STATE OF MAINE
BUREAU OF INSURANCE

In re: Senior Health Insurance Company of Pennsylvania (in rehabilitation) NAIC Company Code 76325 Docket No. INS-22-200	**DECISION AND ORDER**

Introduction

The foundation of insurance is spreading risk. The many pool their resources in the form of premiums so that those who must make claims for covered events have protection against their losses. Spreading risk also applies when insurers become insolvent. The admitted insurers in each state pay assessments into the state's guaranty fund, and the guaranty fund arranges for payment of covered claims, up to a statutory cap, paid for by an assessment on other insurers in the same general category of business as the insolvent insurer. In property/casualty insolvencies, assessments may be reflected in rates.[1] In life/health insolvencies, insurers may offset assessments against their premium tax liability.[2] In either case, the public policy is to spread the impact of an insolvency far beyond the insolvent carrier's policyholders. This is important because, if it is unlikely that the insolvent insurer can be rehabilitated, responsible regulation should protect the insolvent carrier's policyholders from further losses.

Procedural Background

On February 8, 2022, through counsel, Maine Bureau of Insurance Staff submitted a Verified Complaint alleging that Senior Health Insurance Company of Pennsylvania (the "Company") is transacting insurance business in this State in a manner that is causing or is reasonably expected to cause significant, imminent, and irreparable injury to Maine policyholders. Superintendent Cioppa issued an Emergency Cease and Desist Order the same day, pursuant to 24-A M.R.S. § 12-A(2-A), and served notice on the Company, in accordance with 24-A M.R.S. § 12-A(2-A)(C), of the Emergency Order and scheduled hearing to determine whether there were grounds to continue the Order in force, and if so, to consider appropriate sanctions for any proven violations and such additional remedial measures as may be appropriate for the protection of Maine policyholders. The notice advised the Company that failure to appear

[1] 24-A M.R.S. § 4447.
[2] 24-A M.R.S. § 4621.

may result in a disposition by default, which could be set aside for good cause. *See* 5 M.R.S. § 9053(3).

On February 15, Superintendent Cioppa issued an order pursuant to 24-A M.R.S. §§ 210 and 231(1) designating me as hearing officer and delegating the power to act as decisionmaker with all powers that would otherwise be exercised by the Superintendent. There was no request for continuance. However, on February 17, a letter was submitted by the Company's attorney stating that neither the Company, its Rehabilitator, nor its Special Deputy Rehabilitator intended to appear in this proceeding and that the Company does not consider itself subject to the jurisdiction of this State. A public adjudicatory hearing was held as scheduled, by videoconference, on February 18. As stated in its February 17, 2022 letter, the Company did not attend or otherwise participate in the proceeding.

Staff, participating in an advocacy capacity pursuant to 5 M.R.S. § 9054(5), presented testimony, supported by documentary evidence,[3] by one of the Company's Maine policyholders and by the actuary in charge of reviewing long-term care insurance rate filings on behalf of the Superintendent. When the public was invited to present comments and testimony, the daughter of another policyholder gave sworn testimony about her mother's situation. I took official notice of four additional documents: the Company's Rehabilitation Plan; its application for approval of its Pennsylvania rates; the February 2, 2022 order of the Pennsylvania Commonwealth Court concerning the Company's use of those rates on an extraterritorial basis; and the Company's letter advising me of its refusal to appear.

Findings and Discussion of Facts

Staff has the burden to prove its factual allegations through credible evidence, notwithstanding the Company's refusal to participate in this proceeding. Based on the evidence in the record, I find that:

The Company is a Pennsylvania-domiciled life and health insurance company with a principal place of business in Carmel, Indiana. The Company and its predecessor entities have been continuously licensed in Maine since May 3, 1991, and the Company holds Maine Certificate of Authority LHF32655. The Company specialized in long-term care insurance,[4] and ceased writing new business in 2003. The Company currently has approximately 350 policies still in force that were issued in Maine. Each of these policies remains subject to Maine law for as long as the policy is still in force, even if the policyholder lives elsewhere.

