

**UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY**

MARLENE CARIDE, as Commissioner of the New Jersey Department of Banking and Insurance, and
THE NEW JERSEY DEPARTMENT OF BANKING
AND INSURANCE,

Plaintiffs,

v.

JESSICA K. ALTMAN, as Rehabilitator of Senior Health Insurance Company of Pennsylvania and her successors in office, in their capacity as Rehabilitator of Senior Health Insurance Company of Pennsylvania, PATRICK H. CANTILO, as Special Deputy Rehabilitator of Senior Health Insurance Company of Pennsylvania, MICHAEL HUMPHREYS, as Successor Rehabilitator of Senior Health Insurance Company of Pennsylvania, and SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA,

Defendants.

No. 3:22-cv-01329-FLW-LHG

Motion Date: May 16, 2022

DEFENDANTS' REPLY BRIEF
IN FURTHER SUPPORT OF THEIR MOTION TO STAY

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COZEN O'CONNOR
Michael J. Broadbent
1650 Market Street, Suite 2800
Philadelphia, PA 19103
Telephone: (215) 665-4732
Facsimile: (215) 701-2288
mbroadbent@cozen.com

TUCKER LAW GROUP
Leslie Miller Greenspan
Ten Penn Center
1801 Market Street, Suite 2500
Philadelphia, PA 1910
Telephone: (215) 875-0609
Fax No.: (215) 559-6209
Email: lgreenspan@tlgattorneys.com

ATTORNEYS FOR DEFENDANTS

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Defendants respectfully submit this Reply Brief in further support of their Motion to Stay. For the reasons set forth herein and in Defendants' initial brief, the motion for stay should be granted. Plaintiffs cannot show any harm arising out of a short stay to allow the Judicial Panel on Multidistrict Litigation to decide Defendants' motion to consolidate, and their remaining arguments against a stay are unavailing.

ARGUMENT IN REPLY

Stays of a civil action are "common when the issue of transfer is before the JPML." *Gustin v. Novartis Pharms. Corp.*, No. 20-2753 (JMV), 2021 WL 3508807, at *5 (D.N.J. Aug. 10, 2021) (M.J.). Plaintiffs cannot show that a stay should not be entered here.

A. This Court can and should enter a stay before deciding the Motion to Remand.

Plaintiffs assert that the Court should decide their motion to remand before the motion to stay, relying on a test from *Meyers v. Bayer AG*, 143 F. Supp. 2d 1044 (E.D. Wis. 2001) adopted in *Nekritz v. Canary Capital Partners, LLC*, No. Civ. 03-5081, 2004 WL 1462035 (D.N.J. Jan. 12, 2004). Assuming the *Meyers* analysis could apply here, Plaintiffs fail to satisfy its requirements.

First, remand is not "patently appropriate" here because Defendants have raised two meritorious grounds for jurisdiction in this Court, one of which requires an extensive factual analysis. Defendants invoke diversity jurisdiction, and Plaintiffs' motion to remand depends on a finding that they are the alter of ego of New Jersey, requiring this Court to engage with the three-part test set forth in *Fitchik v. New Jersey Transit Rail Operations*, 873 F.2d 655, 659 (3d Cir. 1989) (applying the test to evaluate Eleventh Amendment immunity); *see also Blake v. Kline*, 612 F.2d 718, 723–25, 726 n. 16 (3d Cir. 1979) (applying same test to diversity jurisdiction analysis). Under *Fitchik*, a court must consider: "(1) whether the payment of the judgment would come from the state; (2) what status the entity has under state law; and (3) what degree of autonomy the entity has." *Karns v. Shanahan*, 879 F.3d 504, 513 (3d Cir. 2018). This Court cannot simply review the

Complaint and conclude that remand is appropriate without an extensive consideration of the facts.¹ Defendants also invoke federal question jurisdiction, and Plaintiffs’ efforts to downplay their allegations as “passing references . . . to the McCarran-Ferguson Act” are unavailing. (ECF #15 at 14 (ECF p. 18).) Indeed, Plaintiffs clearly contend that federal law governs and provides their purported right to relief: Plaintiffs’ cause of action for declaratory relief *expressly alleges* that Defendants’ efforts to implement the Approved Plan violate Plaintiffs’ regulatory rights under and as provided by the federal McCarran-Ferguson Act. (ECF #1-1 Compl. ¶ 65 (seeking declaratory relief because “under the McCarran-Ferguson Act, the Act, and the Police Powers of New Jersey, New Jersey has the exclusive authority and right to govern the business of insurance in New Jersey).) Given a second opportunity to address the issue in briefing filed with their Complaint, Plaintiffs doubled-down, arguing “[a]s *a matter of federal law*, the authority to control and regulate the business of insurance in a given state reside[s] with insurance regulators of the state” and that state powers are “in addition to” federal law, identified as the McCarran-Ferguson Act. (ECF #1-1, Brief at 20 (emphasis added).) These are the bases of Plaintiffs’ claims, not passing references.

Second, Plaintiffs confusingly claim that there is no likelihood of tagalong cases following Plaintiffs’ playbook because Plaintiffs are not challenging Commissioner Humphreys’ authority as Rehabilitator—and then cite the fact that “various insurance commissioners and their departments . . . are already participating in proceedings that concern the implementation of the

¹ *Causey v. Altman*, cited by Plaintiffs, does not change this analysis. (ECF #14-1.) The remand motion in *Causey* was scheduled for full briefing before Defendants filed their motion to consolidate, and the Court had informed the parties that it would enter a decision before April 28, 2022. (*Id.* at 5.) *Causey* did not involve McCarran-Ferguson and had a far more limited set of factual allegations than those included in Plaintiffs’ Complaint here. (*Id.* at 3-4.) *Causey* also relied on Plaintiffs’ (outdated and incorrect) allegation that plan modifications would occur before May 1, providing the Court with a sense of urgency, even if misguided. (*Id.* at 5.)

Plan.” (ECF #17 at 13 (ECF p. 17).) This illogical argument turns on Plaintiffs’ disingenuous claim that they are not challenging Commissioner Humphreys’ authority or implementation of the Plan. To the contrary, Plaintiffs’ Complaint shows that Plaintiffs in fact do challenge the authority of Commissioner Humphreys and the Pennsylvania courts. For example:

- “Defendants are currently implementing the Plan pursuant to an order that disregards New Jersey law. The order approving the Plan was entered by the Commonwealth Court, which has no jurisdiction over New Jersey, DOBI, or Commissioner Caride.” (*Id.* ¶ 61.)
- “The Commonwealth Court’s authority over SHIP does not give the Rehabilitator the authority over the laws or legislature of New Jersey.” (*Id.* ¶ 62.)
- “The Commonwealth Court’s authority over SHIP does not give the Rehabilitator the authority over the laws or legislature of New Jersey.” (*Id.* ¶ 63.)

In perhaps the clearest example, Plaintiffs ask for a *prospective* declaratory judgment finding that the Supreme Court of Pennsylvania’s orders are “void and unenforceable in New Jersey.” (ECF #1-1, Compl. WHEREFORE A.) As with Plaintiffs’ reliance on federal law, Plaintiffs cannot oppose Defendants, the Plan, and the Pennsylvania courts when it suits them and then disclaim those allegations when it does not. The question of jurisdiction over SHIP policyholders and Full Faith and Credit are before multiple other courts, and, should the cases be consolidated, the multidistrict court rather than this Court should decide those issues. It is inevitable that these issues will continue to arise, and remand will lead to more litigation by other states waiting in the wings, including the regulators with whom Plaintiffs are working to stop the Plan in other jurisdictions.

