHGA to fulfill their statutory obligations. NOLHGA has been involved in approximately 100 multi-state insurance receiverships, nine of which involved long-term care insurance. If SHIP goes into liquidation, most NOLHGA member guaranty associations would be activated to

provide coverage to SHIP policyholders, subject to the statutory limit on coverage in the member's state, which is generally \$300,000 per resident.

Gallanis testified that the Second Amended Plan should emphasize that the options that policyholders select in Phase One will be permanent. The Second Amended Plan's discussion of SHIP's unfunded liability needs clarification, or it should be eliminated. The subject need not be addressed until a liquidation may occur.

He testified that the Rehabilitator's sample Illustrative Policyholder Guidance Pages on guaranty association coverage and premium rates in liquidation could be misleading. In response, NOLHGA prepared a sample Summary of Policyholder Protection by Guaranty Associations in Liquidations that it believes should be sent to policyholders during Phase One. Ex. N-1. Gallanis believes NOLHGA should review all policyholder communications that refer to liquidation or guaranty associations and be allowed to comment on these communications before they are sent to policyholders.

Gallanis testified that NOLHGA wants more information on SHIP's reinsurance agreements with Transamerica, American Health and Life Insurance Company, and Primerica Life Insurance Company. NOLGHA also seeks more information on SHIP's in-force policies that are not long-term care policies.

Gallanis explained that members of a guaranty association are licensed life and health insurers. If SHIP is placed under an order of liquidation, the guaranty associations will provide resident policyholders with coverage up to the lesser of the maximum benefit level provided in the policy or the statutory limit for guaranty

association coverage, which is \$300,000 per resident in most states.¹² The guaranty associations may continue coverage under the policy; work with the receiver to transfer the business to a financially solvent insurer; or issue alternative policies. The guaranty associations may seek premium rate increases or offer policyholders modified benefits based on current premium rates, as was recently done in the Penn Treaty liquidation. The guaranty associations generally do not charge premiums to policyholders who have been on premium waiver. The options offered by the guaranty associations in the Penn Treaty liquidation are illustrative of what could be offered in a potential SHIP liquidation.

In a liquidation, the guaranty associations will assess their member insurers, using the methodology set forth in their governing statutes to determine each member insurer's assessment. The member insurers pay the assessments from their general accounts. In some states, the member insurers can offset a portion of the assessment against state premium taxes that the insurers would otherwise owe. Member insurers can also impose surcharges on their policyholders to fund assessments. The guaranty associations are not funded by state revenues.

Gallanis explained that NOLHGA does not endorse or oppose the Second Amended Plan. NOLHGA intends to monitor the rehabilitation if this Court approves the Second Amended Plan, so that the guaranty associations will be prepared if SHIP ultimately is liquidated.

b. Matthew Morton

Matthew Morton, an actuary with the Long Term Care Group and an advisor to NOLHGA, testified as a fact witness about guaranty association coverage

¹² The guaranty association limits range between \$100,000 in Puerto Rico, \$300,000 in 42 states and the District of Columbia, \$500,000 in 6 states, \$615,525 in California, and no limit in New Jersey.

and premium rate increases in liquidation. Morton assisted NOLHGA in several long-term care insurer insolvencies, including the Penn Treaty liquidation.

In a liquidation, a policyholder receives a continuation of coverage from a guaranty association. The policy's benefits are paid in full until the policyholder exhausts the maximum benefit amount or maximum coverage period set forth in the policy, or until the payments reach the statutory coverage limit. Many long-term care policyholders are not affected by the statutory coverage limit because: (1) the policy's maximum benefit amount is less than the statutory coverage limit; (2) the policyholder never goes on claim; or (3) the policyholder does not stay on claim long enough to reach the statutory coverage limit.

In the Penn Treaty liquidation, the guaranty associations implemented a nationwide rate increase program, which resulted in 34 states approving 100% of the requested rate increases; 11 states approving between 80% and 100% of the requested rate increases; and 3 states approving less than 60% of the requested rate increases. No state denied a rate increase request. The majority, 44 states, approved the initial rate increase filing within 15 months. The guaranty associations spent 6 to 12 months preparing and filing the rate increase applications.

The guaranty associations' methodology for calculating premium rate increases in the Penn Treaty liquidation was similar to the If Knew Premium methodology proposed in the Second Amended Plan, with two exceptions. First, the Second Amended Plan proposes to calculate rate increases seriatim, or individually, while Penn Treaty's rate increase applications were developed on a cohort basis, by which policyholders were grouped together by policy form. The cohort basis is the industry standard for an insurer that is a going concern. Second, the Second Amended Plan proposes to calculate rate increases based on the total maximum

value of the policy. In Penn Treaty's liquidation, the premium rates were calculated based on benefits being capped at the guaranty association statutory limits.

Morton testified that the premium rate increase methodology used by the guaranty associations in the Penn Treaty liquidation "largely" addressed the inequities in premium rates and the cross-state rate subsidization issue. N.T., 5/20/2021, at 806. When asked on cross-examination to expound on his understanding of "largely," Morton acknowledged that using a cohort method to adjust premium rates results in some policyholders paying more than the If Knew Premium. *Id.* at 817-18. If a seriatim method is used, all policyholders will pay the If Knew Premium and no more.

In the Penn Treaty liquidation, the default option for policyholders who failed to make elections was to accept the rate increase. Policyholders were offered policy modifications, including lowering daily benefits or the inflation rider; a reduced paid-up policy; or a cash-out option in exchange for termination of the policy. Only one state approved the cash-out option. Approximately 76% of the Penn Treaty policyholders accepted the rate increase, among which "a little bit less than a half" took the option by default; 13% of the policyholders reduced their benefits; 8% of the policyholders elected to cash out; and 3% of the policyholders elected a reduced paid-up policy. *Id.* at 812. The guaranty associations treated Penn Treaty policyholders on premium waiver the same before and after the liquidation by continuing the waiver.

iv. Intervening Agents and Brokers' Evidence

a. Daniel Schmedlen

Daniel Schmedlen, Chief Executive Officer of LTC Global, testified on behalf of the Intervening Agents and Brokers. These agents and brokers are all

employed by LTC Global and are paid commissions by SHIP. The commission is set forth in the agency agreement and based on a percentage of premium. The policyholder pays a premium to the insurer, which deducts a certain percentage of the premium and remits it to the agent as a commission. The agent is not obligated to contact the insured after issuance of the policy, although the agent might accept the initial premium payment on behalf of the insurer.

A sample agent agreement was introduced into evidence by the Rehabilitator. It provided that the agent and successors “shall have the vested right to receive all commissions payable under this [a]greement.” Ex. RP-10 at 3. Schmedlen understood this language as creating the agent’s vested property interest in that part of any premium collected by SHIP that it owed to the agent as a commission. LTC Global expects that its agents will continue to receive commissions during SHIP’s rehabilitation, as they did during Penn Treaty’s rehabilitation.

The insurer determines the amount of commission payable to the agents. Once a policy is issued and delivered, the agent is paid a commission in accordance with the commission schedule set forth in the agency agreement. The first-year commission is higher than the renewal commission, and the amount of renewal commission changes with time. The commission schedule in the sample agent agreement showed that the first-year commission ranged from 45% to 70% of the first-year premium, depending on the age of the policyholder. After 10 years, the commission is typically reduced to a percentage of premium in the “middle single digits.” N.T., 5/20/2021, at 850. If the insurer has to refund any portion of the premium to the insured, the agent returns his commission to the insurer in proportion

to the refunded premium. Where there is no premium paid, there is no commission owed to the agent.

v. Intervening Health Insurers' Evidence

Intervening Health Insurers introduced into evidence six sample insurance policies issued by SHIP's predecessors and assumed by SHIP. The policies provided that SHIP may increase premium rates over time without specifying the methodology to be used in calculating the rate increases. The policies are silent on agent and broker commissions.

vi. Intervening Policyholders' Evidence

a. James Lapinski

Intervenor James Lapinski, a policyholder of SHIP as well as a broker, testified on his own behalf. He expressed concern about the Second Amended Plan's discussion of the impact of the COVID-19 pandemic on the long-term care insurance industry. He requested that the Rehabilitator update the discussion with more recent data. Lapinski presented a three-page excerpt from the Society of Actuaries report, dated September 30, 2020, which indicated that COVID-19 has had an impact on emerging long-term care insurance experience through higher mortality and lower claim incidence. An excerpt of a newsletter produced by Fairfax County, Virginia, suggested that more than 80% of COVID-19 deaths have been adults over 65 years old. Further, 34% of COVID-19 deaths in the United States have been seniors living in long-term care facilities, which accounts for less than 1% of the U.S. population. Lapinski opined that a combination of a decline in claim utilization and increase in lapse or cancellation of policies suggests that SHIP has experienced a major decrease in claims experience due to the pandemic.

Lapinski presented a balance sheet of SHIP showing that the value of SHIP's bond holdings as of December 31, 2020, declined by approximately \$500 million from the previous year. SHIP's reported cash on hand and short-term investment income also declined from the previous year by approximately \$500,000. This does not correlate with the decrease in the value of the bonds. Lapinski questioned the changes in reserves shown in the balance sheet. Specifically, he requested the Rehabilitator to explain the decline in SHIP's capital and surplus from approximately \$12 million in 2017 to a deficit of \$916 million in 2019, as well as the decline in the number of policies in force from 151,000 in 2009 to approximately 39,000 as of the filing of the Second Amended Plan. Observing that the Second Amended Plan contains excerpts from SHIP's unfiled 2019 statutory financial statement and the internal 2020 financial information (*see* Appendix B of the Second Amended Plan), Lapinski requested that SHIP file its 2019 and 2020 statutory financial statements before this Court rules on the Second Amended Plan.

Lapinski and his wife pay annual premiums totaling \$9,000 for their three policies. Over the past 25 years, they have paid over \$200,000 in premiums. He estimated that skilled nursing facilities cost \$500 per day, which they cannot afford without insurance coverage. Lapinski raised concerns with the timing of the rehabilitation and stated his desire for SHIP to avoid the lengthy process that Penn Treaty had gone through prior to liquidation.

b. Rose Marie Knight

Rose Marie Knight, a policyholder, also testified. She agreed with Lapinski's testimony. She has been a policyholder for 22 years and currently pays an annual premium of \$1,200. She questioned why SHIP has not raised her premium for the last four or five years. Knight's policy has a lifetime benefit period. She will

have to pay a higher premium to retain this maximum coverage period under the Second Amended Plan. Knight expressed concern about her ability to pay a higher premium and becoming a burden on her children. N.T., 5/21/2021, at 935. She noted that the government has recently incurred great debts, which will cause inflation that “is starting to hit.” *Id.* at 933-34.

Both Lapinski and Knight expressed concern and confusion as to the Second Amended Plan’s proposed policy restructuring, which they interpreted as removing benefits or cancelling guaranty association coverage.

III. Standard of Review

Section 516(b) of Article V authorizes the Rehabilitator to “take such action as [she] deems necessary or expedient to correct the condition or conditions which constituted the grounds for the order of the court to rehabilitate the insurer. ... [She] shall have full power ... to deal with the property and business of the insurer.” 40 P.S. §221.16(b). The legislatively stated purpose of Article V, to which the Court must give effect, is “the protection of the interests of insureds, creditors, and the public generally....” and the “equitable apportionment of any unavoidable loss” through, *inter alia*, “improved methods for rehabilitating insurers....” *Grode v. Mutual Fire, Marine and Inland Insurance Co.*, 572 A.2d 798, 803 (Pa. Cmwlth. 1990) (*Mutual Fire I*) (single-judge opinion) (quoting Section 501 of Article V, 40 P.S. §221.1).

The Pennsylvania Supreme Court has explained this Court’s role in a rehabilitation as follows:

In overseeing the course of rehabilitation to check any abuse of discretion by the Commissioner, the Commonwealth Court is authorized to “approve or disapprove the plan [of rehabilitation] proposed, or may modify it and approve it as modified. If it is approved, the rehabilitator shall carry out the plan.” 40 P.S. §

221.16(d). Therefore, in order for the Plan to warrant the Commonwealth Court's imprimatur it must be found to be free from any abuse of the Rehabilitator's discretion.

Foster v. Mutual Fire, Marine and Inland Insurance Co., 614 A.2d 1086, 1091 (Pa. 1992) (“*Mutual Fire II*”). Further, “it is not the function of the courts to reassess the determinations of fact and public policy made by the Rehabilitator.” *Id.* Our Supreme Court has explained:

‘It has been established as an elementary principle of law that courts will not review the actions of governmental bodies or administrative tribunals involving acts of discretion *in the absence of bad faith, fraud, capricious action or abuse of power* That the court might have a different opinion or judgment in regard to the action of the agency is not a sufficient ground for interference; *judicial* discretion may not be substituted for *administrative* discretion.’

Id. at 1092 (quoting *Norfolk and Western Railway Co. v. Pennsylvania Public Utility Commission*, 413 A.2d 1037, 1047 (Pa. 1980) (emphasis in original)).

With the above principles in mind, the Court considers whether the Rehabilitator abused her discretion in formulating the Second Amended Plan. The Court is also mindful that “the Rehabilitator is constrained by constitutional mandate[s].” *Mutual Fire I*, 572 A.2d at 804.

IV. Legal Analysis

A. The Second Amended Plan Serves a Rehabilitative Purpose and is within the Discretion of the Rehabilitator

1. Goals of the Plan

There is no fixed goal that every rehabilitation plan must satisfy to obtain this Court's approval. Specifically, the Pennsylvania Supreme Court has stated that a

rehabilitation, in order to be legitimate, does not have to restore the company to its exact original condition. So long as the rehabilitation properly conserves and equitably administers “the assets of the involved corporation in the interest of investors, the public and others, (with) the main purpose being the public good” the plan of rehabilitation is appropriate.

