SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA, IN REHABILITATION

UNDERSTANDING LONG-TERM CARE INSURANCE AND THE APPROVED REHABILITATION PLAN

I. LONG-TERM CARE INSURANCE

Long-term care insurance is a relatively new insurance product first developed in the 1970s and 1980s to cover long-term care services as an alternative to Medicaid and Medicare for those whose financial condition made them ineligible for government funded long-term care or who preferred and could afford more generous coverage. Covered services include 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 eligibility requirements vary but typically include things like the policyholder requiring care for at least 90 days and having cognitive impairment and/or being unable to perform two or more Activities of Daily Living (eating, dressing, bathing, transferring, toileting, and continence) without substantial assistance (hands on or standby).

As developed initially, long-term care insurance policies were generally expected to mirror life insurance lapse rates and to generate few claims in their early years with the expectation of large claims in later years. The concept behind the product was that the issuing insurer will collect large sums in premiums during that early phase, investing what is not used for administration to create a fund from which claims will be paid in the policies' later years. The policies turned out to have lower lapse rates than expected and tend to have long duration, often lasting twenty and thirty years, or more. They were conceived as "level premium" products, the idea being that when the initial premium was calculated for a block of policies, it would suffice (together with investment income) to fund benefits due in the future. While the policies reserved the right for the insurer to increase those premiums, generally that could only be done with regulatory approval and for all similar policies in the same amount. Unlike health insurance, long-term care insurance premiums were not routinely adjusted annually or semi-annually. As a result, when they purchased the policies, many policyholders came to believe that premiums would remain steady or rise only moderately over the life of the policies.

Key characteristics of these insurance policies included that premiums could never change due to an insured's changing individual circumstances, such as age and health condition and that the policies did not have a cash or surrender value. In addition, the policies are non-cancelable or guaranteed renewable so that, as long as the policyholder pays the required premium, the insurer cannot cancel the coverage.

Given these features, establishing an adequate premium when the policies were first sold was particularly important. However, when this type of insurance was first developed, historical

morbidity data did not exist permitting accurate predictions of how much premium would be required to fund eventual benefits. The amount of premium required depended on certain key forecasts, including:

1. Mortality - how many insureds would pass away during a given year;
2. Lapses - how many policies would terminate in a given year due to non-payment of premium, exhaustion of covered benefits, or death;
3. Morbidity - how many insureds would become ill and require care;
4. Claims incidence - how many claims for benefits would arise in a given year;
5. Claims severity - how much it would cost to pay for the required care;
6. Claims duration - how long insureds would require covered care; and
7. Investment yield - how much money the insurer would earn from investing premiums collected.

Over time it became evident that initial assumptions about these factors were often inaccurate. For example, improvements in general health resulted in policyholders living longer than anticipated so that more policies would remain in force longer than expected and more insureds would live long enough to require benefits than anticipated. Similarly, the products proved more popular than expected so that voluntary terminations or lapses occurred less often than expected and, as a result, more people remained insured long enough to require claim payments.

Moreover, unexpected changes in the capital markets resulted in lower investment yields than had been projected when the premiums were first set. Cost of care also proved to be higher than anticipated, pacing ahead of inflation, and at times due to unexpected developments in the industry. Thus, when long-term care insurance was first developed, insureds needing care generally had two options: receive care at home from a family member or professional caregiver (generally at moderate cost) or be confined to a nursing home (typically at a higher cost), which was often viewed as a last resort due to the checkered reputation of the nursing home industry. However, astute entrepreneurs saw an opportunity and there developed in the early part of this century a blossoming assisted living industry. Assisted living facilities provided an attractive third option for care, being far more desirable than nursing homes and far more expensive than home health care. The language of long-term care insurance policies was such that confinement in assisted living facilities was also covered and presented an unexpected cost for the insurers. In the past decade, the insurers left in the market began to innovate product designs, looking for more affordable options. More recent policies tend to include more home care or informal care options and to emphasize allowing consumers more flexibility in selecting site-of-care options. However, these developments emerged after SHIP ceased selling new policies. SHIP's "legacy" policies generally have the characteristics that are now recognized to produce far more potential liability than widely affordable premiums can fund.