B. The equities favor entering a stay here.

Defendants should not be compelled to litigate Plaintiffs’ improper and belated opposition to the Plan in multiple courts if the matter is to be heard by the multidistrict court. In contrast, Plaintiffs suffer no harm, damage, or other injury if this matter is stayed, because Plaintiffs’ inability to act on their mistaken analysis of the Plan and receivership law works no prejudice at all.

1. Defendants will be harmed if a stay is not entered.

Courts regularly recognize the hardships arising from the burden of piecemeal litigation in far-flung fora. (See Defs’ Memo, ECF #7-3 at 6-8.) This burden is even greater in the context of a rehabilitation, because—unlike ordinary litigants—all litigation costs are paid out of the limited assets of the insurer in receivership, negatively impacting SHIP’s future and its prospects for rehabilitation. Receivership law similarly recognizes the propriety of and need for a single forum in rehabilitation proceedings. See *Ballesteros v. New Jersey Prop. Liab. Ins. Guar. Ass’n*, 530 F. Supp. 1367, 1370-71 (D.N.J. 1982) (collecting cases), *aff’d sub nom. Appeal of Ballesteros*, 696 F.2d 980 (3d Cir. 1982) (“A rehabilitation proceeding is an in rem action in which the state court generally has exclusive control over the assets of the impaired insurance company.”).

Plaintiffs claim this Court should disregard Defendants’ concerns, ignoring that an immediate decision in this Court requires Defendants to continue litigating in multiple jurisdictions, whereas a stay allows Defendants to conserve resources in the event a multidistrict court entertains this matter. Plaintiffs ignore, however, that the law of New Jersey—as in Pennsylvania—recognizes the significant harm and risk that arises out of wasting an insurers’ assets.² Public policy and statutory law in both states place significant weight on preserving the assets of a distressed insurer whether it is in rehabilitation or liquidation. See 40 P.S. § 221.5(a) (authorizing actions to avoid, *inter alia*, “waste of the insurer’s assets,” “the obtaining of preferences,” “interference with the receiver or with the proceeding,” “the levying of execution against the insurer, its assets, or its policyholders,” or “any other threatened or contemplated action

² Plaintiffs claim that “Defendants are the parties who created this jurisdictional debacle,” ignoring that Plaintiffs had—and refused—numerous opportunities to act prior to filing the Complaint seeking to stop implementation of the already-approved Plan. Plaintiffs also claim that Defendants want a stay “whilst they continue to violate New Jersey insurance laws,” ignoring that election results have been collected and no policy modifications will be made for many months—long after the consolidation motion and any other motions have been decided. (ECF #15 at 3 (ECF p. 7).)

that might lessen the value of the insurer’s assets or prejudice the rights of policyholders....”); N.J. Stat. § 17B:32-35 (same). For this reason, both Pennsylvania and New Jersey law authorize receivers to seek stays or other relief to avoid waste or diminishment of the insurer’s assets. *See* 40 P.S. § 221.17 (stay “whenever necessary to protect the estate of the insurer”); N.J. Stat. § 17B:32-44 (same). Pennsylvania and New Jersey statutes also evidence their states’ policy in favor of “[i]mproved methods for rehabilitating insurers” and “lessening the problems of interstate rehabilitation.” 40 P.S. § 221.1(c)(v); N.J. Stat. § 17B:32-31. As a result, any unnecessary litigation causes a waste of assets in violation of both Pennsylvania and New Jersey law.

Plaintiffs argue that there is no harm from denying a stay because Defendants’ motion will not be granted, but that is a question for the Judicial Panel on Multidistrict Litigation to decide. Plaintiffs filed their opposition in that Court, and Defendants ask only that this Court allow the process to continue to completion—an event likely to occur quickly, given that briefing has closed and oral argument is scheduled for the end of May. Even on the merits of their arguments, however, Plaintiffs’ argument against a stay must fail, because consolidation will have significant benefits to all parties. Plaintiffs’ claims and Defendants’ responses on the merits will depend on actuarial analyses, both in calculating SHIP’s anticipated future assets and liabilities (and thus its financial health) and in determining the proposed premiums and benefits available for policyholder elections. There can be no dispute that such analyses constitute complex factual questions that require the involvement of experts. *See, e.g., In re Prudential Ins. Co. of Am. Sales Practices Litig.*, 962 F. Supp. 450, 494-495 (D.N.J. 1997) (describing testimony of actuarial experts considered when reviewing class settlement). A court can only find the Plan coercive and harmful if the court understands the alternatives, a question requiring complex analyses of rates, benefits, and outcomes for SHIP and its policyholders. Similarly, discovery as to policyholder outcomes

will be necessary because injunctions are an inherently equitable form of relief. *See, e.g., S.E.C. v. Gentile*, 939 F.3d 549, 555-56 (3d Cir. 2019) (describing equitable nature of injunctions, even those arising by statute and even under “regulatory statutes enforced by government agencies”). The deciding court must consider whether an injunction against Plan implementation would be equitable to the policyholders governed by Plaintiffs’ Complaints and the tens of thousands of other SHIP policyholders. It is clear that discovery will be necessary for each matter to proceed.

Moreover, notwithstanding their claims to the contrary, Plaintiffs clearly intend to take discovery of the Rehabilitator because Plaintiffs have placed the Rehabilitator’s and Special Deputy Rehabilitator’s beliefs and intentions at issue. Plaintiffs named the Commissioner-as-Rehabilitator and Special Deputy Rehabilitator as defendants, an unnecessary step if Plaintiffs were merely seeking to take regulatory action. Plaintiffs here have alleged facts targeted to the knowledge and intention of Defendants, as did plaintiffs in the related actions, including their claim that “Rehabilitator knew or should have known that implementation of the Plan has left its most elderly policyholders with no option but to accept this ultimatum will be successful” and that Rehabilitator has “chosen to ignore” guaranty associations because he “would rather require the elderly policyholders to pay more money or receive less [benefits]”). (ECF #1-1, Compl. ¶ 45.)

The cost and time inefficiencies from duplicative discovery would be a significant burden on Defendants, who have only a limited set of resources available and are obligated to act for the protection of SHIP’s assets and policyholders. As a result, consolidation will inherently work efficiencies, and Plaintiffs cannot show that this Court should decide the remand motion rather than await a decision by the Panel on whether those efficiencies warrant consolidation.

2. A stay does not force policyholders to suffer any harm.

Plaintiffs claim that SHIP’s elderly “policyholders should not have to face a health decision to keep benefits, lose them, or pay increase [sic] rates that have not undergone review by

Commissioner Caride.” As an initial matter, neither Commissioner Caride nor DOBI or any other person or entity can insulate SHIP’s policyholders from the impact of SHIP’s receivership, regardless of whether it proceeds as a rehabilitation or a liquidation. Indeed, as Plaintiffs well know, liquidation is almost certain to result in significant rate increases—just as it did in prior long-term care insurance liquidations. For example, Plaintiff DOBI authorized a rate increase for policyholders of American Network Insurance Company (“ANIC”) when it was liquidated under the supervision of the Pennsylvania courts and the Pennsylvania Insurance Commissioner acting as Liquidator. DOBI explained that, “[b]ecause of ... mispricing and market issues” with ANIC’s policies, DOBI approved rate a increase “possibly in excess of 400%” under calculations that “approximate[d] the cost of similar LTC coverage if it were sold today, and will not recoup past losses under the ANIC policies.” State of New Jersey, Department of Banking & Insurance, *FAQs for American American Network Insurance Company (ANIC) or Penn Treaty Network America Insurance Company Long Term Care (LTC) Insurance Policyholders*, available at https://www.state.nj.us/dobi/division_insurance/solvency/anis_faqs.html (last accessed May 9, 2022). (A copy is attached as Exhibit C). Plaintiffs cannot co-opt the impact of receiverships generally and then declare it a harm uniquely suffered in this case as a result of a stay.