On January 9, 2020, the Pennsylvania Commonwealth Court placed the Company into rehabilitation because of the continuing deterioration of its financial condition, and appointed the Pennsylvania Insurance Commissioner to manage the Company as its Rehabilitator. The

[3] At the hearing, I granted Staff's motion to file two supplemental exhibits. The evidentiary record closed when those exhibits were filed that afternoon.

[4] Although it also wrote other types of business, all of its non-long-term care business was assumed by another insurer in 2008.

Rehabilitator, on behalf of the Company, waived its right to hearing and consented to an order suspending its Maine certificate of authority and stipulating, in accordance with 24-A M.R.S. § 419(2), that the Company "may not transact any new insurance business in Maine but will be allowed to continue to renew and service existing business. The Company must continue to make required filings and pay all required fees and taxes." *Suspension of Certificate of Authority, In re Senior Health Insurance Company of PA, in Rehabilitation,* Maine Bureau of Insurance. Docket No. INS-20-300, March 9, 2020.

Although the Company is still able to pay claims as they come due, long-term care insurance is a lifetime promise, and the Company's future obligations leave it with a projected shortfall of about 1.2 billion dollars. The Commonwealth Court has approved a Rehabilitation Plan that, by its terms, grants the Rehabilitator the authority to increase premiums and reduce benefits on a nationwide basis in an attempt to close the Company's "Funding Gap." Superintendent Cioppa and the Insurance Commissioners of Massachusetts and Washington intervened in the Pennsylvania court proceeding to challenge the legality and fairness of this Plan. They have appealed the Plan's approval to the Pennsylvania Supreme Court. The chief insurance regulators in 26 other states and the District of Columbia have supported the appeal as *amici curiae.*

While the appeal is pending, the Company has begun measures to implement the Plan, which calls for staged premium increases. In Phase One, the Plan states that policies will be rated on an "If Knew" basis – meaning a premium that in the Rehabilitator's judgment would have been approved by regulators at the time the policy was issued, if we knew then what we know now about the Company's experience over the course of the intervening decades. This general approach is widely used, but the Plan's version of "If Knew" rating differs from the usual methodology. In particular, it uses a *"seriatim"* approach that rates each policy on a stand-alone basis as of its actual date of issue, rather than following a uniform rate schedule applicable to all policies within the same block of business. The Plan also includes a "differential premium" charge for policyholders whose premium is currently being waived as the result of a claim, transforming the policy's waiver-of-premium benefit to a premium discount.[5]

The Plan also offers policyholders up to four different benefit reductions in lieu of the Phase One premium increase; the exact number of choices depends on the type of policy and the premium the policyholder is currently paying. The Plan's centerpiece is the "Basic Policy" option. This comprises Option 2 and Option 2a. The Rehabilitator described the "Basic Policy" in the Pennsylvania proceeding as a "right sized" policy with a more affordable price. The benefit reductions in Option 2 include, but are not limited to: a maximum benefit period no longer than four years, inflation protection not to exceed 1½% per year, a reduced daily benefit, and more stringent conditions to qualify for benefits. Option 2a is similar, but extends the

[5] The differential premium charge applies only to contractual waivers of premium, not to fully paid-up "nonforfeiture" policies which are exempt by law from any further premium charges or benefit reductions.

maximum benefit period to five years and increases the inflation protection to 2% per year, unless these exceed the levels in the policyholder's existing policy.

Although the price of a "Basic Policy" is low enough that most policyholders would get substantial premium reductions instead of premium increases, the degree of benefit reductions would still make these options highly profitable for the Company. The Rehabilitator predicts that the Company's entire deficit would be eliminated if all policyholders downgrade their benefits to one of the two "Basic Policy" packages.