As insurers came to realize that the premium they were charging would prove inadequate, they began seeking approval for premium rate increases from state insurance regulators. These efforts to raise premium rates met with a lot of resistance from consumers and regulators and the

companies were generally unable to raise their rates sufficiently to provide for future benefits. In addition to inadequate rates, distortions emerged as some regulators approved larger rate increases than others. Over time, it became common for two policyholders in similar condition and with similar policies to pay vastly different premiums. Some observers came to characterize this as a subsidization problem in the sense that policyholders whose premiums had been raised more than others were essentially making up for those whose premiums remained too low.

Of course, policyholders were largely unaware of these issues, being at most only aware that their "level-premium" policies were becoming unexpectedly expensive, but in widely varying degrees. As these problems became better understood in the insurance industry, many insurance companies stopped selling these products so that fewer than a dozen companies of any size do so today, down from over one hundred when the industry was at its peak. SHIP is one of several insurers that hold "legacy blocks" of older long-term care insurance policies that today are woefully underpriced. The factors described above account for much of its current deficit. Because SHIP's is a "closed block" (with no new policies being sold for quite some time), it is unable to count on premium from new policies to help defray the cost of the existing policies.

II. SHIP HISTORY

SHIP dates back to 1887 when it was the Home Beneficial Society. Around a century later it began selling long-term care insurance as American Travelers Life Insurance Company. In 1996 it became part of Conseco, Inc. (a large group of insurance companies that became the third largest bankruptcy in U.S. history in 2002)[1] and was renamed Conseco Senior Health Insurance Company. By 2003, it had sold more than 645,000 long-term care policies. At that time it discontinued new business and went into runoff as Conseco Senior Health Insurance Company. In 2008 it was spun-off as Senior Health Insurance Company of Pennsylvania. From then on it was overseen by the newly formed Senior Health Care Oversight Trust comprised of four former chief insurance regulators and a consulting actuary.

By 2017, the Pennsylvania Insurance Department became increasingly concerned that the Company's $28 million in reported surplus as of year-end 2016 might not be reliable. That was already about a 50% decrease from the prior year reported surplus. In March 2018 it reported another decrease of more than 50% to $13 million as of year-end 2017. By that time the Pennsylvania Insurance Department was engaged in a vigorous effort to drill down on SHIP's financial condition. In March 2019 the company reported a $467 million deficit for 2018. It was placed in rehabilitation in January 2020. We now believe that the deficit (or funding gap) is around $1.2 billion.

III. PLAN DEVELOPMENT

Even before requesting that the Commonwealth Court of Pennsylvania place SHIP in

[1]Conseco, Inc. eventually emerged from bankruptcy and in 2010 was renamed CNO Financial Group Inc. SHIP is no longer part of that group.

rehabilitation, Pennsylvania Insurance Commissioner Jessica Altman began evaluating options for addressing the company's apparently severe financial problems. She engaged a team of experts in insurance rehabilitation and long-term care insurance which, together with the Commissioner and her staff, evaluated available options. These included conventional measures like selling the company or exploring capital-raising opportunities, measures of last resort like liquidation, and more challenging and creative rehabilitation options.

Throughout this process, Commissioner Altman's team engaged in an unprecedented outreach to insurance regulators around the country, informing them of her findings and ideas and soliciting their own views. As part of this process, the team provided these regulators updated and detailed information about SHIP's business and financial condition, much of it not publicly known. Coinciding with the early days of the COVID-19 pandemic, much of the outreach entailed video conferences and telephone conferences. But there were also a number of meetings in person. As this process continued, Commissioner Altman and her advisors began focusing on a particular structure for rehabilitating SHIP, which was explained in detail to the insurance regulators in the other states. It is worth noting that at no point during this process did any other regulator propose another, let alone a better, plan for SHIP's rehabilitation.

After extensive analysis, in January 2020, the Commissioner requested that the Commonwealth Court place SHIP in rehabilitation. On the 29th of that month, Commissioner Altman was appointed SHIP's Rehabilitator and she then appointed Patrick H. Cantilo Special Deputy Rehabilitator (SDR), placing him in charge of the efforts to rehabilitate SHIP. Shortly thereafter, the Commissioner's team had concluded that the Proposed Rehabilitation Plan they had been developing offered the best protection for policyholders. Commissioner Altman's statement regarding these matters is available online at Commissioner's Statement.

The first version of the Plan was submitted to the court on April 22, 2020, and distributed widely. Policyholders and all interested parties, including the chief insurance regulators of all the other states, were invited to submit formal or informal comments and even afforded the opportunity to become formal parties in the court proceeding for evaluation of the Plan. The chief insurance regulators of Maine, Massachusetts, and Washington accepted this opportunity and became intervenors (Regulator Intervenors) in the proceeding.