3. A stay does not harm policyholders or Plaintiffs simply because Commissioner Caride does not sit in review of the Pennsylvania Insurance Department and the Commonwealth Court of Pennsylvania.

Plaintiffs similarly cannot show that policyholders are damaged because *Commissioner Caride* did not review and approve the rating methodology used by Defendants and approved by the Commonwealth Court of Pennsylvania. At a minimum, Plaintiffs cite no provision of New Jersey law that authorizes Plaintiffs to insert themselves in receivership proceedings of another state, and likewise cite no provision of New Jersey law requiring review of rates or benefits of

policies of an insurer in receivership in another state.³ But even if these laws *could* apply, Plaintiffs conflate *process* requirements with *substance* requirements, and Plaintiffs cannot show that the rating methodology under the Plan violates the substance of New Jersey law. The statutes cited by Plaintiffs require only that “benefits are reasonable in relation to the premium charged and that the rates are not excessive, inadequate, or unfairly discriminatory.” N.J. Stat. § 17B:27-11. (ECF #15 at ECF p. 10 (citing same).)

Relying on an actuarial memorandum containing the types of data cited in the New Jersey statutes, the Rehabilitator and the Commonwealth Court both concluded that the If Knew methodology was reasonable and actuarially justified, thus satisfying the requirements of New Jersey law. (See Order on Actuarial Memorandum, attached as Exhibit D; Actuarial Memorandum, attached as Exhibit E; PID Approval Letter, attached as Exhibit F; *see also* ECF #7-4, Stay Motion Ex. B, Approval Order at 27 (recognizing that If Knew premium methodology and accompanying 60% lifetime loss ratio were “reasonable in relation to the benefits paid).)⁴ The rating methodology employed by the Plan also complies with the code cited by Plaintiffs, which requires only that “[p]remiums and benefits” for LTC “meet the loss ratio requirements of N.J.A.C.

³ To the contrary, the cited statutes show that Plaintiffs’ authority to review rates is and should be limited to insurers operating in the ordinary course rather than those implementing court-approved rate or benefit changes in receivership. For example, N.J.S.A. § 17B:27-11 notes that rates should not be “inadequate,” an analysis that includes an insurer’s right to profit—*i.e.*, a reasonable rate of return” on the business. *See Matter of Aetna Cas. & Sur. Co.*, 591 A.2d 631, 641-42 (N.J. App. Div. 1991). Unlike a business in the ordinary course, there is no reason to empower the New Jersey Commissioner to reject premium rates for failing to provide for a profit when SHIP is in receivership and under the supervision of the Commonwealth Court of Pennsylvania.

⁴ A “loss ratio” is effectively the percentage of premium payments used to pay claims. *See, e.g., Munich Reins. Am., Inc. v. Am. Nat. Ins. Co.*, 893 F. Supp. 2d 686, 694 n.4 (D.N.J. 2012) (loss ratio is a comparison of losses incurred to premiums charged). Presumably, Plaintiffs would assert that the 55% loss ratio in § 11.4-18.5(a)(4)(ii) applies here because long-term care is guaranteed renewable insurance. The only loss ratio exceeding 60% is not applicable here, as it is limited to over-65 medical or prescription coverage.

11:4-18.5.” Plaintiffs never identify which loss ratio they think must be applied to SHIP’s policies, but the 60% loss ratio of Defendants’ premium rating methodology satisfies any applicable requirement.

Plaintiffs fail to allege any legal or factual defect in the premium rates or benefit modifications that Commissioner Caride’s review could have cured. As a result, Plaintiffs fail to show any harm to New Jersey policyholders from the review and approval process through the Pennsylvania courts. Plaintiffs similarly fail to show that a stay or removal causes any harm to Plaintiffs’ ability to regulate insurers in the ordinary course. (ECF #15-21 (ECF p. 25).) The unique facts of this case—*i.e.*, the filing of a collateral opposition to a court-approved rehabilitation Plan implemented by the Pennsylvania Insurance Commissioner—mean there is no “signal to present and future insurers to refuse to comply with New Jersey laws and run into federal court as a means to shield themselves” from Plaintiffs’ authority. (*Id.*) The distinctions between Defendants here and insurers in the ordinary course are obvious, as insurers *not* in receivership take action without the approval of a court of competent jurisdiction (*i.e.*, the Commonwealth Court) and without the guidance of a regulator to whom deference is given (*i.e.*, Defendant Humphreys). The risk of which Plaintiffs complain exists—if at all—only because Plaintiffs ignore established receivership law by shoehorning their collateral attacks into New Jersey rate-regulation principles. Finding that Plaintiffs cannot attack the Plan has no impact on the future regulation of insurance in New Jersey.

C. Plaintiffs’ injunctions will harm New Jersey’s policyholders, all of whom are within the Commonwealth Court of Pennsylvania’s jurisdiction.

Plaintiffs’ Complaint and supporting briefs offer very little information as to the effect of their injunction on SHIP’s policyholders. Because New Jersey is an opt-in state as a result of Commissioner Caride’s decision not to opt-out, New Jersey’s policyholders have submitted

election responses to the packages mailed by Defendants, and they have made clear what options they wish to pursue as part of SHIP's rehabilitation. As a result, although Plaintiffs' injunction action seeks to undo and overrule policyholder preferences, Plaintiffs never explain how policyholders will benefit in the event injunctions or declaratory orders are entered. Plaintiffs do not assert that they have the authority to stop SHIP's rehabilitation in its entirety, nor do they claim that they can force SHIP into liquidation.

Tellingly, Plaintiffs never address what happens next if New Jersey policyholders' elections are disregarded and SHIP's rehabilitation moves on without New Jersey policyholders. SHIP's policyholders are within the *in rem* jurisdiction of the Commonwealth Court, which has exclusive authority over the distribution of SHIP's assets. *See, e.g., Ballesteros*, 530 F. Supp. at 1370-71 (collecting cases) ("A rehabilitation proceeding is an *in rem* action in which the state court generally has exclusive control over the assets of the impaired insurance company."); *In re Rehab. of Manhattan Re-Ins. Co.*, No. 2844-VCP, 2011 WL 4553582, at *4 (Del. Ch. Oct. 4, 2011) ("[T]his Court does possess original and exclusive jurisdiction over the *in rem* proceedings of the rehabilitation."); *Garamendi v. Exec. Life Ins. Co.*, 21 Cal. Rptr. 2d 578, 583-90 (Cal Ct. App. 1993) (holding "A State Court Overseeing an Insurance Insolvency Proceeding Has *In Rem* Jurisdiction Over the Assets of Third Parties Which Have an 'Identity of Interest' With the Insolvent Insurer.").

It is well settled that a rehabilitation plan may modify policies through a centralized plan. *See, e.g., Underwriters Nat'l Assurance Co. v. N. C. Life & Accident & Health Ins. Guar. Ass'n*, 455 U.S. 691, 696-97 (1982) (discussing approved rehabilitation plan where rehabilitation court increased premiums and reduced benefits despite state regulatory requirements); *Ballestros*, 530 F. Supp. at 1372 (overruling objections to policy restructuring in rehabilitation by out-of-state

policyholder). Indeed, the New Jersey Commissioner of Insurance previously sought and obtained approval of a rehabilitation Plan that involved a modification of policies that also prohibited policyholders from seeking to be excluded from the modification options to avoid unlawful preferences. *See Brooks v. AIG SunAmerica Life Assur. Co.*, 480 F.3d 579, 581 (1st Cir. 2007) (New Jersey rehabilitator obtained approval of plan to offer out-of-state policyholders the option to receive cash value or have their policies restructured); *Matter of Rehab. of Mut. Ben. Life Ins. Co.*, 687 A.3d 1035, 1037-39 (N.J. App. Div. 1997) (barring special treatment for policyholders).