As an incentive to "right-size" their policies, the Plan exempts policyholders from Phase Two rate increases if they agree to cut their benefits to the Basic Policy level or to surrender their policies in return for a paid-up "nonforfeiture" policy. Otherwise, in Phase Two the Plan will impose "self-sustaining" premium rates unless the policy is "Fully Covered." To be "Fully Covered" means that there is no chance, however remote, that the policy's future benefits could possibly exceed the applicable guaranty association limit by even a dollar. "Self-sustaining" premium rates mean rates that are sufficient to recoup the policyholder's proportionate share of the Company's deficit. In other words, a policyholder aged 86[6] would be required, within his or her remaining life span, not only to pay back every dollar the Company has lost over the past two or three decades on his or her own policy,[7] but also to pay a share of the Company's much greater losses on all the policyholders who have died, surrendered their policies, or had their premiums waived – approximately 95% of the Company's original policyholder base.[8]

The Plan puts these rates in place by purporting to exempt the Company from the filing requirements of any state except Pennsylvania, unless the state agrees to become an Opt-Out State under the so-called "Issue-State Rate Approval Option." Under this process, the Company files premiums for review in each Opt-Out State, and the state determines a fair and lawful rate for each policy according to the laws of that state. But the Company will only honor that determination if the premium approved by the Opt-Out State is at least as high as the premium the Company has requested. If an Opt-Out State determines that a premium requested by the Company is excessive, the affected policyholders lose the right to keep their current policies and pay the state-approved premium for those policies. If the policyholders keep their policies, they must pay the full requested premium that their state had disapproved. If they choose instead to pay the state-approved premium, the Company will substitute a different policy with reduced benefits.[9]

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[6] This is the average age of the Company's policyholders.

[7] "If knew" rates, by contrast, are intended to charge a fair price going forward, but not to claw back what a company has already lost in past years by its failure to predict the full expected cost of the policy.

[8] Although Self-Sustaining rates are priced on a break-even basis, the impact of removing the profit load that is built into the Phase One rates is dwarfed by the magnitude of the past losses that the Company seeks to recapture in its Phase Two rates but not in its Phase One rates.

[9] This is the default option. The Plan's Options 2, 2a, and 3 are not available in Opt-Out States. The Plan provides that the only way a policyholder in an Opt-Out State can avoid Self-Sustaining rates in Phase Two is to surrender his or her existing policy and accept a statutory nonforfeiture policy with lower benefits than Option 3.

Consumers buy insurance products with affordability in mind, but the point of rate review is to ensure that the premium is appropriate for the benefits provided. As the Bureau's Life and health actuary, Mary Hooper, testified, "you can't approve rates unless you also know what benefits those correspond to. So when we approve for a rate filing, it comes with the rate tables that correspond to that benefit." An Opt-Out State's authority to determine a reasonable price for a policy is meaningless if the state must relinquish its authority to decide what policy the Company may sell for that price.[10] As Ms. Hooper observed, holding the premium steady while reducing the benefits is still an increase in the premium rate – the unit cost of coverage – so the Plan's branding of the opt-out process as Issue-State "Rate Approval" is deceptive. This process fails to comply with the statutory requirement to submit the premiums for each specific policy form for review and approval under 24-A M.R.S. § 2736. Because the Superintendent could not ignore his statutory obligation to enforce the Maine Insurance Code,[11] Maine declined to participate in the Plan's Opt-Out process.

On November 4, 2021, the Pennsylvania Department approved an actuarial memorandum submitted on behalf of the Rehabilitator in support of the proposed rating methodology. On the basis of that approval, the Commonwealth Court found that "The Rehabilitator has established the reasonableness of the premium rates charged," and issued an order on February 2, 2022, authorizing the Company to use its Phase One rates in Pennsylvania and in any other state, including Maine, that did not agree to participate in the so-called "opt out" process. The Order also authorizes the Company to use the Phase One Pennsylvania rates "for the calibration of benefit adjustments" in "opt-out" states.