The dialogue with other regulators, policyholders and other interested parties continued and the Proposed Rehabilitation Plan was amended twice, once after six months, and again another seven months later. The amendments reflected changes incorporated in the Plan as a result of comments received by the Commissioner's Rehabilitation Team. In May 2021, the Proposed Rehabilitation Plan was presented to the Commonwealth Court for approval. The Court held a week-long hearing in which several parties appeared, including the Regulator Intervenors. They objected to the Plan principally for two reasons: they asserted that the Plan's mechanisms for setting new premium rates for all SHIP policies would usurp their regulatory authority. They also argued that SHIP was too sick for rehabilitation and that it should be liquidated instead. These matters will be addressed below.

After extensive briefing by the parties, the Court approved the Plan at the end of August 2021. The Regulator Intervenors appealed that decision to the Supreme Court of Pennsylvania and asked that the Commonwealth Court suspend implementation of the Plan pending that appeal. The Court rejected that request ruling that delay would hurt the Plan and policyholders. The Regulator Intervenors then made a similar "stay" request to the Supreme Court, which also concluded it should be rejected. The Plan is therefore in the process of implementation, but it remains subject to a pending appeal. Recently, acting Pennsylvania Insurance Commissioner Mike Humphreys[2] delayed implementation of policy modifications until the earlier of the Supreme Court of Pennsylvania's decision or October 1, 2022. If the Supreme Court has not ruled by that date, the Commissioner will evaluate future steps. Other steps to implement the Plan continue to avoid the cost of delay.

IV. PLAN SUMMARY

While the complete Plan is available for review at www.shipltc.com (along with many other related documents), the following summary is offered for convenience. The Plan is designed to operate in three phases. The principal stage is Phase One, currently in progress, and strives to reduce substantially or eliminate the Funding Gap. SHIP staff and consultants determined which policies require modification because their current premium is below the If Knew Premium[3] for the benefits they provide. Selecting from among five Plan options, policyholders increase their premiums or reduce their benefits so that the premium will be adequate prospectively. Policyholders whose current premium is at or above the If Knew Premium are not required to modify their policies but may choose to make some such modifications if they prefer to do so. Note that this option would not be available in liquidation.[4] For the 1,200 or so holders of policies issued in Opt-out States (those that opted out of the Plan's premium modification provisions), only four options were available, two not available for other policyholders and excluding three preferable options available to other policyholders.

At the conclusion of Phase One, the Plan's results will be evaluated, and consideration will be given to implementation of Phase Two. The Plan describes a Phase Two similar to Phase One but with a different premium basis. However, the Rehabilitator will evaluate all options after Phase One, including whether at that stage liquidation would be preferable. Before implementing Phase Two, the Rehabilitator will return to the Court with his proposal.

At the conclusion of Phase Two, the Plan will go into Phase Three during which the company will be wound down and other creditors will receive distributions if, and to the extent that, assets are available. It is not possible at this time to predict when and how Phase Two and

[2]At the end of February 2022, Jessica Altman left her position as Pennsylvania's insurance commissioner and was replaced by her chief of staff, Mike Humphreys.

[3]The If Knew Premium is an accepted methodology which sets premiums at the rate at which, if charged from inception, would have produced a 60% lifetime loss ratio. 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.

[4]More than half of SHIP policyholders who have received Policyholder Election Packages have already made their selections, almost two thirds choosing options that would not have been available in liquidation.

Phase Three will be implemented.

The Plan has one overriding goal and some subsidiary goals. The overriding goal is to maximize protection for affected policyholders. The subsidiary goals are to maximize meaningful choice for these policyholders, to adjust SHIP's premium rates *prospectively* so that going forward the long-term care policies will be properly priced, and to eliminate *prospectively* the discriminatory premium rate structure that results in some policyholders involuntarily and unknowingly subsidizing others.

The Plan seeks to accomplish these goals by having most of its policyholders adjust their policies by selecting from among a number of options intended to enable policyholders to adjust their coverages and the cost of those coverages in ways best suited to their individual circumstances. In general, the options include, retaining the current premium but reducing benefits, retaining the current benefits but increasing premiums, selecting from newly created combination of basic benefits at reasonable rates, or selecting an "enhanced" Non-forfeiture Option under which no further premium need ever be paid and as much as two-and-a-half years of coverage would still be provided.