Moreover, there should be no doubt that the Pennsylvania courts had authority over SHIP policyholders and policies. “As a general rule, a court’s decree approving the rehabilitation plan for an insolvent insurer domiciled in its state has a res judicata effect upon out-of-state policyholders so as to preclude a subsequent attack upon the plan in another state.” 1 COUCH ON INS. § 5:31; *see also United States v. Obaid*, 971 F.3d 1095, 1098–105 (9th Cir. 2020) (recognizing “minimum contacts” is not a required component of in rem jurisdiction). SHIP’s policyholders are understood to have “availed themselves of the protection of [Pennsylvania] law regarding insolvent and delinquent insurers,” making the exercise of jurisdiction over them as non-parties proper. *Comm’r of Ins. v. Arcilio*, 561 N.W.2d 412 (Mich. Ct. App. 1997).

As a result, if SHIP’s policyholders in New Jersey are barred from making Plan elections, the *only* possible outcomes are (1) benefit reductions while SHIP is in rehabilitation, with almost no recourse to avoid those reductions, and/or (2) eventual liquidation, where SHIP policyholders could face significant rate increases as well (*see* Exhibit C) but not have the same breadth of options that were available in rehabilitation. Neither outcome is good for policyholders, and this Court should not consider Plaintiffs’ incomplete and ill-conceived arguments unless and until the Judicial Panel on Multidistrict Litigation decides whether to grant the consolidation motion.

CONCLUSION

For the reasons set forth herein and in Defendants’ Motion to Stay and supporting brief, the Motion to Stay should be granted.

Dated: May 9, 2022
Respectfully submitted,

/s/ Michael J. Broadbent

Michael J. Broadbent
COZEN O’CONNOR
1650 Market Street, Suite 2800
Philadelphia, PA 19103
(215) 665-2000

/s/ Leslie Miller Greenspan

Leslie Miller Greenspan
TUCKER LAW GROUP
Ten Penn Center
1801 Market Street, Suite 2500
Philadelphia, PA 19103
(215) 875-0609

*Counsel for Jessica K. Altman,
former Insurance Commissioner of the Commonwealth of Pennsylvania,
as Statutory Rehabilitator of Senior Health Insurance Company of Pennsylvania, Patrick H. Cantilo,
as Special Deputy Rehabilitator of Senior Health Insurance Company of Pennsylvania, and Senior
Health Insurance Company of Pennsylvania*

CERTIFICATE OF SERVICE

I hereby certify that on May 9, 2022, I have caused to be filed DEFENDANTS' REPLY BRIEF IN FURTHER SUPPORT OF THEIR MOTION TO STAY using the Court's ECF system and that copies were served by ECF email on the below counsel:

G. Glennon Troublefield, Esquire
Brian H. Fenlon, Esquire
Sean Kiley, Esquire
Carella, Byrne, Cecchi, Olstein, Brody & Agnello, P.C.
5 Becker Farm Road
Roseland, NJ 07068-1739
gtroublefield@carellabyrne.com
bfenlon@carellabyrne.com
skiley@carellabyrne.com

/s/ Michael J. Broadbent
Michael J. Broadbent

EXHIBIT C



[Home](#) > [Division of Insurance](#) > [Solvency Regulation](#) > FAQs - American Network Insurance Company (ANIC)

FAQs for American Network Insurance Company (ANIC) or Penn Treaty Network America Insurance Company Long Term Care (LTC) Insurance Policyholders

What happened to ANIC and Penn Treaty?

As policyholders were previously notified, the Commonwealth Court of Pennsylvania issued an Order of Liquidation for American Network Insurance Company (ANIC) and Penn Treaty Network America Insurance Company on March 1, 2017. Liquidations are governed by laws specific to troubled insurance companies, but they are similar to bankruptcies. At the time of the liquidation, all ANIC/Penn Treaty LTC policyholders were notified that the future handling of these policies and claims would be transferred to the guaranty associations in the states where ANIC/Penn Treaty LTC policyholders reside, and that those guaranty associations may seek premium increases for the ANIC or Penn Treaty LTC policy to ensure adequate funding to pay future claims. New Jersey's guaranty association is the New Jersey Life and Health Insurance Guaranty Association (NJLHIGA).

Why did ANIC and Penn Treaty need to be liquidated?

ANIC/Penn Treaty mispriced their premiums for the LTC benefits provided under their policies, and when combined with increasing life spans and market circumstances like low interest rates, this resulted in the companies having fewer assets than liabilities. This situation compelled the Pennsylvania court to order liquidation.

What is LHIGA and what does it do?

NJLHIGA is an entity created under New Jersey law (N.J.S.A. 17B:32A-1 et seq.) to pay for the claims of current New Jersey residents under life, health, LTC policies, and annuities issued by insurers allowed to sell in this State, when a court has declared that insurer insolvent and has issued an order of liquidation. NJLHIGA pays claims up to certain monetary limits as set by statute. However, LTC claims are considered health claims and thus have no maximum limit on the total amount that can be paid during the life of the policyholder. The claims assumed by NJLHIGA are funded by insurers writing the same lines of business as the liquidating company – in the case of ANIC/Penn Treaty, it is all other NJ health insurers and LTC writers. Those health and LTC insurers in return receive a state tax credit for a portion of the payments to NJLHIGA. Thus, a good portion of the liquidating company's claims are paid by all New Jersey taxpayers.

Has NJLHIGA requested a premium rate increase?

Yes. NJLHIGA exercised its statutory ability to request premium rate increases for its ANIC policyholders residing in New Jersey, and submitted a plan to provide various options to lessen or eliminate premium increases.

Has a premium rate increase been approved?

Yes. The New Jersey Department of Banking and Insurance (DOBI) has worked with NJLHIGA to ensure

payment of any current or future claims filed by New Jersey residents with ANIC policies, while balancing the costs to all New Jersey LTC and health insurers and all New Jersey taxpayers. After months of review, adjustments and discussion regarding NJLHIGA's premium rate request and plan of policyholder options, the Department has approved a plan for premium increases that allows NJLHIGA to charge increased premiums for ANIC LTC policies to approximate what would be charged for similar coverage in the LTC market today. The Department also required NJLHIGA to offer ANIC LTC policyholders various options to reduce or eliminate any proposed rate increase. All policyholders will receive a written notice of changes to their specific premiums for the ANIC policy that includes an offer to choose reduced benefits in exchange for a lesser or no premium increase, or to surrender their long term care insurance in exchange for a cash payment specified in the offer.

Who is covered by LHIGA and/or impacted by the ANIC premium rate increase?

Current New Jersey residents who hold LTC policies issued by ANIC will be impacted the ANIC premium rate increase. Those NJ ANIC policyholders are protected by NJLHIGA up to the full amount of the policy limit if they continue to pay the increased premium, or to the full amount of any reduced policy limit or cash payment that is selected by those NJ residents in response to the options discussed above.

New Jersey residents with Penn Treaty policies are not impacted by the ANIC premium rate increase, and those Penn Treaty policyholders will be covered by the guaranty fund of its state of domicile, the Commonwealth of Pennsylvania, because Penn Treaty never conducted business in New Jersey.

Former New Jersey residents with ANIC policies purchased in New Jersey who now live elsewhere will be impacted by the [premium rate increase; however, their claims will be paid by the guaranty association of their current state of residence.

Should I still pay my ANIC/PT premiums? Do I need to send those payments to a new address?