The Company asserts that the Rehabilitation Plan exempts it from compliance with Maine law. It has therefore not filed any proposed rates or proposed modifications to policy forms for review in Maine.

In January 2022, shortly before the Commonwealth Court approved the Pennsylvania rates, the Company sent "election packages" to policyholders around the country,[12] including Maine. Each policyholder's election package included a form, to be signed and returned to the Company, which included:

- Notice that the Company intends to implement the premium increase or benefit reduction on a specified date in April 2022, which is the same day of the month as the policy's original effective date;
- A table comparing, for each option offered by the Company: the premium the Company intends to charge and the percentage increase or decrease from the

[10] The terms of the Plan also provide that policyholders in "opt out" states are not given the right to protect themselves from Phase Two rate increases by agreeing to slash their benefits to the "Basic Policy" level.

[11] 24-A M.R.S. § 211.

[12] A different timetable and different options will apply in Opt-Out States.

current premium, the maximum lifetime benefit and the percentage decrease if applicable, and whether "Phase Two Rate Increase / Benefit Reduction Possible";

- Notice that the form must be signed and postmarked by a specified date or the Company will select the designated "default option." The two election forms in evidence in this proceeding had response deadlines of March 11 and March 15,[13] 2022;[14]
- A set of checkboxes and the instruction: "Select the option that best suits your needs"; and
- An attestation that: "I understand the election I have made above and acknowledge that I have made the election voluntarily. I agree that the changes I have requested will become effective April [date], 2022 and cannot be reversed after [date], 2022."

The package also included 22 pages of more detailed explanatory material, including this warning for policyholders who choose to keep their current coverage: "The premium rates and benefits associated with this option are not guaranteed and may change significantly in Phase Two of the Rehabilitation Plan."

One witness, AS, who turned 93 shortly after the hearing, has been a policyholder since 1989. She testified that she was initially tempted to throw her election package away, and that she found it "very confusing for – I don't know about a younger person, but for an elderly person to know which – which was the correct way to jump on the matter." Another witness, CB, testified that her mother asked her for help because she "was just overwhelmed with the decision that she was going to have to make, the amount of information that she was going to have to go through.... [I]t went to the point where she and I are having conversations of, you know, I'm 90 years old, I've paid all this – these premiums for my long-term care policy, now I'm not going to be covered when I need it the most." CB testified that it was "very unfair of SHIP to be asking these elderly policyholders to make these kinds of decisions at their ages."

CB's mother is also one of the policyholders affected by the Plan's conversion of premium waivers to premium discounts. She and her late husband had paid for a lifetime waiver-of-premium rider, a benefit described as follows in the Plan:

> The ***Lifetime Waiver of Premium*** provision permits suspension of premium payments upon the death of a covered spouse after a qualifying period

[13] The reason for the difference is not clear. The policyholder with the earlier effective date had the later response deadline.

[14] Policyholders who are not subject to a Phase One premium increase will keep their own policies unless they affirmatively choose some other option. However, the Company will involuntarily downgrade policyholders to the "Basic Policy" if they are subject to any proposed Phase One increase and fail to return the election form, unless they are on waiver of premium, in which case they will be downgraded to a level sufficient to eliminate the proposed "differential premium."

(typically five, seven, or ten years). The Lifetime Waiver of Premium provision, as the name implies, is permanent.

However, "permanent" means something different under the Plan than policyholders had understood it to mean. CB testified that when her mother became the sole policyholder in 2014, she was promised that she would never have to pay premium again. But now, the Company intends to charge her a "differential premium" each month unless she agrees to a benefit reduction, and she must agree to a more drastic benefit reduction in order to avoid the risk of being saddled with a "self-sustaining differential premium" in Phase Two. In CB's words: "And, you know, what I don't understand is how a company offer a lifetime waiver of premium and now come back and say, well, if you want your coverage, you're going to have to pay premiums.... [Y]ou know, the rug is kind of being pulled from under her not knowing – not having that sense of security that if she needs nursing home care, you know, will it be covered?"