Mutual Fire II, 614 A.2d at 1094 (quoting 2A COUCH ON INSURANCE 2d §22.10).

The unrefuted testimony of the Rehabilitator’s witnesses established two overarching goals of the Second Amended Plan: (i) to reduce or eliminate the Funding Gap and (ii) to eliminate SHIP’s inequitable and discriminatory premium rate structure, which is marked by cross-policyholder subsidies. The Plan will meet these goals by setting premium rates for all policyholders pursuant to an actuarially sound methodology, the If Knew Premium rate, which is widely accepted by regulators across the country, and by offering policyholders meaningful options. Instead of being forced to accept rate increases commensurate with their current coverages, policyholders will have the option to reduce coverages, thereby reducing their indicated premium increase.

In pursuing these goals, the Second Amended Plan addresses one of the major causes of SHIP’s financial distress: policy underpricing. The Plan will address underpricing by (i) resetting premiums, on a prospective basis, to what they would have been without the erroneous actuarial assumptions and (ii) doing so on a seriatim basis, thereby ensuring that the premiums going forward are consistent across the entire pool of policyholders so that similarly situated policyholders will not be paying different premiums. The Plan will give policyholders meaningful choices for coverage in lieu of rate increases, without placing the cost of SHIP’s historical policy underpricing upon the public through the guaranty association system. These goals serve the public good. See *Mutual Fire II*, 614 A.2d at 1094,

n.4 (determining that the state’s interest in “regulat[ing] the fiscal affairs of its insurers for the welfare of the public” is a legitimate and significant public purpose).

2. No Contrary Evidence

The Intervening Regulators, who object to the Second Amended Plan in its totality, did not introduce an expert witness to dispute any of the Rehabilitator’s actuarial projections, including the impact of the various options on policyholders and the Funding Gap, or the Plan’s proposed premium rate methodologies. The Intervening Regulators’ actuary, Frank Edwards, testified as a fact witness, and he acknowledged that he was not asked to evaluate the Rehabilitator’s work.

Edwards’ testimony consisted of “mathematical exercises,” N.T., 5/19/2021, at 564, that compared the Plan to a liquidation. He assumed that policyholders are “better off” with the “maximum present value” of their policies. *Id.* at 568. Known as the “Carpenter value,” maximum present value is future benefits minus future premiums, adjusted to their present value. Edwards acknowledged that he could not opine on policyholder preferences. Cantilo and Bodnar, both qualified experts, testified persuasively that policyholders do not make choices based on the maximum present value of their policies. Rather, policyholders will rely on other metrics, most notably the maximum policy value, such as maximum daily benefit and maximum benefit period, to make choices. Using those metrics provides a better outcome for policyholders than they would experience in liquidation.

B. The Goals of the Plan Could Not Be Achieved in Liquidation

The Rehabilitator’s evidence demonstrated that immediate liquidation of SHIP would be improvident for several reasons. First, a liquidation of SHIP will not address the Funding Gap. Second, a liquidation will not address the existing

inequitable premium rate structure and cross-policyholder subsidies. Instead, it will perpetuate those problems. Third, a liquidation of SHIP will unnecessarily delay any resolution of SHIP's financial condition. Fourth, the options available to policyholders under the Second Amended Plan are better than what would be offered by guaranty associations in a liquidation.

1. Liquidation Will Not Address the Funding Gap

As noted, the Funding Gap is largely attributable to significant historical underpricing of SHIP's policies. In a liquidation, the entire cost of this shortfall will be shifted to the guaranty association system and, ultimately, to the public. As NOLHGA's Peter Gallanis acknowledged, the guaranty associations will fund the cost of the underpricing by assessing their member companies, which, in turn, fund the assessments from their policyholder generated funds. These insurers will then recoup some portion of the loss through premium tax offsets or by raising rates they charge to their own policyholders. The Rehabilitator concluded that shifting the burden to taxpayers and policyholders of other life and health insurers will not serve the "public good." *Mutual Fire II*, 614 A.2d at 1094. That determination is within her discretion and is entitled to deference. *Id.* at 1091 ("[T]he involvement of the judicial process is limited to the safeguarding of the plan from any potential abuse of the Rehabilitator's discretion.").

2. Liquidation Will Perpetuate the Inequitable Premium Rate Structure

In a liquidation of SHIP, assuming the guaranty associations would seek rate increases as they did in the Penn Treaty liquidation, similarly situated policyholders will continue to pay different rates. NOLHGA's actuary, Matthew Morton, acknowledged that this is attributable to the guaranty associations' practice of seeking rate increases for cohorts of policyholders. Using a cohort method results

in some policyholders paying more than the If Knew Premium in liquidation. The Second Amended Plan will adjust premium rates on a seriatim basis, which eliminates the possibility of any policyholder paying more than the If Knew Premium.

Further, the guaranty associations must request rate increases from the state of issue, not the state where the policyholder resides. The experience from the Penn Treaty liquidation showed that states do not act uniformly. For example, Florida (one of Penn Treaty's largest states by premium) granted only 50% of the guaranty associations' requested, and actuarially justified, rate increases for policies written in that state. Florida similarly has refused to grant SHIP's requested rate increases, and there is no reason to believe the result would be any different in a liquidation. *See* Ex. RP-53 (showing that since 2009, SHIP has requested approximately \$62.6 million in premium rate increases from the Florida Insurance Department, but only \$7.6 million has been approved).

The Intervening Regulators' States of Maine, Massachusetts and Washington are illustrative of the problem. Since 2009, only Massachusetts has approved a significant percentage of the rate increases sought by SHIP. *See* Ex. RP-53 (showing a 90% approval ratio in Massachusetts but an 11% approval ratio in Maine and a 63% approval ratio in Washington). The Rehabilitator's evidence demonstrated that a liquidation will not alleviate SHIP's premium rate inequities and cross-policyholder subsidization issues.

3. Liquidation Involves Inherent Delays

At a minimum, a liquidation would cause a material delay in addressing the policy underpricing which lies at the root of SHIP's insolvency. NOLHGA's actuary testified that in the Penn Treaty liquidation it took six months to a year to

prepare and file the rate applications on behalf of the guaranty associations. It took an additional 15 months to receive decisions from most of the state insurance regulators, with the final state's approval taking more than 4 years. Bodnar testified that the rate approval process can take anywhere from 90 days to 2 years or more. Thus, at best, in a liquidation of SHIP it would take nearly two years to prepare, file and receive approvals on rate increase requests, and there would be no certainty that the rates would be approved at the requested actuarially justified level.

By contrast, the Second Amended Plan can be implemented quickly, thereby addressing the causes of SHIP's financial distress, preserving assets, and reserving flexibility for Phase Two and beyond. Cantilo testified that it would take approximately six months to prepare and transmit election packages to policyholders and gather any Issue State Opt-out elections. Upon implementation of the Plan, the Rehabilitator will know within approximately eight months how much of the Funding Gap will be eliminated. The outcome of Phase One will determine whether Phase Two will be necessary and, if so, its scope. While the self-sustaining premium methodology proposed for Phase Two is actuarially justified according to Bodnar's undisputed expert testimony, the Rehabilitator may consider alternatives as necessary depending on the outcome of Phase One. The Rehabilitator will also provide reports to the Court at the appropriate times with her recommendations regarding Phase Two. A liquidation does not offer this kind of flexibility. See *Mutual Fire I*, 572 A.2d at 803 (“[T]he benefits of rehabilitation – its flexibility and avoidance of inherent delays – are preferable to the static and cumbersome procedures of statutory liquidation.”).

4. Policyholders Will Have Fewer Choices in Liquidation

In a liquidation of SHIP, policyholders will not be offered the choices provided under the Second Amended Plan. NOLHGA's witnesses acknowledged that the benefit modification offers made by the guaranty associations in the Penn Treaty liquidation, which were the first of their kind in a long-term care insurance liquidation, do not match the options offered under the Plan. Specifically, there was no equivalent to the basic policy coverages provided in Option 2/2a. There was no enhanced non-forfeiture option similar to Option 3. There was no option similar to Option 4 that could provide coverage above the applicable guaranty association cap. The Plan provides greater flexibility for policyholders than they would have in liquidation by offering meaningful policy modification alternatives that will also alleviate the Funding Gap and inequitable rate structure.

C. The Plan Meets the Legal Standards for Confirmation

1. The Plan's Rate Approval Mechanism and Issue-State Rate Approval Alternative are Permissible Under Pennsylvania Law and the United States Constitution

The Intervening Regulators object to the Second Amended Plan for the stated reason that the Plan proposes to have premium rates set by the Rehabilitator and this Court rather than by state-of-issue regulators. Intervening Regulators' Memorandum of Law, 6/14/2021, at 41. The Intervening Regulators assert that the Rehabilitator's power under Article V to "direct and manage" the "property and business of the insurer," Section 516(b) of Article V, 40 P.S. §221.16(b), does not include authority to change "SHIP's policies and rates without required regulatory approvals." Intervening Regulators' Memorandum of Law at 44. They also assert that the Plan's deviation from the ordinary state-by-state rate review process violates

the Full Faith and Credit Clause of the United States Constitution¹³ and is inconsistent with the principle of comity. The Plan’s Issue State Rate Approval Option does not cure these infirmities because it is coercive and offers, at most, a “nominal deference” to the state of issue’s authority to regulate the premium rates for policies issued in that state. Intervening Regulators’ Memorandum of Law at 50, 52.

We begin with a review of Section 516 of Article V, which sets forth the powers and duties of the Rehabilitator. It states, in pertinent part, as follows:

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

* * *

(d) The rehabilitator may prepare a plan for the reorganization, consolidation, conversion, reinsurance, merger or other transformation of the insurer. Upon application of the rehabilitator for approval of the plan, and after such notice and hearing as the court may prescribe, the court may either approve or disapprove the plan proposed, or may modify it and approve

¹³ It states:

Full Faith and Credit shall be given in each State to the public Acts, Records, and judicial Proceedings of every other State. And the Congress may by general Laws prescribe the Manner in which such Acts, Records and Proceedings shall be proved, and the Effect thereof.

U.S. CONST. art. IV, §1. A statute is a “public Act” within the meaning of the Full Faith and Credit Clause. *Franchise Tax Board of California v. Hyatt*, 136 S.Ct. 1277, 1281 (2016) (*Hyatt II*) (citing *Carroll v. Lanza*, 349 U.S. 411, 412 (1955)).

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.

40 P.S. §221.16(b)(d) (emphasis added).

The Rehabilitator may “take such action as [she] deems necessary or expedient to correct the condition” that caused the need for rehabilitation, 40 P.S. §221.16(b), and in doing so, she may prepare a rehabilitation plan to “*impair the contractual rights of some policyholders* in order to minimize the potential harm to all of the affected parties.” *Consedine v. Penn Treaty Network American Insurance Co.*, 63 A.3d 368, 452 (Pa. Cmwlth. 2012) (*Penn Treaty*) (citing *Mutual Fire II*, 614 A.2d at 1094) (emphasis added). This authority includes a reduction of coverage to match the policyholder’s existing premium. It has long been understood that the legislature has vested the Rehabilitator with broad discretion in proposing a rehabilitation plan. *Mutual Fire I*, 572 A.2d at 804, *affirmed*, *Mutual Fire II*, 614 A.2d at 1086 (observing that the insurance commissioner, as statutory rehabilitator of an insurer, is given broader discretion to structure a rehabilitation plan than is given to a statutory liquidator).

In the *Mutual Fire* rehabilitation, the plan amended the policyholders’ contractual right to full payment on covered claims by reducing all claim payments by an equal percentage. Here, the Rehabilitator could have done something similar by reducing the coverage of each policy to match the premium being paid. This would equitably address the Funding Gap. However, this would not give

policyholders a choice. Further, policyholders whose premium is very inadequate might find themselves with a policy with very limited coverage.

Mutual Fire was a different receivership. There, the policies lapsed during the rehabilitation, and the sole object of the rehabilitation was to pay outstanding claims to the fullest extent possible. By contrast, here, the SHIP policies are still in force and will remain in force until SHIP emerges from rehabilitation. In this respect, SHIP's rehabilitation is more complex.

A core cause of SHIP's insolvency is policy underpricing, and the Rehabilitator proposes to "correct the condition" through a combination of benefit modifications and premium rate increases. Section 516(b) of Article V, 40 P.S. §221.16(b). Policyholders will be able to decide which of the four options offered under the Second Amended Plan best fits their individual circumstances. The Plan follows the principles of *Mutual Fire I* and *II* and extends them to a different context, as appropriate for a long-term care insurer. The Plan falls within the Rehabilitator's "broad powers ... to effectuate equitably the intent of the Rehabilitation statutes." *Mutual Fire II*, 614 A.2d at 1094. The Plan's mechanism for setting actuarially justified rates also falls within the Rehabilitator's broad powers, and they will be reviewed by the Court as part of the rehabilitation proceeding.

Arguably, the only contract "right" given up by the SHIP policyholder is the expectation that the state where the policy was issued will approve the premium rate for each of the four options in Phase One. No policyholder commented on this "right" to state-by-state rate regulation. Policyholder Rose Marie Knight expressed concern about the fact that her premium had not been increased for years. N.T., 5/21/2021, at 933.

The Intervening Regulators assert that the Plan’s rate approval provisions “override the insurance laws of other [s]tates” and, thus, violate the Full Faith and Credit Clause of the United States Constitution. Intervening Regulators’ Memorandum of Law at 38. Alternatively, the Intervening Regulators contend that this Court should refrain from approving the Plan under the principle of comity because the Plan’s “displacement of the rate setting authority of the individual [s]tates” is a “blatant intrusion” on the sovereignty of other states. Intervening Regulators’ Memorandum of Law at 49. The Court finds no merit to these arguments.