To be eligible for NJLHIGA coverage, it is very important that ANIC policyholders continue paying their policy premiums in full and on time. Unless otherwise notified by ANIC or LHIGA, premium payment methods and payment addresses, as well as policy and claims administration contact numbers, remain the same.

Why are these premium increases and LTC policy term adjustments being requested now?

Previously, the premiums ANIC/Penn Treaty charged were far below the cost of the benefits that had been promised. This partly contributed to the need to liquidate the companies. The LTC industry as a whole made assumptions about future costs and priced premiums based upon those assumptions. While premiums remained stable for many years, increases in how long people live, the level of LTC care needed, the cost of long term care services, and other changes in the economy – like sustained low interest rates – during the last decade proved earlier assumptions inaccurate. Therefore, the LTC policies for ANIC and Penn Treaty were mispriced. These developments have affected every company offering LTC plans and required all companies to reevaluate the premiums needed to ensure claims payments were made.

Are these premium increases related to my claims history or the amount of my expected claims?

No. When LTC plan premium adjustments such as this prove necessary, they must be based on the insurer's "class" or "category" of policies, meaning increases are instituted by product and may not be related to the claims history or expected claims of any individual policyholder.

How much will my premium increase be?

Here in New Jersey, as in many other states, the amount needed to pay LTC policy claims will be borne by other insurance companies, their policyholders, and State taxpayers. NJLHIGA estimates the costs in New Jersey alone to be approximately \$211 million over several years. Because of the mispricing and market issues discussed above, New Jersey resident ANIC policyholders can expect very significant premium increases, possibly in excess of 400% of the premium charged for current coverage. These amounts will approximate the cost of similar LTC coverage if it were sold today, and will not recoup past losses under the ANIC policies. As noted above, affected policyholders will be given options to reduce or eliminate these increases by choosing lower levels of coverage, or by surrendering their policy in exchange for cash.

What is happening in other states?

The LTC claims of ANIC and Penn Treaty combined are expected to total approximately \$4.5 billion nationwide, and New Jersey is only one of over forty states affected. Many other states' guaranty funds are filing similar premium rate increase requests and each will be evaluated by their states' Insurance Departments.

Do I need to seek financial advice?

It is important to closely review the options in the notice of the premium increase and to seek any needed financial, legal and/or tax advice. Certain options, such as a lump-sum cash payment, may have other financial planning consequences.

What are the typical costs to obtain LTC in New Jersey?

LTC costs are substantial and typically outstrip cumulative LTC plan premium payments. Presently, the cost for long term care in New Jersey can exceed \$65,000 a year. The average length of stay in a long term care facility is two-and-a-half years.

Can I shop around for other LTC plans?

Yes. No matter which option policyholders choose, they can also evaluate other plans made available from other insurers.

How do I get help with an existing ANIC LTC policy or a current claim?

For questions about an existing ANIC LTC claim or policy please contact the ANIC/Penn Treaty Policy Service Center at: 1-800-362-0700.

If I need to make an inquiry or file a complaint with DOBI on the handling of my ANIC LTC claim or policy, what should I do?

Consumers may contact the Department at 1-800-446-7467 or 609-292-7272 or go online to: www.state.nj.us/dobi/consumer.htm.

Where can consumers get more information about LTC coverage?

More general information about LTC coverage is available at: www.state.nj.us/dobi/ins_ombudsman/ltcguide.htm.



OPRA is a state law that was enacted to give the public greater access to government records maintained by public agencies in New Jersey.



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New Jersey Department of Banking and Insurance

EXHIBIT D

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

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

ORDER

AND NOW, this 2nd day of February, 2022, upon consideration of the Rehabilitator's Application for Order Regarding Actuarial Memorandum and Premium Rates in Phase One (Application), to which no response has been filed, and upon consideration of the Actuarial Memorandum and approval thereof by Shannen M. Logue, Deputy Insurance Commissioner, Office of Product Regulation, the Court finds as follows:

(1) The Rehabilitator has complied with the requirements stated in paragraphs 3 and 4 of the Court's order entered August 24, 2021, approving the Second Amended Plan of Rehabilitation, now known as the Approved Plan. The Rehabilitator submitted the Actuarial Memorandum in support of the "If Knew Premium" rating methodology to be used in Phase One of the Approved Plan to the Pennsylvania Insurance Department (Department) for review and approval, and the Department has approved the Actuarial Memorandum.

(2) The Court accepts and adopts the Department's conclusion that the "If Knew Premium" rating methodology is actuarially justified, not unfairly discriminatory, and reasonable in relation to the benefits paid. The Rehabilitator has established the reasonableness of the premium rates charged, and the use and application of the "If Knew Premium" rate is a proper exercise of her discretion.

Accordingly, the Court ORDERS as follows:

(1) The Rehabilitator's Application is GRANTED.

(2) The Rehabilitator is authorized to use the premium rates proposed for Phase One (i) for all policies issued in any state which affirmatively opted in to the Approved Plan; (ii) for all policies issued in any state which is deemed by the Rehabilitator to have opted in to the premium rate modification provisions of the Approved Plan by its inaction or its failure to comply with the opt-out requirements set forth in the Approved Plan; and (iii) for the calibration of benefit adjustments for all policies issued in any state that has opted out of the premium rate modification provisions of the Approved Plan.

(3) This order in no way affects the provisions of the Court's order of August 24, 2021, approving the Approved Plan.

s/Mary Hannah Leavitt

MARY HANNAH LEAVITT, President Judge Emerita

EXHIBIT E



REHABILITATION PLAN OF SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA

*PREMIUM RATING AND INSURANCE LIABILITY
RESTRUCTURING: ACTUARIAL CONSIDERATIONS*

Pennsylvania Insurance Department

October 14, 2021

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Similarly, our industry is very competitive. We view our approaches and insights as proprietary and therefore look to our clients to protect our interests in our proposals, presentations, methodologies and analytical techniques. Under no circumstances should this material be shared with any third party without the prior written consent of Oliver Wyman.

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Laura Slaymaker, Esq.
Deputy Insurance Commissioner
Office of Liquidations, Rehabilitations and Special Funds
Pennsylvania Insurance Department

Patrick Cantilo, Esq.
Special Deputy Rehabilitator, on behalf of
Pennsylvania Insurance Department

Robert Robinson
Chief Rehabilitation Officer, on behalf of
Pennsylvania Insurance Department

October 14, 2021

**Rehabilitation Plan of Senior Health Insurance Company of Pennsylvania
Premium Rating and Insurance Liability Restructuring**

Ms. Slaymaker, Mr. Cantilo and Mr. Robinson:

This report describes actuarial considerations and methodologies associated with If Knew Premium rating, Self-Sustaining Premium rating, and the insurance liability restructuring associated with the Rehabilitation Plan of the Senior Health Insurance Company of Pennsylvania ("SHIP"). We are seeking the Pennsylvania Insurance Department's approval of the calculation methodology underlying the insurance liability restructuring.

Section 1 provides background and the scope of our work. Section 2 provides a high-level overview of the Rehabilitation Plan Options and Phases. If Knew Premium rating is described in Section 3. Self-Sustaining Premium rating is described in Section 4. Insurance liability restructuring is described in Section 5.

Section 6 specifies the distribution and use of this report. Section 7 defines the limitations and restrictions on the usage of this report.

The purpose of this report is to explain the aforementioned methodologies and demonstrate that they represent actuarially justifiable methodologies. As such, the report is considered a statement of actuarial opinion under the guidelines promulgated by the American Academy of Actuaries. The Oliver Wyman professionals responsible for developing this report are members of the Academy and meet the Qualification Standards of the Academy to render the statements and opinions contained herein.

Sincerely,

A handwritten signature in black ink that reads 'Dean Kerr'.