V. OBJECTIONS TO THE PLAN

As noted above, objections to the Plan fell mainly in two categories: assertions that the Plan invaded regulators' authority to govern rates and benefits, and suggestions that liquidation would be better. Both of these objections were presented to the Court by the Regulator Intervenors in great detail with supporting testimony, exhibits and argument. In due course, the Court concluded that these objections did not justify rejection of the Plan.

As to the first, the Court was not persuaded that other state regulators had the authority to set rates and benefits for the company in rehabilitation. Moreover, the Plan includes an "issue-state rate approval" mechanism under which states can set their own rates, and benefits are adjusted proportionately to prevent unfair and involuntary subsidization of some policyholders by others. Taking this into account, the Court found that the Regulator Intervenors had not shown that this aspect of the Plan actually hurt them in any way. Interestingly, twelve states initially availed themselves of this option, but five of these later opted back into the premium rate setting provisions of the Plan, leaving fewer than 1,200 policyholders in Opt-out States.

As to the second line of attack, the court found that the Regulator Intervenors had not shown that liquidation would be better. In this regard, the court considered the Rehabilitator's presentation of the advantages of the Plan over liquidation. Among these advantages were several valuable policyholder choices available under the Plan but (based on experience and applicable law) not available in liquidation. Moreover, liquidation involuntarily reduces maximum policy benefits to the arbitrary statutory guaranty association limits. And liquidation could not eliminate the involuntary subsidization of some policyholders by others as does the Plan.

A key argument made by the Regulator Intervenors in support of liquidation was that it would enable policyholders to receive guaranty association benefits. But the Rehabilitator pointed out, and the Court noted, that the Plan offered every policyholder at least one option that would provide as much coverage as would the guaranty associations. Moreover, even if it later becomes appropriate to place SHIP in liquidation, guaranty association benefits will remain available. So, contrary to some suggestions, the Plan does not eliminate these benefits and it is misleading to characterize it as an "either or" choice. If the circumstances make it appropriate, SHIP can be placed in liquidation later and the full statutory limits will remain available at that time.[5]

Contrary to long-standing tradition of deference to the chief insurance regulator of the state in which a troubled company is domiciled (Pennsylvania in SHIP's case), a number of other regulators commenced "collateral" attacks on the Approved Rehabilitation Plan in other courts or administrative proceedings. Generally, these attacks are aimed at preventing implementation of the Plan in their states, unfairly expecting those policyholders to remain unaffected by SHIP's financial problems while other policyholders make required adjustments. In part, these attacks suggest that policy modifications should be submitted to each of those states for individual review and approval. That system is precisely what contributed to SHIP's current problems, especially its discriminatory and unfair premium rate structure. The Rehabilitator is addressing each of these attacks even while he pursues affirmance of the Plan's approval in the Supreme Court of Pennsylvania.

VI. CONCLUSION

SHIP's financial condition is dire, owing in large part to many of its policies having been substantially underpriced for a long time. Clearly, one option available to Commissioner Altman when she stepped in was to simply place SHIP in liquidation, limit all policyholders to the benefits available from guaranty associations, and shift to taxpayers and other policyholders the remaining burden attributable to the severe underpricing of SHIP's policies. After extensive and careful evaluation, Commissioner Altman concluded that it would be preferable to implement a rehabilitation plan that affords policyholders meaningful choices while striving to eliminate the underpricing going forward. This will also eliminate prospectively the involuntary unfair subsidization of some policyholders by others. A hallmark of the Plan is that its carefully constructed policyholder options enable each to select the one best suited to his or her individual needs and circumstances. Many of these options would not have been available in liquidation. It is notable that, as this Primer is published, a substantial majority of the more than two thirds of policyholders who have already selected Plan options have preferred those not available in liquidation. The Plan is not a "magic bullet." In the judgment of the Commissioner and his advisors, it is however the best way to protect policyholder interests under the circumstances.

[5]To the extent that some policies are modified under the Plan, benefits recoverable from guaranty associations might be reduced for some policyholders. That would be the case to the extent that a policyholder currently entitled to benefits potentially in excess of the applicable guaranty association limit modifies his or her policy so that maximum benefits are reduced below that limit. It is impossible to predict at this time how much in potential guaranty association benefits would be eliminated by the Plan in this way.