Article V empowers this Court to rehabilitate the business of “a domestic insurer or an alien insurer domiciled in this Commonwealth.” Section 515(a) of Article V, 40 P.S. §221.15(a). As a general rule, the insolvent insurer’s state of domicile “has an overriding interest in assuring that the rehabilitation, if possible, is effectuated.” *Matter of Mutual Benefit Life Insurance Co.*, 609 A.2d 768, 777 (N.J. Super. 1992). The court’s “decree approving the rehabilitation plan for an insolvent insurer domiciled in its state has a *res judicata* effect upon out-of-state policyholders so as to preclude a subsequent attack upon the plan in another state.” 1 COUCH ON INSURANCE 3d §5:31.

Maine, Massachusetts, and Washington have adopted, in substantial part, the Uniform Insurers Liquidation Act (UILA),¹⁴ which was approved by the National Conference of Commissioners on Uniform State Laws in 1939. The UILA addressed the difficulties that arise in the receivership of an insolvent insurer with assets and liabilities located in several states; the UILA provides a “uniform system

¹⁴ See 24-A Me. Stat. Ann. §4363; *In re Liquidation of American Mutual Liberty Insurance Company*, 747 N.E.2d 1215, 1225 n.13 (Mass. 2001); and *American Star Insurance Co. v. Grice*, 865 P.2d 507, 509 (Wash. 1994).

for the orderly and equitable administration of the assets and liabilities of defunct multistate insurers.” *Altman v. Kyler*, 221 A.3d 687, 692 n.6 (Pa. Cmwlth. 2019) (quotations omitted). Pennsylvania, on the other hand, adopted the Insurer’s Supervision, Rehabilitation and Liquidation Model Act (Model Act) approved by the National Association of Insurance Commissioners. *See Koken v. Reliance Insurance Co.*, 893 A.2d 70, 76 (Pa. 2006). Following the Model Act, Article V addresses “the problems of interstate rehabilitation and liquidation by facilitating cooperation between states in the liquidation process, and by extending the scope of personal jurisdiction over debtors of the insurer outside this Commonwealth.” Section 501(c) of Article V, 40 P.S. §221.1(c).

Because Maine, Massachusetts, and Washington have adopted the UILA and Pennsylvania has adopted the similar Model Act, a single, cohesive, uniform handling of SHIP’s rehabilitation through a single state is consistent with those laws. Notably, the laws of Maine, Massachusetts and Washington also designate the domiciliary insurance commissioner as the receiver of an insurer undergoing liquidation or rehabilitation.¹⁵ The Intervening Regulators have presented no reason to set aside Pennsylvania’s primacy in SHIP’s receivership.

Nor does the Full Faith and Credit Clause require this Court to apply the insurance rate regulatory laws of Maine, Massachusetts, and Washington with respect to the establishment of the If Knew Premium rate in the Second Amended Plan. The purpose of the full faith and credit command

was to alter the status of the several states as independent foreign sovereignties, each free to ignore obligations created under the laws or by the judicial proceedings of the others, and to make them integral parts of a single nation throughout which a remedy

¹⁵ See 24-A Me. Stat. Ann. §4364; Mass. Gen. Laws Ann. 175 §180B; Wash. Rev. Code §48.99.020.

upon a just obligation might be demanded as of right, irrespective of the state of its origin.

Baker by Thomas v. General Motors Corporation, 522 U.S. 222, 232 (1998) (citation omitted). Congress’ Full Faith and Credit Act¹⁶ requires that “all courts ... treat a state court judgment with the same respect that it would receive in the courts of the rendering state.” *Standard Chartered Bank v. Ahmad Hamad Al Gosaibi and Brothers Co.*, 99 A.3d 936, 941 (Pa. Super. 2014) (citing *Matsushita Electric Industrial Co. v. Epstein*, 516 U.S. 367, 373 (1996)).

The relevant precedent differentiates between the credit owed to *laws* and the credit owed to *judgments* under the Full Faith and Credit Clause. *Baker*, 522 U.S. at 232. The Full Faith and Credit Clause “does not compel a state to substitute the statutes of other states for its own statutes dealing with a subject matter [] which it is competent to legislate.” *Id.* (citation omitted). Instead, “it is frequently the case under the Full Faith and Credit Clause that a court can lawfully apply either the law of one State or the contrary law of another.” *Franchise Tax Board of California v. Hyatt*, 538 U.S. 488, 496 (2003) (*Hyatt I*). By contrast, “[a] final judgment in one State, if rendered by a court with adjudicatory authority over the subject matter and persons governed by the judgment, qualifies for recognition throughout the land.” *Baker*, 522 U.S. at 233. A court may be guided by the forum state’s public policy

¹⁶ It provides:

Such Acts, records and judicial proceedings or copies thereof, so authenticated, shall have the same full faith and credit in every court within the United States and its Territories and Possessions as they have by law or usage in the courts of such State, Territory or Possession from which they are taken.

28 U.S.C. §1738.

Likewise, the Pennsylvania legislature has enacted the Uniform Enforcement of Foreign Judgments Act, which defines “foreign judgment” as “any judgment, decree, or order of a court of the United States or of any other court requiring the payment of money which is entitled to full faith and credit in this Commonwealth.” 42 Pa. C.S. §4306.

in determining the law applicable to a controversy, but there is no “public policy exception” to the full faith and credit due a court’s judgment. *Id.* at 233.

At issue here is whether the Second Amended Plan, if approved by this Court, would give full faith and credit to the insurance laws of Maine, Massachusetts, and Washington. The Court concludes that it would.

In *Carroll v. Lanza*, 349 U.S. 411 (1955), the United States Supreme Court considered a negligence action brought by a Missouri worker against a general contractor in Arkansas, where he sustained injuries. Both Missouri and Arkansas had enacted a workers’ compensation law that provided the exclusive remedy of the employee for a work-related injury. The Arkansas law, however, also allowed the injured employee to pursue common-law tort claims against a third party. The Supreme Court held that the Full Faith and Credit Clause did not make Missouri’s statute a bar to enforcement of Arkansas’ law. Arkansas had sufficient grounds to apply its own law because of its interest in protecting persons injured within its borders and, thus, “opened its courts to negligence suits against prime contractors, refusing to make relief by way of workmen’s compensation the exclusive remedy.” *Id.* at 412-13. In sum, Missouri law (compared with Arkansas Law) embodied “a conflicting and opposed policy,” and Arkansas law did not embody “any policy of hostility to the public Acts of Missouri.” *Id.* at 413.

Likewise, in *Hyatt I*, 538 U.S. 488, a former California resident who had moved to Nevada brought tort actions in Nevada state court against the California franchise tax board, alleging negligent misrepresentation, invasion of privacy, fraud, and other torts in connection with the board’s assessments and penalties for taxes he allegedly owed. The Nevada Supreme Court applied Nevada law, which gave state agencies immunity for negligence but not for intentional torts.

Accordingly, the Nevada Supreme Court ordered the trial court to dismiss the negligence claim for lack of jurisdiction but allowed the intentional tort claims to proceed to trial. The tax board appealed.

The United States Supreme Court upheld the Nevada Supreme Court's decision. The Court emphasized that the Full Faith and Credit Clause does not require one state to apply another state's law that violates its "own legitimate public policy." *Id.* at 497 (internal quotations omitted). Nevada's choice of law in that case did not "exhibi[t] a policy of hostility to the public Acts of a sister State." *Id.* at 499 (citing *Carroll*, 349 U.S. at 413). Further, Nevada had "sensitively applied principles of comity with a healthy regard for California's sovereign status" by "relying on the contours of Nevada's own sovereign immunity from suit as a benchmark for its analysis." *Id.* at 499.

Following remand, a jury found in the taxpayer's favor and awarded him almost \$500 million in damages and fees. The tax board again appealed to the Nevada Supreme Court, arguing that the Full Faith and Credit Clause required Nevada to limit damages to \$50,000, the maximum that Nevada law would permit in a similar suit against its own agencies. The Nevada Supreme Court affirmed \$1 million of the award. Instead of applying the Nevada statute applicable to suits against Nevada's own agencies, the Nevada Supreme Court applied a special rule for one case. On further appeal, the United States Supreme Court held that this decision of the Nevada Supreme Court violated the Full Faith and Credit Clause because it lacked the "healthy regard for California's sovereign status" and "reflect[ed] a constitutionally impermissible policy of hostility to the public Acts of a sister State." *Franchise Tax Board of California v. Hyatt*, 136 S.Ct. 1277, 1282-83 (2016) (*Hyatt II*) (citation omitted).

In the case *sub judice*, the evidence demonstrated that the Rehabilitator will use the If Knew Premium methodology in the implementation of the Plan. This methodology will assume a 60% lifetime loss ratio, which is the benchmark for a premium rate increase in Pennsylvania and most other states. The If Knew Premium methodology is used by insurance regulators nationwide to set long-term care insurance premium rates. The self-sustaining premium to be implemented in Phase Two of the Plan will likewise use a 60% lifetime loss ratio. *See* 31 Pa. Code §89a.117 (“Benefits under long-term care insurance policies shall be deemed reasonable in relation to premiums provided the expected loss ratio is at least 60%[.]”).

A review of the insurance statutes of Maine, Massachusetts, and Washington shows that these sister states share Pennsylvania’s interest in ensuring that long-term care insurance premium rates are not excessive, unfairly discriminatory, or unreasonable in relation to the benefits provided under the policy.¹⁷ This commonly-shared interest will be advanced, rather than impaired, by the Second Amended Plan, which seeks to correct SHIP’s discriminatory premium rate structure; sets the premium rates to appropriate levels; and employs the If Knew

¹⁷ The Maine Insurance Code requires that the state insurance regulator determine that the rate filings on health insurance policies comply with “the requirements that rates not be excessive, inadequate or unfairly discriminatory.” 24-A Me. Stat. Ann. §2736. The insurance statute in Massachusetts provides that the insurance commissioner may “disapprove such form of policy if the benefits provided therein are unreasonable in relation to the premium charged, or if it contains any provision which is unjust, unfair, inequitable, misleading or deceptive, or which encourages misrepresentation as to such policy[.]” Mass. Gen. Laws Ann. Ch. 175 §108(8)(A). Likewise, the insurance statute in Washington provides that long-term care insurance rate increases are not permitted “if the benefits provided therein are unreasonable in relation to the premium charged.” Wash. Rev. Code §48.18.110. These standards are similar to the Pennsylvania standard for adjusting long-term care insurance premium rates. *See* Section 353 of The Insurance Company Law of 1921, Act of May 17, 1921, P.L. 682, *as amended, added by* the Act of June 23, 1931, P.L. 904, 40 P.S. §477a.

Premium methodology to establish a premium level that is reasonable in relation to the benefits paid.

Alternatively, under an Issue-State Rate Approval Option, a state may opt out of the rate approval section in the Plan. If a state opts out, the Rehabilitator will file an application to increase rates for policies issued in that state to the If Knew Premium level. The regulator for the opt-out state will render a decision on the Rehabilitator's rate increase application; if it is only partially approved, the Rehabilitator will downgrade the benefits under the affected policies accordingly. Cantilo testified that policyholders in an opt-out state will still have four options, although they are not exactly the same as those offered in the Second Amended Plan. This does not render the Issue-State Rate Approval Option "coercive" or "nominal," as the Intervening Regulators assert; rather, it provides the issue state with a meaningful way to control the mix of benefit reductions and premium rate increases. It prevents the opt-out state from interfering with Pennsylvania's ability to rehabilitate SHIP. In sum, the Second Amended Plan gives a "healthy regard" for the insurance laws of other states by "relying on the contours of [Pennsylvania insurance law] as a benchmark for its analysis." *Hyatt I*, 538 U.S. at 499.

The Second Amended Plan does not follow the ordinary rate review process for a solvent insurer, but it preserves the substantive rights of SHIP's policyholders to have their premium reviewed by a qualified actuary and an insurance regulator to ensure that the rate is actuarially justified and reasonable in relation to the benefits. The Plan changes the forum for the premium determinations to the state responsible for the rehabilitation of SHIP, *i.e.*, Pennsylvania. The conflict between Pennsylvania law and the laws of Maine, Massachusetts, and Washington, if any, is one of procedure, to which this Court owes no deference. *See*

Wilson v. Transport. Ins. Co., 889 A.2d 563, 571 (Pa. Super. 2005) (citation omitted) (the “choice of law” analysis applies only to conflicts of substantive law, which “creates the rights and duties of the parties to a judicial proceeding”).

The insistence of the Intervening Regulators that the Rehabilitator submit rate increase applications to 46 states, the District of Columbia, and the U.S. Virgin Islands renders a rehabilitation of SHIP an impossibility. Pennsylvania has a compelling interest in enforcing Article V, which protects “the interests of insureds, creditors, and the public generally” through

(i) early detection of any potentially dangerous condition in an insurer, and prompt application of appropriate corrective measures; (ii) improved methods for rehabilitating insurers, involving the cooperation and management expertise of the insurance industry; (iii) enhanced efficiency and economy of liquidation, through clarification and specification of the law, to minimize legal uncertainty and litigation; (iv) equitable apportionment of any unavoidable loss; (v) lessening the problems of interstate rehabilitation and liquidation by facilitating cooperation between states in the liquidation process, and by extending the scope of personal jurisdiction over debtors of the insurer outside this Commonwealth; and (vi) regulation of the insurance business by the impact of the law relating to delinquency procedures and substantive rules on the entire insurance business.

Section 501(c) of Article V, 40 P.S. §221.1(c) (emphasis added).¹⁸ Furthermore, as this Court observed in *Mutual Fire I*,

the benefits of rehabilitation—its flexibility and avoidance of inherent delays—are preferable to the static and cumbersome procedures of statutory liquidation. The statute’s purpose is, in the end, that to which we must give effect. That legislatively

¹⁸ Section 501(b) of Article V states that its provisions “shall be liberally construed to effect the purpose stated in subsection (c).” 40 P.S. §221.1(b).

stated purpose is “the protection of the interests of insureds, creditors, and the public generally....” and the “equitable apportionment of any unavoidable loss” through, *inter alia*, “improved methods for rehabilitating insurers....” Section 501 of the Act, 40 P.S. §221.1. No interest is served by adding to the delay which has already occurred in this case. On the contrary, the goals of Article V of the Act are better served by a rehabilitation which effectively ensures more distribution in a shorter period of time than would occur in liquidation.