Dean Kerr, FSA, MAAA, ACIA
Partner

A handwritten signature in black ink that reads 'Dustin Plotkin'.

Dustin Plotkin, FSA, MAAA, ACIA
Principal

A handwritten signature in black ink that reads 'Stephanie Moench'.

Stephanie Moench, FSA, MAAA
Senior Consultant

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1. BACKGROUND AND SCOPE

The Pennsylvania Insurance Department (“PID”) retained Oliver Wyman Actuarial Consulting, Inc. (“Oliver Wyman”, “we”, or “us”) to provide actuarial services in support of the Rehabilitation Plan (“Plan”) of Senior Health Insurance Company of Pennsylvania (“SHIP”). On January 29, 2020, SHIP was placed in rehabilitation by the Commonwealth Court of Pennsylvania. The Pennsylvania Insurance Commissioner, acting in her capacity of Statutory Rehabilitator, submitted an initial draft of the Plan on April 22, 2020, an amended version of the Plan on October 21, 2020, a second amended version of the Plan on May 3, 2021, and an approved version of the Plan on September 30, 2021.

SHIP’s insurance business (the “Block”) contains long-term care (“LTC”) policies that were primarily issued in the 1990s. SHIP ceased issuing new policies in 2006. The Block consists of 35,692 in-force lives and \$52 million of annualized premium¹ as of July 31, 2021.

The Plan requires actuarial calculations that will be used for several purposes, including but not limited to: (1) the measurement of SHIP’s current liabilities, (2) the liabilities that may emerge under various Plan outcome scenarios, and (3) the development of premium rates for several options that will be offered to policyholders in rehabilitation.

This report describes actuarial considerations and methodologies associated with If Knew Premium rating, Self-Sustaining Premium rating, and insurance liability restructuring associated with the Plan.

This report is considered a statement of actuarial opinion under the guidelines promulgated by the American Academy of Actuaries (the “Academy”). The professionals responsible for developing this report are members of the Academy and meet the Qualification Standards of the Academy to render the opinion contained herein.

This report and the information contained herein are furnished solely for PID’s internal use. They shall not be disclosed in whole or in part to any third party without Oliver Wyman’s prior written consent.

The values and conclusions discussed in this report are subject to the limitations described in Section 7 of this report.

¹ Policies assumed from Transamerica, Primerica, and American Health and Life (the “Assumed Policies”) will not be modified under the Plan. In-force lives and annualized premium figures exclude assumed business. Additionally, the annualized premium amount does not include policies that are in nonforfeiture status or have a lifetime waiver of premium.

2. REHABILITATION PLAN OVERVIEW

The Plan presents several policy modification options (“Options”) to SHIP’s policies.

The Plan will operate in three phases. The steps to implement Phase One will commence following the Plan's approval and will present five Options to policyholders:

1. **Option 1:** Continue paying the current premium rate but, if it is less than the “If Knew Premium Rate” (described in Section 3), have benefits reduced in accordance with Plan provisions so that the premium for the reduced benefits on an If Knew Premium Rate basis is equal to the current premium rate.
2. **Option 2:** Select a standardized set of policy endorsements that provide essential benefits at a lower premium rate than Option 4. Specifically, the premium rate charged will be the If Knew Premium Rate corresponding to the policy's benefits after implementing the endorsements.
3. **Option 2a:** An enhanced version of Option 2 in which richer benefits will be available at a higher premium rate.
4. **Option 3:** Receive a non-forfeiture option (“NFO”) through which the policyholder will receive a Reduced Paid-Up (“RPU”) policy providing limited benefits, but for which SHIP will charge no future premiums. Policyholders who elect this Option will never pay additional premiums, and their policies will never lapse.
5. **Option 4:** Retain the current policy benefits and pay the greater of the If Knew Premium Rate (associated with their current policy benefits) and the current premium rate.

The Plan will provide policies issued in states that formally opt out of the Plan’s modification of premium rates an alternative set of options in Phase One upon approval by the Rehabilitator and the Commonwealth Court (“Opt-out States”). The premium rating methodology for Opt-out States in Phase One is also on an If Knew Premium rating basis, consistent with the definition in Section 3 below.

SHIP has 8,116 policies that are in NFO status as of July 31, 2021. These policies will never pay a premium and will not be subject to modification by the Plan.

In addition, there are 9,608 policies subject to the Plan as of July 31, 2021 for which the current premium rates are no less than the corresponding If Knew Premium Rates. These policyholders can elect Plan Option 4 to maintain their current benefits without requiring a premium rate increase in Phase One. Option 4 is the default Plan Option for policies with current premium rates that are no less than the corresponding If Knew Premium Rates.

In Phase Two, the Rehabilitator will evaluate the results of Phase One and will determine if additional policy modifications are necessary for certain cohorts of policies. The Plan will use “Self-Sustaining Premiums” (described in Section 4) to make such modifications. The specific details and calculation methodologies for Phase Two of the Plan are subject to change depending on the circumstances following Phase One.

In Phase Three, SHIP will complete its run-off of the Block. The methodology of Phase Three is outside the scope of this report.

3. IF KNEW PREMIUM RATING

3.1. Background

The Plan prescribes the use of an If Knew Premium rating methodology to calculate premium rates in Phase One. The principle underlying If Knew Premium rating is that it represents the premium rate that would have been requested at policy issue had current assumptions been used in original pricing. Under this approach, policies are re-priced such that premiums would be adequate on a lifetime basis, but past losses are not recuperated.

The If Knew Premium Rate described in the Plan is the premium rate that, if applied from policy issue, achieves an expected lifetime loss ratio of 60%.

3.2. Calculation methodology

If Knew Premium Rates are calculated on a seriatim basis based on each policyholder's individual characteristics (e.g., gender, issue age) and product features (e.g., benefit period, inflation protection), and without regard to a policyholder's current attained age, state of issue, state of residence, health conditions, or premium-paying status.

If Knew Premium Rates are calculated using the following methodology:

1. Assume all in-force policyholders who are subject to the Plan to be active and premium paying.
2. Calculate the present value ("PV") of benefits and premiums for each policy, as of its original policy issue date, under SHIP's best estimate actuarial assumptions, as documented in Oliver Wyman's Assumption Report dated August 24, 2021.
 - a. Current premium, which may differ from the premium at policy issue, is used in this calculation.
 - b. Current product features and benefit coverages are reflected in this calculation.
3. Calculate the ratio of PV of benefits divided by PV of premiums for each policy. Divide this value by a 60% target loss ratio to determine the If Knew Premium Rate factor.
4. Set each policy's If Knew Premium Rate to the current premium rate multiplied by the If Knew Premium Rate factor.

The above methodology is represented formulaically as follows:

$$\text{If Knew Premium Rate}_{\text{policy}} = \text{Current Premium Rate}_{\text{policy}} \times \frac{\text{PV benefits}_{\text{policy}} / \text{PV premiums}_{\text{policy}}}{\text{Target Loss Ratio (60\%)}}$$

3.3. Rehabilitation Plan usage

If Knew Premium rating is used in Phase One for all premium calculations associated with Plan Options 2, 2a, and 4. If Knew Premium rating is also used to determine benefit reductions associated with Option 1 of the Plan.

Benefit reductions under Option 1 are calibrated such that the If Knew Premium Rate for the reduced benefits is equal to the current premium rate.

The premium rate under Options 2 and 2a is the If Knew Premium Rate under the Basic Policy or Enhanced Basic Policy endorsements, respectively. The calculation methodology for these options is consistent with that described in Section 3.2, with the exception that the If Knew Premium Rate is based on a policy's benefits after implementing the endorsements.

Unless it is already at or above that rate, the premium rate associated with Option 4 is the If Knew Premium Rate based on current product features and benefit coverages.