572 A.2d at 803.

Here, the evidence established that the ordinary rate filing process often involves 6 to 12 months of preparation and years of review in some states. “No interest is served by adding to the delay which has already occurred in this case.” *Mutual Fire I*, 572 A.2d at 803. Further, a state-by-state rate filing process would not address the inconsistent rate approvals from state insurance regulators, which leave SHIP with less revenue than needed and similarly situated policyholders paying vastly different premiums for the same coverage. Cantilo credibly testified that the Plan’s premium rate methodologies and approval mechanisms are necessary to address the inequities in SHIP’s current rate structure. The use of the If Knew Premium across all policies will put all policyholders on a level playing field because it is calculated on a seriatim basis.

In sum, under Article V, the Rehabilitator has the authority to propose, and this Court has the authority to approve, the Second Amended Plan’s provisions regarding the establishment of premium rates for the four policyholder options in Phase One. The Full Faith and Credit Clause does not require the Rehabilitator to submit these premium rates to 46 states, the District of Columbia, and the U.S. Virgin Islands for their review and approval. This would fracture Pennsylvania’s “own legitimate public policy” in the rehabilitation of SHIP, a Pennsylvania-

domiciled insurer. *Hyatt I*, 538 U.S. at 497. In no way does this aspect of the Second Amended Plan reflect “a policy of hostility to the public Acts of a sister State.” *Id.* at 499. To the contrary, the interests of Maine, Massachusetts, and Washington in ensuring that long-term care insurance premium rates are not excessive, unfairly discriminatory, or unreasonable to the benefits provided will be advanced, rather than impaired, by the Plan.

Finally, the Court rejects the Intervening Regulators’ arguments on comity. Application of comity is “a matter of judicial discretion,” and Pennsylvania courts exercise comity “when application of another state’s law contradicts no public policy of Pennsylvania and instead furthers a Pennsylvania policy.” *Chestnut v. Pediatric Homecare of America, Inc.*, 617 A.2d 347, 350 (Pa. Super. 1992). The Plan has “sensitively applied principles of comity with a healthy regard” for the insurance laws of other states by “relying on the contours of [Pennsylvania insurance law] as a benchmark for its analysis.” *Hyatt I*, 538 U.S. at 499.

Once this Court renders a judgment on the Second Amended Plan, it is Maine, Massachusetts, and Washington that owe this Court’s judgment full faith and credit. *See Underwriters National Assurance Co. v. North Carolina Life and Accident and Health Insurance Guaranty Association*, 455 U.S. 691 (1982). *See also* 1 COUCH ON INSURANCE 3d §5:31 (discussing state court’s violation of Full Faith and Credit Clause by refusing to treat prior judgment of another state’s insurance rehabilitation court as *res judicata*).

2. The Plan Satisfies all Constitutional Requirements

The Intervening State Insurance Regulators argue that the Second Amended Plan is unconstitutional because it does not satisfy the standard that “[c]reditors and policyholders must fare at least as well under a rehabilitation plan

as they would under a liquidation.” *Koken v. Fidelity Mutual Life Insurance Co.*, 803 A.2d 807, 826 (Pa. Cmwlth. 2002) (citing *Neblett v. Carpenter*, 305 U.S. 297 (1938)). In applying the *Carpenter* standard, this Court is guided by the three-part test adopted in *Mutual Fire II*.¹⁹ The “threshold inquiry” is whether the state action “has operated to substantially impair a contractual relationship” in violation of Article I, Section 10 of the United States Constitution and Article I, Section 17 of the Pennsylvania Constitution.²⁰ *Mutual Fire II*, 614 A.2d at 1094 n.4. An impairment of contractual rights is not a *per se* violation of law. *Id.* If a particular policyholder is found to be worse off under a rehabilitation plan, the impairment could be considered “substantial,” but the Court still needs to determine whether (1) the rehabilitator has acted for a legitimate and significant public purpose and (2) the adjustment of contractual rights is reasonable and of a nature appropriate to that public purpose. *Id.* To that end, the Court must be mindful that Article V is intended to protect “the interests of insureds, creditors, and the public generally[.]” Section 501(c) of Article V, 40 P.S. §221.1(c).

i. The Plan Satisfies Pennsylvania’s Interpretation of *Carpenter*

Under the so-called “*Carpenter* test,” a rehabilitation plan should be confirmed if creditors will fare at least as well under the plan as they would in liquidation. *Mutual Fire II*, 614 A.2d at 1093-94. As our Supreme Court has

¹⁹ Several of the objectors to the Mutual Fire rehabilitation plan argued that the plan impaired their contractual rights. In analyzing their argument, our Supreme Court expressly adopted the three-part test announced by the United States Supreme Court in *Energy Reserves Group, Inc. v. Kansas Power and Light Co.*, 459 U.S. 400, 411 (1983), for determining when a state law may impair a contractual right. *Mutual Fire II*, 614 A.2d at 1094 n.4. Thus, whether an alleged contractual impairment is caused by a receiver’s workout plan or a statute, the analysis is the same.

²⁰ Article I, Section 10 of the United States Constitution states, in pertinent part: “No State shall ... pass any ... Law impairing the Obligation of Contracts[.]” U.S. CONST. art. 1, §10. Article I, Section 17 of the Pennsylvania Constitution states: “No ... law impairing the obligation of contracts ... shall be passed.” PA. CONST. art. I, §17.

explained, this does not mean that every single policyholder must satisfy that test. *See id.* at 1102 (“individual interests might have to be sacrificed or compromised in order to preserve the ultimate goal of [the rehabilitation] process[.]”); *see also Penn Treaty*, 63 A.3d at 453 (“[*Carpenter*] did not establish the broad principle that a rehabilitation plan is *per se* invalid unless every policyholder will fare as well in rehabilitation as in liquidation.”). Instead, the Court is guided by the three-part test established by *Mutual Fire II. Penn Treaty*, 63 A.3d at 453.

Under that test, if a particular policyholder is found to be worse off under a rehabilitation plan than in liquidation, and that impairment is “substantial,” the Court should confirm the plan so long as the Rehabilitator has acted for a legitimate and significant public purpose and the contractual modification is reasonable and appropriate to that public purpose. *Id.* In this regard, “[t]he Court must consider the greater good, including the consequences to the larger class of policyholders and the taxpaying public.” *Id.* (citing *Vickodil v. Insurance Department*, 559 A.2d 1010, 1013 (Pa. Cmwlth. 1989)).

The Second Amended Plan meets that test. Even assuming, *arguendo*, that the Plan substantially impairs policies, it serves a legitimate and significant public purpose, and the policy modifications are reasonable and appropriate to that purpose. At the hearing, Special Deputy Rehabilitator Cantilo aptly observed:

And the question that we were debating [was], is it reasonable, if a policyholder has been paying a quarter for a dollar’s worth of insurance for decades, to adopt, as the workout plan, a plan in which the taxpayers step up to pay their remaining 75 cents.

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

N.T., 5/17/2021, at 78-79. In short, the Plan narrows the Funding Gap, promotes fairness and equity among policyholders, and appropriately balances the interests of the policyholders and the broader taxpaying public.

ii. The Intervening Regulators' Interpretation of *Carpenter* is Flawed

The Intervening Regulators urge a rigid application of *Carpenter*, i.e., that all policyholders must fare as well in rehabilitation as they would in liquidation. To that end, the Intervening Regulators compared the net present value of the benefits policyholders will receive under the Second Amended Plan with the net present value of the benefits they can expect to receive in a liquidation. Notably, the Court in *Carpenter* was comparing the cash payment to policyholders under a rehabilitation plan with the cash payment they would receive in a liquidation, at a time when there was no guaranty association protection for policyholders.²¹ Here, the alternatives are not cash payments but continued insurance coverage. The value comparison of coverage to SHIP policyholders in a rehabilitation as compared to a liquidation cannot be reduced to dollar amounts.

The Intervening Regulators' metric is one not actually used by policyholders when making the decision to purchase long-term care insurance. As testimony from Cantilo and Bodnar established, consumers choose their policy benefits and limits according to their personal circumstances. For example, a

²¹ The judicially created requirement that a rehabilitation must treat policyholders better than would a liquidation pre-dates the creation of guaranty associations. Arguably, guaranty association protection should not be part of that analysis because the associations exist as a matter of legislative grace. Legislatures can repeal the guaranty association statutes or reduce the benefit caps. As it is, there is commonality but not uniformity. In any event, the existence of guaranty association protection was part of the Rehabilitator's analysis and, practically speaking, that protection cannot be ignored. Nor can its cost to other stakeholders, i.e., policyholders of the guaranty associations' member insurers and taxpayers.

policyholder may wish to protect his estate against dissipation by an extended stay in a nursing home. Each policyholder will have different goals and different financial situations that will affect the type and amount of coverage they purchase. Not a single witness testified that the liquidation value of a policy figures into this analysis. Cantilo and Bodnar opined that the comparison methodology policyholders use is the maximum policy value, not the *Carpenter* value. Cantilo provided compelling examples of actual SHIP policyholders whose *Carpenter* value, using the Intervening Regulators’ proposed net present value metric, would, in fact, produce a poor option for that policyholder. See Ex. RP-56 at 102-03. The Court credits Cantilo’s statement that “[t]here are many cases where the raw projection of future benefits less future premiums [doesn’t] really tell you what the real value of the policy is.” N.T., 5/17/2021, at 177.

In any event, even under the Intervening Regulators’ metric, 85% of SHIP policyholders will be offered one option with a value equal to or higher than the value of the policy they will have in liquidation. Several other metrics produced even higher percentages of policyholders who will fare at least as well under the Plan as in liquidation.

3. The Plan is Feasible to the Extent Required by Pennsylvania Law

The Intervening Regulators argue that the Second Amended Plan is not feasible because it is unlikely to eliminate the Funding Gap and restore SHIP to solvency. To begin, there is no statutory requirement in Pennsylvania that a rehabilitation plan must be “feasible” in order to be approved, nor has that standard been adopted in our decisional law. The only reference to feasibility anywhere in Pennsylvania law occurred in the Mutual Fire receivership during the implementation of an already approved rehabilitation plan. *Mutual Fire II*, 614 A.2d

1086. The Intervening Regulators have not cited any other case in which “feasibility” appears. Notably, in *Mutual Fire*, the rehabilitator raised “feasibility” to support a request to modify the Court-approved rehabilitation plan. *Id.* at 1090. The Intervening Regulators’ attempt to read a non-existent pre-approval “feasibility” requirement into Article V has no support in *Mutual Fire II*.

The Intervening Regulators argue that a “feasible” rehabilitation plan must be “reasonably likely to succeed in restoring the company to solvency” in order to be approved. Intervening Regulators’ Post-Hearing Memorandum at 5.

First, the Court notes that the meaning of “company solvency” is context specific. The peak of SHIP’s activity in the insurance marketplace was in the late 1990s, when it had more than 300,000 policies in force. N.T., 5/17/2021, at 40; Ex. RP-56 at 18. By 2003, when SHIP discontinued writing new business and went into run-off, the number of policies in force was already in a steep decline. *Id.* The Second Amended Plan, if successful, will restore SHIP to what it was pre-receivership, *i.e.*, an insurer winding down its long-term care insurance business and able, as a going concern, to continue coverage and pay the claims of its existing policies. The Court rejects the Intervening Regulators’ suggestion that a return to solvency by SHIP requires more than a return to its pre-receivership status. SHIP had long ceased being an active and growing presence in the insurance marketplace.

Second, the Pennsylvania Supreme Court has stated that “[s]o long as the rehabilitation properly conserves and equitably administers ‘the assets of the involved [insurer] in the interest of investors, the public and others, (with) the main purpose being the public good’ the plan ... is appropriate.” *Mutual Fire II*, 614 A.2d at 1094 (quoting 2A COUCH ON INSURANCE 2d §22.10). Simply, the Court rejected

the notion that a rehabilitation plan must contemplate a resuscitation of the insolvent insurer's operations.

Under any outcome, the Second Amended Plan will materially reduce the Funding Gap and significantly improve SHIP's financial condition. The Intervening Regulators offered no substantive evidence to overcome the Rehabilitator's evidence on this issue. The Intervening Regulators correctly point out that the ultimate goal of the Mutual Fire rehabilitation plan was to restore the company to solvency. The Second Amended Plan has, as its ultimate goal, SHIP's return to solvency. It "does not have to restore the company to its exact original condition." *Mutual Fire II*, 614 A.2d at 1094.

Further, as a matter of public policy the rehabilitation of an insurer, where possible, is the preferred course. *Penn Treaty*, 63 A.3d at 440 (recognizing liquidation as a remedy of last resort); *Koken v. Legion Insurance Co.*, 831 A.2d 1196, 1230 (Pa. Cmwlth. 2003) (same); and *Mutual Fire II*, 614 A.2d at 1094 (same). As this Court explained, "a liquidation, no matter how 'successful,' is certain to cause harm to the policyholders, creditors and taxpaying public[.]" *Penn Treaty*, 63 A.3d at 461.

In summary, Article V does not require the Second Amended Plan be "feasible" in order to be approved, and the Intervening Regulators' arguments to the contrary simply voice a disagreement with the Rehabilitator's exercise of discretion. The Plan will eliminate or reduce the Funding Gap, which is a legitimate purpose. The ultimate goal of the Second Amended Plan is to return SHIP to the level of solvency needed to run-off its long-term care insurance business.

4. The Plan is Fair and Equitable

As stated, SHIP's current premium rate structure is unfairly discriminatory because policyholders with substantially similar coverage are not paying the same premium, thereby burdening some policyholders with subsidizing the premium payments of other policyholders. This Court has recognized that eliminating these unfair "subsidies between policyholders in different states and between different groups of policyholders" is itself a legitimate goal of rehabilitation. *Penn Treaty*, 63 A.3d at 443, 460.

The Intervening Regulators argue that unless the Plan maintains SHIP's current unequal treatment of policyholders on a state-by-state basis, then the Plan is unlawful. The Intervening Regulators' position fails for several reasons.

First, the Intervening Regulators lack standing to assert the claim that the Plan treats "policyholders in different States differently." Intervening Regulators' Post-Hearing Memorandum at 32. They expressly disavowed that they were appearing in a *parens patriae* or other representative capacity for policyholders in their states. N.T., 5/19/2021, at 541-47. Even so, the Intervening Regulators failed to present any evidence showing how policyholders in their respective states would be unfairly treated by the Plan's proposal to eliminate unfair subsidies between groups of policyholders.

Second, the Plan will end the existing unequal treatment of similarly situated policyholders. The Intervening Regulators strain to characterize some policyholders as receiving "more" by "suffering smaller benefit cuts" when compared to other policyholders receiving "less" by "suffering greater benefit cuts." Intervening Regulators' Post-Hearing Memorandum at 38. This is a function of the fact that many policyholders presently pay an inadequate premium. The Court

rejects the Intervening Regulators' characterization of right sizing premium to policy coverage as itself an act of unequal treatment.

To eliminate the unfair subsidies between policyholders, the change in rates or coverages will have a greater impact on the more underpriced (and over-subsidized) policies that have benefited at the expense of other policyholders. The Plan will require similarly situated policyholders to pay the same premium for the same coverage. The Plan's elimination of unfair subsidies between policyholders aligns with this Court's precedent in the Penn Treaty receivership, which recognized that a rehabilitation plan may properly eliminate such subsidies. *Penn Treaty*, 63 A.3d at 443, 460.

Third, the Intervening Regulators improperly invoke Section 544(b) of Article V, 40 P.S. §221.44(b), which states that no subclasses may be created within the policyholder class in a liquidation. As a threshold matter, this is a rehabilitation, not a liquidation. More fundamentally, the Plan does not give "some policyholders greater consideration than others." Intervening Regulators' Post-Hearing Memorandum at 35. To the contrary, the Second Amended Plan treats similarly situated policyholders the same regardless of the state in which their policy was issued.

D. Other Concerns and Objections Raised at the Hearing are Overruled or Have Been Adequately Addressed

1. Intervening Regulators' Application for Reconsideration

At the close of the hearing on May 21, 2021, this Court granted the Rehabilitator's oral motion "for judgment in the nature of a directed verdict" against the Intervening Regulators regarding the Issue State Rate Approval Option in the Second Amended Plan. N.T., 5/21/2021, at 981. The Rehabilitator argued that the Intervening Regulators did not present any evidence that their interests would be

harm by the Issue State Rate Approval Option, and as such, their objection to the Issue State Rate Approval Option cannot serve as a basis for this Court to disapprove the Plan. *Id.* at 986-88.

On June 1, 2021, the Intervening Regulators filed an application for reconsideration for the stated reason that the Rehabilitator’s motion was vague, was made without notice and lacked support in the applicable court rules. More specifically, the Intervening Regulators contend that the term “[I]ssue [S]tate [R]ate [A]pproval [O]ption” is not “meaningful,” as “it is impossible to tell” whether it was referring to the “opt-out” provision under the Second Amended Plan. Application for Reconsideration at 7. They also contend that a motion for a directed verdict can be filed only in a “jury case” or an “adversarial proceeding,” which is not the case here. *Id.* at 8, 12. Even so, to grant a motion for a directed verdict requires this Court to consider “all of the evidence before it in the light most favorable to the [Intervening] Regulators.” *Id.* at 14. They assert that the Rehabilitator’s motion “[f]ails on the [r]ecord” because Cantilo and Bodnar testified that the Plan seeks to “supersede the existing state rate approval system,” which would impact state regulators and policyholders. *Id.* at 14-15. The Intervening Regulators’ arguments are not persuasive.

To begin, the Rehabilitator’s motion for a directed verdict was not vague. In moving for a directed verdict, the Rehabilitator’s counsel stated that “the [Intervening Regulators] have failed to put on any evidence which would or could support an interest they purport to represent with respect to the issue[] state rate approval option.” N.T., 5/21/2021, at 981-82. Counsel went on to assert that “absent any testimony as to the ways in which a regulator is constrained or harmed by that option, the [Intervening Regulators] here have no argument to present which would

show that [the option] does not sufficiently address the concerns that they have raised at some earlier stage in these proceedings.” *Id.* at 986. The Intervening Regulators objected to the motion for the reason that granting a directed verdict would be improper under the circumstances as the case presents “significant open legal issues.” *Id.* at 989. The Rehabilitator’s counsel responded:

To be clear, we’re only seeking the directed verdict on the [I]ssue [S]tate [R]ate [A]pproval [O]ption issue. I don’t have here where it was raised in the memorandum. We’re not seeking a directed verdict as to, generally, the questions of whether the [P]lan is fair and equitable or the exercise of the [R]ehabilitator’s discretion generally. This is a narrow motion, Your Honor, on the [I]ssue [S]tate [R]ate [A]pproval [O]ption and the opt-out offer thereunder[.]

Id. at 991.

After hearing arguments from both parties, the Court granted the motion. It stated that “there is an opt-out option that preserves the right of the [] ... state of issue to pursue a state rate approval powers and [Intervening Regulators’] witness did not address why the [P]lan was deficient ... in that way.” *Id.* at 994. In short, the motion was not vague.

This Court also rejects the Intervening Regulators’ argument that the Rehabilitator’s motion for a directed verdict lacked due notice. The Intervening Regulators do not cite, and this Court did not find, any legal authority which would have required such notice. The Rehabilitator did not need to disclose her litigation strategy at the hearing with the Intervening Regulators. In any event, the Intervening Regulators were given an opportunity to file with this Court an application for reconsideration, which they did on June 1, 2021.

Nor did the Intervening Regulators cite any legal authority to support their proposition that a directed verdict can only be entered in a jury trial. Notably, the Intervening Regulators' proposition is at odds with their earlier position that this Court should have ruled on the legal issues before holding an evidentiary hearing on the Second Amended Plan.

Pennsylvania Rule of Appellate Procedure 106 provides:

Unless otherwise prescribed by these rules the practice and procedure in matters brought before an appellate court within its original jurisdiction shall be in accordance with the appropriate general rules applicable to practice and procedure in the courts of common pleas, so far as they may be applied.

PA. R.A.P. 106. However, the Intervening Regulators point to Pennsylvania Rule of Appellate Procedure 3783(b), which provides that “[t]he Pennsylvania Rules of Civil Procedure shall apply to adversarial proceedings.”²² PA. R.A.P. 3783(b). Because an action to rehabilitate an insurer pursuant to Article V is a “formal proceeding,” not an “adversarial proceeding,” PA. R.A.P. 3772(f), the Intervening Regulators argue that it is not subject to the Rules of Civil Procedure.

The Intervening Regulators overlook the precept that the Court has discretion to conduct a statutory proceeding as is expedient and appropriate to move the case to a conclusion in a methodical fashion. *See, e.g., In re Tax Sale Held*

²² Rule 3772(c) defines “adversarial proceeding” as

[a]ny action (1) initiated by the rehabilitator or liquidator against persons other than the insurer, (2) asserting a right or interest afforded by Article V and for which neither Article V nor prior orders of the Court provide an avenue for redress, and (3) that the Court determines shall be governed by Pa. R.A.P. 3783 (adversarial proceedings) as an adversarial proceeding.

PA. R.A.P. 3772(c). Pennsylvania Rules of Appellate Procedure 3771 to 3784 (Summary and Formal Proceedings Against Insurers) apply to all actions in the Commonwealth Court arising under Article V. PA. R.A.P. 3771-3784.

September 10, 2003 by Tax Claim Bureau of County of Lackawanna, 859 A.2d 15, 18 (Pa. Cmwlth. 2004) (recognizing that while a trial court is not required to use the Pennsylvania Rules of Civil Procedure in tax sale proceedings, it has discretion to use the Rules of Civil Procedure where appropriate).

Here, the Rehabilitator seeks approval of the Second Amended Plan in this Court’s original jurisdiction.²³ Pennsylvania Rule of Civil Procedure 226(b) provides that a trial court may, “[a]t the close of all the evidence ... direct a verdict upon the oral or written motion of any party.” PA. R.C.P. No. 226(b). This Court has affirmed the entry of a directed verdict following a single-judge bench trial. *See, e.g., Geschwindt v. Wagner*, 1 A.3d 970 (Pa. Cmwlth. 2010) (affirming directed verdict entered by trial court following bench trial). This Court has entered directed verdicts in matters brought within its original jurisdiction. *See, e.g., Pennsylvania Human Relations Commission v. School District of Philadelphia*, 651 A.2d 177 (Pa. Cmwlth. 1993) (granting a school district’s motion for a directed verdict by treating it as a motion for a compulsory nonsuit²⁴ against the Pennsylvania Human Relations Commission on the ground that it had failed to demonstrate that mandatory desegregation measures were feasible).

A directed verdict can be entered in one of two circumstances:

one, the movant is entitled to judgment as a matter of law and/or
two, the evidence is such that no two reasonable minds could

²³ 42 Pa. C.S. §761(a)(3) (This Court has “original jurisdiction of all civil actions or proceedings ... [a]rising under Article V of the act of May 17, 1921 (P.L. 789, No. 285), known as ‘The Insurance Department Act of 1921.’”).

²⁴ While the trial court may, “[a]t the close of all the evidence ... direct a verdict upon the oral or written motion of any party,” PA. R.C.P. No. 226 (emphasis added), “the court, on oral motion of the defendant, may enter a nonsuit on any and all causes of action if, *at the close of the plaintiff’s case on liability*, the plaintiff has failed to establish a right to relief.” PA. R.C.P. No. 230.1(a)(1) (emphasis added).

disagree that the outcome should have been rendered in favor of the movant. With the first, the court reviews the record and concludes that, even with all factual inferences decided adverse to the movant, the law nonetheless requires a verdict in his favor. Whereas with the second, the court reviews the evidentiary record and concludes that the evidence was such that a verdict for the movant was beyond peradventure.

Hall v. Episcopal Long Term Care, 54 A.3d 381, 395 (Pa. Super. 2012) (quoting *Campisi v. Acme Markets, Inc.*, 915 A.2d 117, 119 (Pa. Super. 2006)).

The issue raised in the Rehabilitator’s motion for a directed verdict is a narrow one: whether the Issue State Rate Approval Option is unlawful as the Intervening Regulators alleged. This is a mixed question of law and fact. The Intervening Regulators assert that the Issue State Rate Approval Option is coercive and provides them with no meaningful review of the rate filings. In their application for reconsideration, the Intervening Regulators contend that the “opt-out” provision cannot be “separated from the larger concern over superseding [s]tate rate approval statutes[.]” Application for Reconsideration at 7.

The Intervening Regulators did not present any evidence to support their challenge to the opt-out provision of the Plan. Cantilo credibly testified that if a state chooses to exercise the Issue State Rate Approval Option, the Rehabilitator will file an application on a seriatim basis to increase rates for policies issued in that state. The Intervening Regulators assert that the requirement that opt-out states act within 60 days and review the rate filings on a seriatim basis is “inconsistent” with “state practices.” Application for Reconsideration at 16. However, no evidence in the record supports this claim.

In sum, the Intervening Regulators did not show that the Issue State Rate Approval Option is unconstitutional or otherwise is harmful to their interests.

Collectively, those interests involve approximately 2,000 of the 39,000 policyholders affected by the Plan. Ex. RP-22 at 2. This Court properly entered a directed verdict on the Intervening Regulators' objection to the Issue State Rate Approval Option. However, this Court disagrees with the Rehabilitator's proposition that the Intervening Regulators should be dismissed from the rehabilitation proceeding. The Rehabilitator's motion was a narrow one, as was this Court's order granting the motion.

For the foregoing reasons, this Court denies the Intervening Regulators' application for reconsideration.

2. Policy Restructuring

NOLHGA and Lapinski raised concerns about the policy restructuring provisions in the Second Amended Plan that impact SHIP's tax liability. The restructuring will address potential taxable income owed by SHIP for cancellation of indebtedness and will bifurcate policy liabilities into funded and unfunded portions. This policy restructuring will not affect coverage for policyholders either now or in the event of a liquidation. Cantilo testified that the restructuring does not affect policyholder choices and will not be performed on a seriatim basis. N.T., 5/17/2021, at 143.

As a result of the concerns raised at the hearing, the Rehabilitator will file a separate application with this Court to address the restructuring and tax issues. N.T., 5/21/2021, at 996. All parties will have an opportunity at that point to raise objections.

3. Policyholder Communications

NOLHGA raised concerns regarding policyholder communications, especially with respect to information related to guaranty associations and their

coverage limit. However, NOLHGA's president and fact witness, Peter Gallanis, acknowledged that the Rehabilitator has not refused to engage with NOLHGA regarding its concerns with the Plan or consider NOLHGA's proposed changes. N.T., 5/20/2021, at 686. NOLHGA is free to propose modifications to the Plan and continue to communicate with the Rehabilitator, as NOLHGA has done to date. Gallanis acknowledged that the Rehabilitator is a "capable commissioner" who understands the "important aspects" of the guaranty association system. *Id.* at 680.