Policies on waiver of premium as of the Phase One Effective Date are only required to pay an If Knew Differential Premium, calculated as the difference between the If Knew Premium Rate and the current premium rate (i.e., the premium rate prior to Phase One).

Policies issued in Opt-out States will be offered an alternative set of options. Premium and benefit reductions under these options will be calculated using the If Knew Premium rating methodology in Phase One of the Plan.

3.4. Rationale for use

If Knew Premium rating is one of several common actuarial methodologies used in part or in whole for premium rate re-pricing. The mechanics of the calculation are analogous to a net level premium calculation often used in the determination of statutory reserves. If Knew Premium rating or similar methodologies are often requested of insurers seeking LTC premium rate increase by state insurance departments as a comparator to the rating methodologies employed by insurers. Further, the use of If Knew Premium rating has precedence under similar circumstances to SHIP: it was the methodology used to set premiums in the liquidation of Penn Treaty.

A key element of If Knew Premium rating is that it does not seek to recuperate potential past losses incurred by the company; rather, it re-prices policies adequately on a lifetime basis using current actuarial assumptions. In general, If Knew Premium rating results in premium rates that are lower than other common methodologies used by insurers seeking premium rate increases.

Finally, the Plan employs the If Knew Premium rating methodology on a seriatim basis. This means that a distinct premium rate is determined for each individual policy based on individual policy characteristics and product features without regard to a policyholder's current attained age, state of issue or state of residence. In doing so, the Plan does not take into account the policyholder's current state of health. Performing the If Knew Premium calculation on a seriatim basis, rather than on a grouped basis, reduces the potential for premium rate subsidization within and across different cohorts of policies.

4. SELF-SUSTAINING PREMIUM RATING

4.1. Background

In the event Phase One of the Plan does not eliminate the company's deficit, the Plan prescribes the use of a Self-Sustaining Premium rating to calculate policy premiums and benefits in Phase Two.

Self-Sustaining Premium Rates are the projected premium rate levels required to eliminate any remaining deficit after Phase One of the Plan. A policy is considered Self-Sustaining if its projected future premium payments and Allocable Assets (as defined in Section 4.2) equal or exceed its projected future benefits and expenses.

Please note that the specific details and calculation methodologies for Phase Two of the Plan are subject to change depending on the circumstances following Phase One.

4.2. Calculation methodology

Similar to If Knew Premium Rates, Self-Sustaining Premium Rates are calculated on a seriatim-basis based on each policyholder's individual characteristics (e.g., gender, issue age) and product features (e.g., benefit period, inflation protection), and without regard to a policyholder's current attained age, state of issue, state of residence, health conditions, or premium-paying status.

Self-Sustaining Premium Rates take into consideration the company's deficit, asset balance, and cumulative premium paid (or waived) for each policy.

Self-Sustaining Premium Rates are calculated using the following methodology:

1. Assume all in-force policyholders who are subject to Phase Two modifications (as defined in Section 4.3) are active and premium-paying.
2. Calculate Gross Premium Reserves ("GPV") for each policy as of the Phase Two Effective Date under SHIP's best estimate assumptions. GPV is defined as the PV of future benefits, plus the PV of future expenses, minus the PV of future premiums.
3. Notionally allocate assets to each policy as of the Phase Two Effective Date using the following formula:

$$\text{Allocable Assets}_{\text{policy}} = \text{Allocable Assets}_{\text{aggregate}} \times \frac{\text{Accumulated Premium}_{\text{policy}}}{\text{Accumulated Premium}_{\text{aggregate}}}$$

Allocable Assets is defined as SHIP's book value of invested assets less a portion set aside to pay for costs and expenses of administration, contingencies, accrued but unpaid claim payments, and certain debts of higher priority. Accumulated Premium is the sum of all premiums paid and waived from issue for in-force policies, without allowance for interest. Aggregate values reflect all in force lives (i.e., active and disabled lives).

4. Calculate the Shortfall Amount for each policy as the difference between its GPV and Allocable Assets.
 - a. A redundancy exists if the Shortfall Amount is below zero. When this occurs, the redundancy is allocated on a pro-rata basis to policies with a positive Shortfall Amount.

5. Set each policy's Self-Sustaining Premium Rate to the premium rate that would eliminate its remaining Shortfall Amount (after any pro-rata redundancy allocation), based on the following formula:

$$\text{Self-Sustaining Premium Rate}_{\text{policy}} = \text{Phase One Premium Rate}_{\text{policy}} \times \left(1 + \frac{\text{Shortfall Amount}_{\text{policy}}}{\text{PV premiums}_{\text{policy}}} \right)$$

where Phase One Premium Rate is the premium rate applicable to each policy at the conclusion of Phase One. PV premiums is the present value of future Phase One premiums.

Policies on waiver of premium as of the Phase Two Effective Date are only required to pay a Self-Sustaining Differential Premium, calculated as the difference between the Self-Sustaining Premium Rate and the current premium rate (i.e., the premium rate prior to Phase One). As a result, premiums paid by policies on waiver are insufficient to cover their entire Shortfall Amount (if a Shortfall Amount exists); thus, an aggregate multiplicative factor is applied to the Self-Sustaining Premiums of all policies (including those on waiver) to ensure that the sum of total projected premiums (based on SHIP's best estimate assumptions) is sufficient to cover the total Shortfall Amount.

4.3. Rehabilitation Plan usage

The Plan will use Self-Sustaining Premiums to determine Phase Two policy modifications in a manner that is similar to the Plan's use of If Knew Premium Rates in Phase One (refer to Section 3.4). Self-Sustaining Premium rating is used in Phase Two for all premium calculations associated with Plan Options 2, 2a, and 4. Self-Sustaining Premium rating is also used to determine benefit reductions associated with Option 1 of the Plan.

The Plan exempts from Phase Two modifications any policy satisfying at least one of the following three criteria.

1. Policies who elect Options 2, 2a, or 3 in Phase One of the Plan.
2. Policies that are Self-Sustaining after Phase One of the Plan.
3. Policies whose benefits are fully covered by applicable Guaranty Associations after Phase One of the Plan (i.e., policies that have a Maximum Policy Value below Guaranty Association limits, where Maximum Policy Value is as defined in the Plan).

Similar to Phase One of the Plan, policies issued in Opt-out States will be offered an alternative set of options in Phase Two. Premium and benefit reductions associated with Opt-out State options will be calculated using the Self-Sustaining rating methodology. Separate pools of assets will be determined for use in the calculation of the total Shortfall Amount for Opt-in and Opt-out States. Assets will be allocated between the two pools in proportion to the Accumulated Premium paid by the policies in each pool.

4.4. Rationale for use

The goal behind Self-Sustaining Premium rating is to eliminate any shortfall that may remain at the conclusion of Phase One of the Plan. Self-Sustaining premium rating determines premium rates that are projected (based on SHIP's best estimate assumptions) to fund in-force policies without additional future premium rating activities.

Please note that the specific details and calculation methodologies for Phase Two of the Plan are subject to change depending on the circumstances following Phase One.

5. INSURANCE LIABILITY RESTRUCTURING

5.1. Background

As part of the Plan, policyholders will make policy elections that will consequently reduce SHIP's statutory and tax liabilities through a combination of modifications to premiums and benefits. A significant and immediate reduction in SHIP's liabilities is anticipated upon the effective date associated with Phase One and subsequently upon the effective date associated with Phase Two.

In order to minimize adverse federal income tax consequences to SHIP and its policyholders stemming from rehabilitation, policy liabilities will be restructured in accordance with the yet-to-be-completed Rehabilitator's Statement Regarding Restructuring of Insurance Liabilities in Rehabilitation ("Restructuring Statement"). The planned restructuring will not affect any policyholder's or other creditor's rights under the Plan or the obligations of any State's Guaranty Association ("GA").