4. COVID-19 Pandemic

Policyholder James Lapinski raised concerns regarding the impact of COVID-19 on long-term care insurance experience through higher mortality and lower claim incidence. With regard to this issue, Cantilo credibly testified that SHIP has experienced a moderate increase in mortality since the beginning of the pandemic in 2020, which generated a moderate increase in lapses of policies. The pandemic also caused a small increase in morbidity and adversely affected SHIP's expected yield on invested assets. However, the actuarial report prepared by Oliver Wyman shows that the aggregate effects of the pandemic had a moderate impact on SHIP's financial condition and are not material to the implementation of the Second Amended Plan. N.T., 5/17/2021, at 26; N.T., 5/21/2021, at 944.

Lapinski requested that the Second Amended Plan's discussion on COVID-19 be updated with more recent data. Oliver Wyman's actuarial report noted the evolving nature of COVID-19's impact and stated that while certain assumptions "were developed based on claims data predating the effects of COVID-19[,] [the actuarial team] will consider the effects of COVID-19 when [they] update [their] actuarial assumptions in 2021." Ex. RP-16 at 28. As Bodnar testified, upon approval of the Plan, Oliver Wyman will prepare an actuarial memorandum in

support of the If Knew Premium rates, similar to one that would ordinarily be submitted to state regulators in a rate increase filing. All parties will have an opportunity at that point to raise objections.

5. Funding Gap and SHIP's Balance Sheet

Lapinski questioned the size of SHIP's Funding Gap and the decline of SHIP's capital and surplus and value of its bond holdings as reflected in its balance sheet ending December 31, 2020. In that regard, Cantilo provided extensive testimony on SHIP's hazardous financial condition, the causes of SHIP's insolvency, and the actions taken by the Pennsylvania Insurance Department prior to rehabilitation. The evidence that the Second Amended Plan will substantially reduce the Funding Gap and address SHIP's inequitable rate structure was extensive. As for the decline in the value of SHIP's bond holdings, Cantilo credibly explained that it was due to a decline in yield in the markets in which SHIP's bonds were invested, which added to SHIP's deficit from 2019 to 2020. N.T., 5/21/2021, at 950-51.

6. Timing

Finally, Lapinski raised concerns with the timing of the rehabilitation proceeding and stated his desire for SHIP to avoid the lengthy process that Penn Treaty went through prior to liquidation. This Court shares Mr. Lapinski's desire to address SHIP's financial condition swiftly, as does the Rehabilitator. Cantilo testified that the Plan can be implemented quickly: within eight months of approval, the Rehabilitator anticipates receiving policyholder elections, which will enable her to measure the precise impact of Phase One on SHIP's Funding Gap. N.T., 5/18/2021, at 339-40.

V. Conclusions of Law

1. The Rehabilitator is authorized to “take such action as he deems necessary or expedient to correct the condition or conditions which constituted the grounds for the order of the court to rehabilitate the insurer.” Section 516(b) of Article V, 40 P.S. §221.16(b). This includes preparing “a plan for the reorganization, consolidation, conversion, reinsurance, merger or other transformation of the insurer.” Section 516(d) of Article V, 40 P.S. §221.16(d).

2. Upon application of the Rehabilitator for approval of a plan of rehabilitation, and after notice and a hearing thereon, “the court may either approve or disapprove the plan proposed, or may modify it and approve it as modified. If it is approved, the rehabilitator shall carry out the plan.” Section 516(d) of Article V, 40 P.S. §221.16(d).

3. “[I]t is not the function of the courts to reassess the determinations of fact and public policy made by the Rehabilitator[]” in formulating a plan of rehabilitation. *Mutual Fire II*, 614 A.2d at 1091. “Rather, the involvement of the judicial process is limited to the safeguarding of the plan from any potential abuse of the Rehabilitator’s discretion.” *Id.*

4. The Rehabilitator’s evidence established that the Second Amended Plan will conserve and equitably administer the assets of SHIP in the interest of policyholders, creditors and the public, “with the main purpose being the public good.” *Id.* at 1094. The Plan is designed to return SHIP to its pre-receivership status as a run-off company able to meet its obligations as they come due.

5. The Rehabilitator’s evidence established that the Second Amended Plan will reduce or eliminate the Funding Gap and eliminate SHIP’s inequitable and

discriminatory premium rate structure by offering policyholders meaningful choices to modify their long-term care insurance policies.

6. The Rehabilitator's evidence established that policyholders will fare as well or better under the Second Amended Plan than they would in liquidation. The Plan will provide the benefits of rehabilitation, such as flexibility and the accelerated disposition of claims, which is preferable to the static procedures of liquidation.

7. The Rehabilitator is authorized under Article V to establish actuarially sound premium rates for SHIP policyholders, as needed to rehabilitate SHIP, and without the additional approval of the state insurance department where the policy was initially issued.

8. The Rehabilitator did not abuse her discretion in formulating the Second Amended Plan.

VI. Conclusion

The Rehabilitator has made a compelling case in support of her Second Amended Plan of Rehabilitation. Indeed, her evidence was not contradicted on any material fact. The Intervening Regulators suggest that they would have exercised their discretion differently, but this is not a basis for the Court to disapprove the Plan.

The opposition of the Intervening Regulators is based upon their belief that the state-by-state regulation of premium rates must be the starting point of any plan to rehabilitate an insolvent insurer. The Court has several responses.

First, the standard for an appropriate premium rate is substantially the same in every state: the premium must be reasonable in relation to the coverage provided in the policy. The evidence presented at the hearing demonstrated that the premium rates used in the four options in Phase One of the Second Amended Plan

will satisfy that standard. The Rehabilitator will be tasked with proving satisfaction of that standard in her actuarial memorandum. The Intervening Regulators presented no evidence that she cannot or will not be able to do so.

Second, the Issue State Rate Approval Option preserves the state-by-state procedure for those states that share the concerns of the Intervening Regulators. To the extent a state does not believe that the Rehabilitator, and this Court, should be solely responsible for the task of establishing the seriatim premiums used for the four policyholder options in Phase One, the state can assume responsibility to do so by opting out of this aspect of the Second Amended Plan.

Neither SHIP's policies nor state rate regulatory statutes insulate policyholders from paying a reasonable premium for their coverage. To the contrary, they require the opposite. The Second Amended Plan will advance, not undermine, a reasonable and non-discriminatory premium rate structure, which is the point of rate regulation.

Essentially, the Intervening Regulators exalt the process by which insurance premium rates are set over the rehabilitation of an insolvent insurer whose condition was caused by an inadequate and discriminatory premium structure. As was established by the Rehabilitator's evidence, a rehabilitation of SHIP cannot be accomplished by placing the correction of the company's premium rates into the hands of 46 states.

In all respects, the Second Amended Plan satisfies applicable constitutional requirements. Neither the Full Faith and Credit Clause nor principles of comity require this Court to apply the insurance rate regulatory laws of other states when considering a plan to rehabilitate SHIP, a Pennsylvania domiciled insurer in receivership. Nevertheless, the Second Amended Plan, consistent with Article V,

does not evidence “a policy of hostility” to the laws of sister states. Rather, it advances their shared interests in insurance premium rates that are not unfairly discriminatory and reasonable in relation to the benefits provided in the policy.

The Intervening Regulators support a liquidation because it will require guaranty associations to solve SHIP’s Funding Gap. However, a liquidation will do nothing to address SHIP’s discriminatory premium structure. As NOLHGA’s actuary, Matthew Morton, explained, guaranty associations can make rate filings with the state of issue but only on a cohort basis, for the segment of policies covered by the filing guaranty association. As a consequence, Morton opined that in a liquidation, many SHIP policyholders will pay more than the If Knew Premium rate for their coverage while others will pay less. Guaranty associations have no opportunity to propose or implement the seriatim If Knew Premium rate that is central to the Second Amended Plan’s correction of the current inadequate and discriminatory premium rate structure. This reason alone supports the Rehabilitator’s decision not to liquidate SHIP.

There is nothing unfair about expecting every policyholder to pay an actuarially justified premium for their coverage. That is expected in any insuring system. In the case of SHIP, it will not happen in the absence of the implementation of the Second Amended Plan.

The Rehabilitator has persuaded the Court that rehabilitation is preferred for another reason. A liquidation will place the burden of an actuarially justified premium upon the policyholders of member insurers of the applicable guaranty associations and, ultimately, upon the taxpayers in those states. No one has provided the Court with an explanation as to why, as a matter of policy, the premium burden of SHIP’s policyholders should be borne by others.

For these reasons, the Court rejects the arguments of the Intervening Regulators. The Court concludes that the Rehabilitator has appropriately exercised her discretion in devising a plan that will address SHIP's financially hazardous condition while protecting the interests of the policyholders, creditors and public generally.

s/Mary Hannah Leavitt

Mary Hannah Leavitt, President Judge Emerita

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

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

ORDER

AND NOW this 24th day of August, the Court hereby ORDERS as follows:

1. The Application for Approval of the Plan of Rehabilitation for Senior Health Insurance Company of Pennsylvania (SHIP) filed by Jessica K. Altman, Insurance Commissioner of the Commonwealth of Pennsylvania, in her capacity as Statutory Rehabilitator of SHIP, is GRANTED. The Second Amended Plan of Rehabilitation, filed on May 3, 2021, is APPROVED, with the exception of Section VI.N of the Plan (relating to suspension of agent and broker commissions).

2. The Court defers resolution of the Joint Application for Approval of Settlement Agreement, filed by the Rehabilitator and Intervenor ACSIA Long Term Care, Inc., Global Commission Funding LLC, LifeCare Health Insurance Plans, Inc, Senior Commission Funding LLC, Senior Health Care Insurance Services, Ltd., LLP, and United Insurance Group Agency, Inc., pending a hearing to be scheduled by separate order. The Rehabilitator shall continue paying commissions until Phase One of the Second Amended Plan of Rehabilitation is implemented.

3. The Rehabilitator shall promptly submit an actuarial memorandum in support of the If Knew Premium rates to be used in Phase One of the Second Amended Plan of Rehabilitation to the Pennsylvania Insurance Department for its review and approval.

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

s/Mary Hannah Leavitt

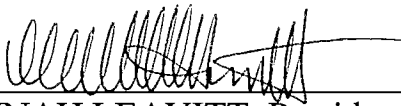
Mary Hannah Leavitt, President Judge Emerita

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

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

ORDER

AND NOW, this 4th day of November, 2021, it is hereby ORDERED that the above-captioned opinion filed August 24, 2021, as amended on November 4, 2021, shall be designated OPINION rather than MEMORANDUM OPINION, and it shall be REPORTED.



MARY HANNAH LEAVITT, President Judge Emerita

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

In Re: Senior Health Insurance
Company of Pennsylvania,
(In Rehabilitation)

:
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:
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:
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Docket No.: 1 SHP 2020

**JOINT APPLICATION FOR INTERVENTION OF THE
MAINE SUPERINTENDENT OF INSURANCE AND THE
MASSACHUSETTS COMMISSIONER OF INSURANCE
AND REQUEST TO GRANT LEAVE TO EXTEND THE TIME
TO INTERVENE**

Pursuant to Pa.R.A.P. 123, 1531(b) & 3775 and the Court's *Case Management Order for Comments and Hearing on the Proposed Plan of Rehabilitation*, dated June 12, 2020 ("Case Management Order"), the Maine Superintendent of Insurance ("Superintendent") and the Massachusetts Commissioner of Insurance ("Commissioner") (collectively, the "State Insurance Regulators"), by and through undersigned counsel, ask that the Court enter an

order permitting them to intervene for the limited purpose of participating in the proceedings concerning and potentially opposing the Rehabilitator's *Application for Approval of the Plan of Rehabilitation for Senior Health Insurance Company of Pennsylvania* as described below.

The State Insurance Regulators further request that the Court grant leave to extend the time for other state insurance regulators to join as intervenors together with the Maine and Massachusetts insurance regulators until and including September 15, 2020 (the formal comment deadline).

In support thereof, the State Insurance Regulators state as follows:

Background

1. Jessica K. Altman, Insurance Commissioner of the Commonwealth of Pennsylvania, in her capacity as Statutory Rehabilitator ("Rehabilitator"), has applied for approval of a plan of rehabilitation (the "Proposed Plan") for Senior Health Insurance Company of Pennsylvania ("SHIP"), an insurance company that specialized in long-term care coverage. The Proposed Plan is attached as Exhibit A to the Rehabilitator's Application.

2. In addition to the business that SHIP transacted within Pennsylvania, SHIP also operated for several decades as a licensed foreign insurer in 45 other states, the District of Columbia, and the U.S. Virgin Islands, subject to the laws of

those respective jurisdictions and the regulatory authority of each jurisdiction's insurance commissioner or comparable state official.

3. Under the terms of the Proposed Plan, "other state insurance departments" are specifically identified as "affected parties," and the Rehabilitator expressly seeks to have them "bound by the Court's approval of the Plan, and its modification of policies and premium rates as part of the Plan." *See* Proposed Plan at p. 80. Accordingly, the Proposed Plan acknowledges that state insurance departments should be "provided an opportunity to object." *Id.* The Case Management Order issued by this Court outlines how such an opportunity may be exercised through informal or formal comments, or intervention in the proceeding. The Case Management Order specifies further: "Any Commenter who intends to call or examine witnesses or introduce exhibits at the hearing on the proposed Plan of Rehabilitation or participate in any discovery that this Court may permit must file an application with the Court to intervene in the proceeding." *See* Case Management Order at ¶ 9.

4. Pennsylvania Rule of Appellate Procedure 3775 states in pertinent part:

Intervention in a formal proceeding shall be allowed if the proven or admitted allegations of the application establish a sufficient interest in the proceedings, unless the interest of the applicant is already adequately represented or intervention will unduly delay or prejudice the adjudication of the rights of the parties.

* * *

(2) *Limited intervention.* When the applicant's interest involves a discrete controversy relating to the administration of the insurer's business or estate, the Court may grant the applicant limited intervention to participate as a party in the discrete controversy. The limited intervenor shall not be placed upon the master service list unless the Court orders otherwise.

Pa.R.A.P. 3775(c). The State Insurance Regulators satisfy the standard for limited intervention concerning the Rehabilitator's Application for Approval of the Proposed Plan, and they are seeking intervention in accordance with the Case Management Order.

Application for Intervention

Interests of the Applicants

5. The State Insurance Regulators have a direct and substantial interest in the Proposed Plan collectively and in their own respective rights. SHIP was licensed in both Massachusetts and Maine, and policyholders from each of those jurisdictions will be subject to the Proposed Plan, if approved. The State Insurance Regulators seek to intervene for the purpose of better understanding how the Proposed Plan affects those interests and to protect those interests by participating in discovery, participating in and presenting evidence at the hearing, and potentially objecting to the Proposed Plan.

State-Specific Interests

Maine

6. The Superintendent enforces state insurance laws and undertakes the duties of regulating insurers. *See* Maine Insurance Code, Title 24-A of the Maine Revised Statutes; specifically, 24-A Me. Rev. Stat. § 211.

7. The Superintendent regulates SHIP. SHIP was licensed in Maine from 1991 until its license was suspended in March 2020. Previously, SHIP sought approval from the Superintendent for long-term care policy rate increases in Maine. SHIP made its most recent Maine rate increase requests between 2011 and 2019. The Superintendent reviewed each increase in accordance with Maine law. SHIP's 2011 and 2019 rate requests were disapproved as excessive after the Superintendent found that SHIP had failed to demonstrate that they met the rating standards required by the applicable regulation; and the Superintendent approved SHIP's 2016 rate request at a level slightly lower than requested.

8. The Proposed Plan will affect Maine policyholders. According to data provided to the Superintendent by the Rehabilitator, there were 388 Maine policies subject to the Proposed Plan as of November 30, 2019. The average estimated Phase One rate increase for Maine policyholders under the Proposed Plan is nearly 70%. Furthermore, that projected increase is not evenly distributed: 146 policies would have no rate increase; 47 policies would have rate increases

below 20%; 160 policies would have increases ranging between 20.1% and 199%; and 33 policies would have rate increases in excess of 200%, reaching as high as 1,275%.¹

9. At the time this information was compiled, 38 Maine residents were entitled to “on-claim waiver” of premium, meaning they are not paying premium because they are currently receiving long-term care. Another 78 policies were entitled to “active waiver,” either because the policyholder’s spouse was currently on claim or because the policyholder’s spouse has already died and the terms of the policy entitled the surviving spouse to a lifetime waiver of premium. The waiver-of-premium benefit is one of the basic protections provided by long-term care insurance. Typically, once a patient has been in a long-term care facility for the waiting period specified in the policy, the patient stops paying the insurer and the insurer begins reimbursing the patient – without diminishing the policy benefit by deducting further premiums. The Proposed Plan would take this benefit away from patients who are already receiving it, turning their premium waiver into a premium discount capped at a fixed dollar amount.

¹ The information about policies in this and the following paragraph was provided by the Rehabilitator to the Superintendent in a May 3, 2020 email and attachments from Patrick H. Cantilo to Benjamin Yardley. The estimated rate increases were calculated based upon that information. The number of policies referred to in this paragraph do not add up to 388 because there were two policies for which the estimated Phase One rate increase could not be calculated.

10. Like other jurisdictions in the United States, Maine has an extensive body of law, in both statute and regulation, protecting insurance policyholders by ensuring that they receive the insurance coverage they have been promised, and prohibiting excessive or unfairly discriminatory rate increases. In particular, long-term care insurance rates must be submitted for review by the Superintendent, which includes an actuarial analysis, and increases may not be implemented unless the Superintendent determines that they comply with applicable legal standards. *See e.g.* 24-A Me. Rev. Stat. § 2736 (“Every insurer shall file for approval by the superintendent every rate, rating formula, classification of risks and every modification” of long-term care rates for use in Maine so that the Superintendent can determine that the filing complies with “requirements that rates not be excessive, inadequate or unfairly discriminatory”); 02-031 Code Me. Rules, ch. 420, § (6)(A)(9) (“The filing must include sufficient supporting information to demonstrate [to the Superintendent] that the rates are not excessive, inadequate, or unfairly discriminatory.”) The Proposed Plan purports to set aside these laws, and comparable laws in other jurisdictions, and replace them with a process for setting rates on a nationwide basis.

Massachusetts

11. The Commissioner enforces state insurance laws and undertakes the duties of regulating insurers. *See* Massachusetts General Laws, Chapter 175; specifically, M.G.L. c. 175, § 3A.

12. The Commissioner regulates SHIP. SHIP has been licensed in Massachusetts to write long term care insurance since 1990. Previously, SHIP sought approval from the Commissioner for long-term care policy rate increases in Massachusetts. SHIP made its most recent Massachusetts rate increase requests in 2011 and 2019. The Commissioner reviewed each increase in accordance with Massachusetts law. The Commissioner permitted SHIP to increase rates at a level lower than requested in the 2011 filing and only after satisfying the applicable statutory and regulatory requirements. The 2019 rate request was withdrawn by SHIP in April 2020 prior to the Commissioner issuing a decision. The reason provided for the withdrawal of the 2019 rate request was SHIP's desire to include the pending rate increases in the Proposed Plan.

13. The Proposed Plan will affect Massachusetts policyholders. According to data provided to the Commissioner by the Rehabilitator, there were 345 Massachusetts policies subject to the Proposed Plan as of November 30, 2019. The average estimated Phase One rate increase for Massachusetts policyholders under the Proposed Plan is nearly 45%. Furthermore, that projected increase is not

evenly distributed: for example, 174 policies without inflation protection would have an average rate increase of 24%; 27 policies with lifetime benefits would have an average increase of 64%; and 11 policies issued to policyholders under age 70 would have an average rate increase of 97%.²

14. At the time this information was compiled, 39 Massachusetts residents were entitled to “on-claim waiver” of premium, meaning they are not paying premium because they are currently receiving long-term care. Another 91 policies were entitled to “active waiver,” either because the policyholder’s spouse was currently on claim or because the policyholder’s spouse has already died and the terms of the policy entitled the surviving spouse to a lifetime waiver of premium. The waiver-of-premium benefit is one of the basic protections provided by long-term care insurance. Typically, once a patient has been in a long-term care facility for the waiting period specified in the policy, the patient stops paying the insurer and the insurer begins reimbursing the patient – without diminishing the policy benefit by deducting further premiums. The Proposed Plan would take this benefit away from patients who are already receiving it, turning their premium waiver into a premium discount capped at a fixed dollar amount.

² The information about policies in this and the following paragraph was provided by the Rehabilitator to the Commissioner in a December 20, 2019 email and attachments from Laura Lyon Slaymaker to Christopher M. Joyce. The estimated rate increases were calculated based upon that information.

15. Like other jurisdictions in the United States, Massachusetts has an extensive body of law, in both statute and regulation, protecting insurance policyholders by ensuring that they receive the insurance coverage they have been promised, and prohibiting excessive or unfairly discriminatory rate increases. In particular, long-term care insurance rates must be submitted for review by the Commissioner, which includes an actuarial analysis, and increases may not be implemented unless the Commissioner determines that they comply with applicable legal standards. See M.G.L. c. 175, § 108, 211 CMR 42.00 and 211 CMR 65. A long-term care insurance policy may be disapproved by the Commissioner “if the benefits provided therein are unreasonable in relation to the premium charged, or if it contains any provision which is unjust, unfair, inequitable, misleading or deceptive, or which encourages misrepresentation as to such policy.” M.G.L. c. 175, § 108(8)A; see also *Genworth Life Ins. Co. v. Comm’r of Ins.*, 126 N.E.3d 1019, 1023 (Mass. App. Ct. 2019)(affirming the Commissioner’s disapproval of requested long-term care insurance rate increases). The Proposed Plan purports to set aside these laws, and comparable laws in other jurisdictions, and replace them with a process for setting rates on a nationwide basis.

Overarching Regulatory Interests

16. The State Insurance Regulators have a regulatory interest in seeing that contract rights of Maine and Massachusetts policyholders are respected and that the standards and protections of the statutory rate-setting process are honored. The Proposed Plan acknowledges that the policies are structured as “level-premium guaranteed-renewable contracts” and that “this meant that, as long as the policyholders paid their premiums, the policies could not be cancelled despite changes in age, health, condition and other circumstances. Moreover, the premiums could only be increased if they were increased by the same percentage for all policyholders who had then same type of policy, and then only if the state regulator approved the increase.” Proposed Plan at 73.

17. The Proposed Plan, however, seeks to restructure the policies and ultimately to discharge certain benefit liability, *see* Proposed Plan at 77, and it expressly seeks to avoid review by Maine and Massachusetts insurance regulators of premium increases and policy modifications, *see* Proposed Plan at 22. It seeks to bind “affected parties (including other state insurance departments)” to the Plan’s “modification of policies and premium rates.” Proposed Plan at 80.

18. The Proposed Plan implicitly acknowledges that it needs “to place policyholders in no worse a position than they would face in a liquidation of SHIP.” Proposed Plan at 8. *See Foster v. Mutual Fire, Marine and Inland Ins.*

Co., 531 Pa. 598, 613 (1992) (“Under *Neblett* [*v. Carpenter*, 305 U.S. 297 (1938)], creditors must fare at least as well under a rehabilitation plan as they would under a liquidation”). The State Insurance Regulators seek to understand how the Plan can comport with this standard in light of the apparently significant premium increases and/or benefit cuts proposed, in particular where those increases or cuts will vary across states. See Proposed Plan at 11, 22, 72, and 74.

19. In sum, the Proposed Plan is unprecedented and ignores the long-standing allocation of authority for state insurance regulators to approve or set rates on a state-specific basis. When a Maine or Massachusetts insurer does business in Pennsylvania, Pennsylvania residents are protected by having the fairness and reasonableness of the rates they pay determined under Pennsylvania law by the Pennsylvania Commissioner, subject to review by Pennsylvania’s courts. Maine and Massachusetts residents are entitled to the same protection when they buy coverage from a Pennsylvania insurer. The State Insurance Regulators’ concerns in this matter include protecting Maine and Massachusetts residents from unfair and excessive rate increases and unreasonable benefit decreases; and preserving a process for reviewing rate increases and benefit decreases that respects state sovereignty and interstate comity.

Purposes for which Intervention is Sought

20. In these circumstances, the State Insurance Regulators seek limited intervention for the purposes of participating in discovery, participating in and presenting evidence at the hearing, and potentially objecting to the Proposed Plan and appealing from orders entered concerning the Proposed Plan. Evidence may include facts such as those cited in paragraphs 8-9 and 13-14 above demonstrating the effect of the Proposed Plan on policyholders and the differing treatment of policyholders both within a state and across states. The potential objections may include non-compliance with the rate-setting statutes of the various states cited in paragraphs 10 and 15 above and the statutory and constitutional limitations on rehabilitation plans. Intervention is necessary because “the fundamental Plan structure is unlikely to change unless the Court requires it.” Proposed Plan at 11.

21. The State Insurance Regulators are considering and analyzing the factual and legal issues presented by the Proposed Plan. The State Insurance Regulators will file Formal Comments on or before September 15, 2020, in accordance with the schedule set in paragraphs 8 and 9 of the Case Management Order. If permitted to intervene, the State Insurance Regulators will provide information concerning the witnesses and exhibits they intend to introduce at the hearing on or before September 30, 2020 in accordance with the schedule set in paragraph 9 of the Case Management Order. In light of the Case Management

Order's schedule for filings, the provision of Pa.R.A.P. 3775(b) concerning attachment of the document to be filed if intervention is granted does not apply.

Request to Grant Leave to Extend the Time to Intervene

22. If other states determine that a similar intervention in this proceeding is an appropriate process for protecting the interests of their own residents, it would promote efficiency and judicial economy to grant all interested states the option of consolidating their claims in a single intervention. The State Insurance Regulators making this application request further that the Court grant leave to permit other state insurance regulators to join as intervenors with the Maine and Massachusetts insurance regulators, until and including September 15, 2020, or other date set by the Court.

Conclusion

For all of the above reasons, the Maine Superintendent of Insurance and the Massachusetts Commissioner of Insurance request that the Court (1) grant them intervention in this matter for the limited purpose of participating in the proceedings concerning and potentially opposing the Rehabilitator's Application for Approval of the Proposed Plan and appealing from orders concerning the Proposed Plan, and (2) grant leave to extend the time for other state insurance regulators to join as intervenors together with the Maine and Massachusetts

insurance regulators by application filed with the Court until and including September 15, 2020, or other date set by the Court.

Respectfully submitted,

By: /s/ Stephen G. Harvey
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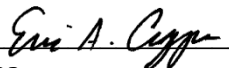
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Counsel to the Maine Superintendent of Insurance and
the Massachusetts Commissioner of Insurance and
Massachusetts Special Assistant Attorneys General

Dated: July 31, 2020

VERIFICATION

I, Eric A. Cioppa, Maine Superintendent of Insurance, hereby state that the facts stated in paragraphs 2, 5, 6–10, 16, and 19–21 above are true and correct to the best of my knowledge, information, and belief. I understand that the statements herein are made subject to the penalties of 18 Pa.C.S. § 4904 (relating to unsworn falsification to authorities).

Date: July 31, 2020



Eric A. Cioppa
Superintendent of Insurance

VERIFICATION

I, Gary D. Anderson, Commissioner of Insurance of the Massachusetts Division of Insurance, hereby state that the facts stated in paragraphs 2, 5, 11-15, 16, and 19-21 above are true and correct to the best of my knowledge, information, and belief. I understand that the statements herein are made subject to the penalties of 18 Pa.C.S. § 4904 (relating to unsworn falsification to authorities).