The purpose of this section of Oliver Wyman's Report is to provide additional detail behind the actuarial calculations described in the Restructuring Statement, including the use of a Premium Deficiency Reserve ("PDR") to mitigate unintended federal income tax consequences associated with the multi-phased Plan.

Please note that Oliver Wyman is not qualified to offer tax advice, and this report does not constitute tax advice.

5.2. Calculation methodology

Per the anticipated Restructuring Statement (of which Oliver Wyman was furnished a draft), policy liabilities, as measured on a GPV basis, will be bifurcated into unfunded and funded components as of the restructuring Effective Date ("ED").

The unfunded component is referred to as the Unfunded Benefit Liability ("UBL"). The funded component is referred to as the Initial Funded Restructured Policy Value ("IFRPV"). Further details are provided in the Restructuring Statement.

5.2.1. Initial Funded Restructured Policy Value

IFRPV will first be calculated at the aggregate level and subsequently allocated to the policy level.

The company level IFRPV will be calculated using the following formula:

$$IFRPV_{aggregate} = Allocable\ Assets_{aggregate}$$

where Allocable Assets is determined as of the restructuring ED and is defined in Section 4.2. IFRPV will be further allocated to the policy-level based on the following formula:

$$IFRPV_{policy} = Allocable\ Assets_{aggregate} \times \frac{Accumulated\ Premium_{policy}}{Accumulated\ Premium_{aggregate}}$$

where Accumulated Premium is determined as of the restructuring ED and is defined in Section 4.2.

IFRPV will be measured on an ongoing basis in accordance with SHIP's financial monitoring activities while in rehabilitation and will not be "locked in" as of the restructuring ED.

5.2.2. Statutory and Premium Deficiency Reserves ("PDR")

Due to the multi-phased nature of the Plan, which is anticipated to occur over multiple years, a mechanism in the actuarial liability calculation is required to mitigate unintended federal income tax consequences that could otherwise negatively impact SHIP and its policyholders in rehabilitation.

A PDR will be used as the mitigant, as fluctuations in PDR do not influence federal income tax calculations. The PDR will be calculated using the following formula:

$$PDR_{aggregate} = \text{Max} [GPV_{aggregate} - IFRPV_{aggregate}, 0]$$

The PDR will be measured on an ongoing basis in accordance with SHIP's financial monitoring activities while in rehabilitation and will not be "locked in" as of the restructuring ED.

The PDR will be allocated to all active (i.e., non-disabled) policies in proportion to their IFRPV using the following formula:

$$PDR_{policy} = PDR_{aggregate} \times \frac{IFRPV_{policy} (active\ lives)}{IFRPV_{aggregate} (active\ lives)}$$

As of the restructuring ED, the PDR will be equivalent to the UBL (as defined in Section 5.2.3). The PDR is anticipated to decrease as policyholders make elections through each Phase of the Plan. The PDR will be eliminated when SHIP's overall GPV reduces to the level of its IFRPV (or Allocable Assets). This would occur in the event SHIP's overall liabilities become Self-Sustaining, as described in Section 4 of this report.

Consistent with SHIP's existing financial reporting activities, statutory reserves will continue to be determined on a GPV basis (since minimum reserves, as defined in the National Association of Insurance Commissioners ("NAIC") Model Regulation 010, are insufficient). However, as part of the liability restructuring, minimum reserves will no longer be calculated in accordance with NAIC Model Regulation 010 and will instead be set equal to IFRPV. As indicated above, aggregate GPV liability in excess of IFRPV will be held as a PDR.

5.2.3. Unfunded Benefit Liability

The UBL will be calculated using the following formula:

$$UBL_{aggregate} = GPV_{aggregate} - IFRPV_{aggregate}$$

The UBL will be measured once as of the restructuring ED and will be "locked in" as of that date (i.e., unlike IFRPV and PDR, UBL will not be remeasured unless a subsequent restructuring event occurs).

5.3. Rehabilitation Plan usage

Per the Restructuring Statement, "in due course coverage attributable to the unfunded portion of policyholder liabilities will be converted into separate SHIP indebtedness to the policy owners".

The restructuring will not affect any policyholder's or other creditor's rights or the obligations of any State's GA. Premiums, premium rate modifications, benefits, and benefit modifications associated with the Plan are not influenced by the liability restructuring.

5.4. Rationale for use

Policy liability restructuring, as described in the Restructuring Statement, including the additional specifications described in this report, is required to minimize adverse federal income tax consequences to SHIP and its policyholders because of the multiple phases of the Plan.

We believe the calculation methodology described in this report to be in accordance with NAIC Actuarial Guideline XXIX, which specifies that the *“minimum reserve requirements should be interpreted in the context of court-ordered contract restructuring to result in the most appropriate reserves under the particular circumstances. In general, this should be left to the regulators to determine”*.

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The findings contained in this report contain predictions based on current data and historical trends. Any such predictions are subject to inherent risks and uncertainties. Oliver Wyman accepts no responsibility for actual results or future events.

The opinions expressed in this report are valid only for the purpose stated herein and as of the date of this report. No obligation is assumed to revise this report to reflect changes, events or conditions, which occur subsequent to the date hereof.

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The opinions expressed in this report are valid only for the purpose stated herein and as of the date of this report. No obligation is assumed to revise this report to reflect changes, events, or conditions, which occur subsequent to the date hereof.

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Oliver Wyman
3560 Lenox Road
Suite 2400
Atlanta, GA 30326
United States

EXHIBIT F



TO Commissioner Jessica K. Altman, Pennsylvania Insurance Commissioner

FROM Shannen M. Logue, Deputy Insurance Commissioner

DATE November 4, 2021

RE Rehabilitation Plan of Senior Health Insurance Company of Pennsylvania, Actuarial Memorandum on Premium Rating and Insurance Liability Restructuring

My division has reviewed the Actuarial Memorandum submitted by Oliver Wyman Actuarial Consulting, Inc. ("Oliver Wyman") regarding Senior Health Insurance Company of Pennsylvania ("SHIP") and proposed Premium Rating and Insurance Liability Restructuring, which describes the actuarial considerations and methodologies associated with If Knew Premium rating, Self-Sustaining Premium rating, and the insurance liability restructuring recommended for the Rehabilitation Plan of SHIP (see attached).

The Pennsylvania Insurance Department ("PID") actuarial staff under my deputate and I acknowledge and approve the actuarial considerations and calculation methodologies underlying the insurance liability restructuring approach presented by Oliver Wyman. Several options under Phase One adjust benefits or premiums to align them with the If Knew re-rating methodology. The If Knew re-rating method calculates the premium, which if paid from policy inception, would produce the desired 60% lifetime loss ratio. The If Knew method uses the current best estimate for morbidity, persistency, and interest rather than the assumptions used in the original pricing. Under the If Knew methodology, policies are re-priced such that premiums would be adequate on a lifetime basis, but past losses are not recuperated. The methodology is actuarially justified and appropriate.

PID acknowledges that the Self-Sustaining Premium rating considered in Phase Two is an acceptable approach to project a self-sustaining premium. A policy is considered self-sustaining if its future premium payments and Allocable Assets are equal or exceed its projected future benefits and expenses. The methodology is actuarially justified and appropriate.

It is our opinion the presented approach is actuarially justified, is not unfairly discriminatory, and it demonstrates that the rehabilitation plan must use multiple measures to address SHIP's liability issues.

Shannen M. Logue

A handwritten signature in black ink, appearing to read 'Shannen M. Logue'.

Deputy Insurance Commissioner, Office of Product Regulation