Date: July 31, 2020



Gary D. Anderson
Commissioner of Insurance

PROOF OF SERVICE

I, Stephen G. Harvey, Esq., hereby certify that on this date, I caused a true and correct copy of the foregoing Joint Application for the Intervention of the Maine Superintendent of Insurance and the Massachusetts Commissioner of Insurance and Request to Grant Leave to Extend the Time to Intervene, to be served upon the following and in the manner indicated below:

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Dated: July 31, 2020

PROOF OF SERVICE

I, Stephen G. Harvey, Esq., hereby certify that on this date, I caused a true and correct copy of the foregoing Joint Application for the Intervention of the Maine Superintendent of Insurance and the Massachusetts Commissioner of Insurance and Request to Grant Leave to Extend the Time to Intervene, to be served upon the following and in the manner indicated below:

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Dated: July 31, 2020

**In Re: Senior Health Insurance :
Company of Pennsylvania :
In Rehabilitation : No. 1 SHP 2020**

Pursuant to Pa.R.A.P. 123, 1531(b) & 3775 and the Court's *Case*

Management Order for Comments and Hearing on the Proposed Plan of Rehabilitation, dated June 12, 2020 (“Case Management Order”), the Insurance Commissioner of the State of Washington (“Washington Commissioner”), by and through undersigned counsel, joins in the Joint Application for Intervention of the Maine Superintendent of Insurance and the Massachusetts Commissioner of Insurance (“Joint Application”) and asks that the Court enter an order permitting him to intervene along with the Maine Superintendent and the Massachusetts Commissioner for the limited purpose of participating in the proceedings concerning and potentially opposing the Rehabilitator’s *Application for Approval of the Plan of Rehabilitation for Senior Health Insurance Company of Pennsylvania* as described below.

In support thereof, the Washington Commissioner states as follows:

Background

1. In the Joint Application, the Maine Superintendent and the Massachusetts Commissioner requested that the Court grant leave to extend the time for other state insurance regulators to join as intervenors until and including September 15, 2020 (the formal comment deadline).

2. In the Rehabilitator's Answer to the Joint Application, the Rehabilitator opposed the request to extend time. However, after the Maine and Massachusetts regulators reported in their Further Answer that the Washington Commissioner wished to join in the Joint Application and to intervene, the Rehabilitator filed an Application for Leave to File a Response that attached the Rehabilitator's Response to Answer and Further Answer of the Maine Superintendent of Insurance and the Massachusetts Commissioner of Insurance dated September 4, 2020 ("Rehabilitator's Response").

3. The Rehabilitator's Response states that "[t]he Rehabilitator will not oppose the Washington Commissioner's application to intervene in this proceeding consistent with Paragraph 9 of the Court's June 12, 2020 Case Management Order if such an application is filed prior to the Formal Comment Deadline of September 15, 2020." Rehabilitator's Response at 2 (emphasis added). The Washington Commissioner accordingly files this application to intervene.

Joinder in Joint Application and Request to Intervene

4. The Washington Commissioner hereby joins the Joint Application filed by the Maine Superintendent of Insurance and the Massachusetts Commissioner of Insurance and requests leave to intervene along with those state regulators. The Washington Commissioner adopts the Joint Application, including the description of regulatory interests and the purposes for intervention and the relief sought therein, and will not repeat what has already been stated in the Joint Application. The Washington Commissioner adds the following with respect to the State of Washington:

Specific Interests of the Applicant

5. The Washington Commissioner has a direct and substantial interest in the Proposed Plan. SHIP was licensed in Washington, and policyholders in the State will be subject to the Proposed Plan, if approved. The Washington Commissioner seeks to intervene for the purpose of better understanding how the Proposed Plan affects those interests and to protect those interests by participating in discovery, participating in and presenting evidence at the hearing, and potentially objecting to the Proposed Plan.

6. The Washington Commissioner enforces state insurance laws and undertakes the duties of regulating insurers. *See* Wash. Rev. Code §§ 48.01.020; 48.02.060.

7. The Washington Commissioner regulates SHIP. SHIP has been licensed in Washington to write long term care insurance since October 20, 1989. Previously, SHIP sought approval from the Commissioner for long-term care policy rate increases in Washington. SHIP made its most recent Washington rate increase requests in September 2018. The Commissioner reviewed this increase in accordance with Washington law, but upon raising multiple substantive legal issues with the company regarding the request, SHIP chose to withdraw the filing, as also occurred with the company's 2016 rate increase request. The last approved rate increase request for SHIP's long-term care business occurred in 2012.

8. The Proposed Plan will affect Washington policyholders. According to data provided to the Commissioner by the Rehabilitator, there were 1,509 Washington policies subject to the Proposed Plan as of November 30, 2019. The average estimated Phase One rate increase for Washington policyholders under the Proposed Plan is 41%. Furthermore, that projected increase is not evenly distributed: 334 policies would have a 30% rate increase; 949 policies would have a rate increase of 40%; 202 policies would have rate increases of 49%; and 24 policies would have rate increases ranging between 88% and 140%.¹

¹ The information about policies in this and the following paragraph was provided by the Rehabilitator to the Commissioner in a December 20, 2019 email. The estimated rate increases were calculated based upon that information.

9. At the time this information was compiled, 96 Washington residents were entitled to “on-claim waiver” of premium, meaning they are not paying premium because they are currently receiving long-term care. Another 252 policies were entitled to “active waiver,” either because the policyholder’s spouse was currently on claim or because the policyholder’s spouse has already died and the terms of the policy entitled the surviving spouse to a lifetime waiver of premium. The waiver-of-premium benefit is one of the basic protections provided by long-term care insurance. Typically, once a patient has been in a long-term care facility for the waiting period specified in the policy, the patient stops paying the insurer and the insurer begins reimbursing the patient – without diminishing the policy benefit by deducting further premiums. The Proposed Plan would take this benefit away from patients who are already receiving it, turning their premium waiver into a premium discount capped at a fixed dollar amount.

10. Like other jurisdictions in the United States, Washington has an extensive body of law, in both statute and regulation, protecting insurance policyholders by ensuring that they receive the insurance coverage they have been promised, and prohibiting excessive or unfairly discriminatory rate increases. In particular, long-term care insurance rate increase requests must be submitted for review by the Commissioner, which includes an actuarial analysis, and increases may not be implemented unless the Commissioner determines that they comply

with applicable legal standards. *See* Wash. Rev. Code §§ 48.83, 48.84; Wash. Admin. Code § 284-54 & 284-60; Wash. Rev. Code § 48.18.110; Wash. Rev. Code § 48.18.480; Wash. Admin. Code §§ 284-83, 284-84. A long-term care insurance rate increase request may be disapproved by the Commissioner if “the benefits provided therein are unreasonable in relation to the premium charged.” Wash. Rev. Code § 48.18.110. In addition, the Commissioner will deny rates if he finds “unfair discrimination between insureds or subjects of insurance having substantially like insuring, risk, and exposure factors, and expense elements, in the terms or conditions of any insurance contract, or in the rate or amount of premium charged therefor, or in the benefits payable or in any other rights or privileges accruing thereunder.” Wash. Rev. Code § 48.18.480. The Proposed Plan purports to set aside these laws, and comparable laws in other jurisdictions, and replace them with a process for setting rates on a nationwide basis.

Overarching Regulatory Interests

11. As set forth in the Joint Application, the Washington Commissioner and the other State regulators have a regulatory interest in seeing that contract rights of policyholders in their States are respected and that the standards and protections of the statutory rate-setting process are honored. The State Insurance Regulators’ concerns in this matter include protecting their residents from unfair and excessive rate increases and unreasonable benefit decreases; and preserving a

process for reviewing rate increases and benefit decreases that respects state sovereignty and interstate comity.

Purposes for which Intervention is Sought

12. As set forth in the Joint Application, the Washington Commissioner joins the Maine Superintendent and the Massachusetts Commissioner in seeking limited intervention for the purposes of participating in discovery, participating in and presenting evidence at the hearing, and potentially objecting to the Proposed Plan and appealing from orders entered concerning the Proposed Plan.²

13. The State Insurance Regulators, including the Washington Commissioner, will file Formal Comments on or before September 15, 2020, in accordance with the schedule set in paragraphs 8 and 9 of the Case Management Order. If permitted to intervene, the State Insurance Regulators will provide information concerning the witnesses and exhibits they intend to introduce at the hearing on or before September 30, 2020 in accordance with the schedule set in paragraph 9 of the Case Management Order.

² As stated in the Rehabilitator's Response, the Rehabilitator does not oppose limited intervention by Maine and Massachusetts (and now presumably Washington) for the purposes set forth in paragraph 9 of the June 12, 2020 Case Management Order, and the Rehabilitator acknowledges that, should the Court grant limited intervention, "that would necessarily include the right to object to the Proposed Plan and appeal relevant orders concerning the Proposed Plan." Rehabilitator's Response at 3.

Conclusion

For the reasons set forth above and in the Joint Application, the Washington Commissioner requests that the Court grant him intervention along with the Maine Superintendent and the Massachusetts Commissioner for the limited purpose of participating in the proceedings concerning and potentially opposing the Rehabilitator's Application for Approval of the Proposed Plan and appealing from orders concerning the Proposed Plan.

September 15, 2020

Respectfully submitted,

By: Steve Harvey Law LLC,

/s/ Stephen G. Harvey
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(*pro hac vice* motions to be submitted)

Counsel to the Washington Insurance Commissioner,
the Maine Superintendent of Insurance, and
the Massachusetts Commissioner of Insurance and
Washington Special Assistant Attorneys General and
Massachusetts Special Assistant Attorneys General

PROOF OF SERVICE

I, Stephen G. Harvey, hereby certify that on September 15, 2020, I served the foregoing JOINDER OF THE WASHINGTON INSURANCE COMMISSIONER IN THE JOINT APPLICATION FOR INTERVENTION OF THE MAINE SUPERINTENDENT OF INSURANCE AND THE MASSACHUSETTS COMMISSIONER OF INSURANCE AND APPLICATION TO INTERVENE via PACFile system as well as via email upon the following counsel:

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Dated: September 15, 2020

PROOF OF SERVICE

I, Stephen G. Harvey, hereby certify that on September 15, 2020, I served the foregoing JOINDER OF THE WASHINGTON INSURANCE COMMISSIONER IN THE JOINT APPLICATION FOR INTERVENTION OF THE MAINE SUPERINTENDENT OF INSURANCE AND THE MASSACHUSETTS COMMISSIONER OF INSURANCE AND APPLICATION TO INTERVENE via PACFile system as well as via email upon the following counsel:

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Dated: September 15, 2020

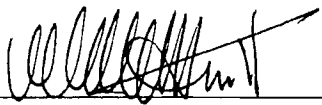
IN THE COMMONWEALTH COURT OF PENNSYLVANIA

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

ORDER

AND NOW, this 15th day of September, 2020, upon consideration of the Joint Application for Intervention of the Maine Superintendent of Insurance and the Massachusetts Commissioner of Insurance and Request to Grant Leave to Extend the Time to Intervene (Joint Application), and the Rehabilitator's response thereto, it is hereby ORDERED that the Joint Application is GRANTED IN PART and DENIED IN PART. The request of the Maine Superintendent of Insurance and the Massachusetts Commissioner of Insurance to intervene in the above-captioned proceeding is GRANTED. The request to extend the time for other state insurance regulators to join as intervenors is DENIED.

The Rehabilitator's Application for Leave to File a Response to the Answer and Further Answer of the Maine Superintendent of Insurance and the Massachusetts Commissioner of Insurance is DENIED.



MARY HANNAH LEAVITT, President Judge

Certified from the Record

SEP 15 2020

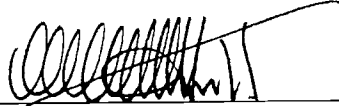
And Order Exit
SIR App. 568

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

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

ORDER

AND NOW this 18th day of September, 2020, upon consideration of the Joinder of the Washington Insurance Commissioner in the Joint Application for Intervention of the Maine Superintendent of Insurance and the Massachusetts Commissioner of Insurance and Application to Intervene, which the Rehabilitator does not oppose, it is ORDERED that the Washington Insurance Commissioner is permitted to join with the intervention of the Maine Superintendent of Insurance and the Massachusetts Commissioner of Insurance in the above-captioned proceeding.



MARY HANNAH LEAVITT, President Judge

Certified from the Record

SEP 18 2020

And Order Exit

SIR App. 569

VERIFICATION

I, Robert Alan Wake, verify that the documents referenced herein and included in the accompanying appendix at pages SIR App. 9-17, SIR App. 19, and SIR App. 20-21 are true and correct copies of the documents included and referenced. I understand that this verification is made subject to the penalties of 18 Pa. C.S. § 4904 relating to unsworn falsification to authorities.

Dated: November 5, 2021



Robert Alan Wake, General Counsel
Maine Bureau of Insurance

IN THE SUPREME COURT OF PENNSYLVANIA

In Re: Senior Health Insurance Company of : 71 MAP 2021
Pennsylvania (In Rehabilitation) :
:

Appeal of: The Superintendent of Insurance of the
State of Maine, The Commissioner of Insurance of
the Commonwealth of Massachusetts and the
Insurance Commissioner of the State of Washington

PROOF OF SERVICE

I hereby certify that this 8th day of November, 2021, I have served the attached document(s) to the persons on the
date(s) and in the manner(s) stated below, which service satisfies the requirements of Pa.R.A.P. 121:

Service

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1341 Strawberry Square
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Appellee Senior Health Insurance Company of Pennsylvania

Served: Dexter Ryan Hamilton
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Appellee Senior Health Insurance Company of Pennsylvania

IN THE SUPREME COURT OF PENNSYLVANIA

PROOF OF SERVICE

(Continued)

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IN THE SUPREME COURT OF PENNSYLVANIA

PROOF OF SERVICE

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IN THE SUPREME COURT OF PENNSYLVANIA

PROOF OF SERVICE

(Continued)

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IN THE SUPREME COURT OF PENNSYLVANIA

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(Continued)

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/s/ Stephen G. Harvey

(Signature of Person Serving)

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