After these witnesses testified, Ms. Hooper reaffirmed her statements in the Verified Complaint and explained the supporting documentation. She described the information that an insurer seeking a premium increase is required to provide to the Bureau and to the affected policyholders, and the Bureau's process for reviewing the proposed increase to verify that the requested premiums are not inadequate, excessive, or unfairly discriminatory.[15] This includes a filing checklist outlining the essential elements of information that must be included in each rate filing and the legal basis for requiring each item. She presented a copy of the completed checklist previously submitted by the Company with one of its Maine rate filings.

Although the Plan's rationale for taking the rate approval power away from the states is that some states have abused that power, Ms. Hooper testified that this has not been the case in Maine, which has a history of granting actuarially justified rate increases. Many policyholders, in Maine and other states, are already paying adequate "If Knew" rates by the Company's own assumptions, as illustrated by the notice that AS will not be subject to a Phase One rate increase, and the Phase One rate increase for CB's mother's policy is only 2%.[16] Nevertheless, each of them has been told that if they do not agree to substantial benefit reductions, they will face "self-sustaining" premium increases in Phase Two.

Ms. Hooper explained why it is impossible to determine, from the limited information that the Company has provided in the Rehabilitation Plan and in its Commonwealth Court rate filing, whether the Company's expected loss ratio calculations are reasonable. The Pennsylvania rate filing says only that the Department of Insurance has reviewed the Company's October 14 Actuarial Memorandum, which in turn says that the rates are based on the Company's "best estimate actuarial assumptions, as documented in Oliver Wyman's Assumption Report dated August 24, 2021." An analysis of those assumptions is at the heart of any meaningful rate

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[15] 24-A M.R.S. § 2736(2).

[16] This is the increase the Company would charge if she had not been promised a lifetime waiver of premium. In her case, she is being charged the 2% amount as the applicable "differential premium."

review process, but the Company did not file the Assumption Report with Maine either in the System for Electronic Rate and Form Filing or in this proceeding. There is no indication that the Company showed it to the Pennsylvania Insurance Department staff that performed the independent review ordered by the Commonwealth Court. Thus, we are unable to judge the reasonableness, for example, of the projections of how many policyholders will be on claim, when those claims will begin, how long they will last, or the discount rate used to reduce those claims to present value. We also do not know whether the Company's calculations charge its policyholders to recoup its substantial losses from the failed Beechwood and Roebling transactions.

Although the "if knew" principle is actuarially sound, at least at a high level of generality, that does not mean it would justify any rate that is branded "the If Knew Rate." In particular, a 60% loss ratio was not designed to be applied in hindsight decades later. Allowing the Company a 40% margin for expenses and profit is based in part upon the risk assumed due to the high level of uncertainty. The Company is asking for a rate that would include 40% for expenses and profit "if we knew," but the 40% is based on the fact that we did not know. There is still a substantial amount of uncertainty remaining in 2022, but not nearly as much as when the policies were issued in the 1980s and 1990s. In Maine, the applicable standards for reconstructing a fair "if knew" margin are set forth in 02-031 C.M.R. ch. 420, and the Company must comply with those standards. The Rehabilitation Plan even seems to recognize this point, by defining "If Knew Premium" to require satisfying "the minimum loss ratio applicable to the policy form." However, the Plan then states that "For the sake of simplicity, under the Plan this will be assumed to be 60%." The problem is that we do not know what analysis underlies the assumed target loss ratio. Furthermore, as discussed earlier, even if the target loss ratio were assumed to be lawful, reasonable, and accurately calculated, the resulting premium rates could nevertheless be excessive if the underlying actuarial assumptions are flawed or unduly conservative. And when a policyholder has met his or her policy's conditions for waiver of premium, charging any premium at all is inherently excessive.

The Pennsylvania filing is also vague about the Company's proposal for premiums to be "based on each policyholder's individual characteristics (e.g., gender, issue age)." Ms. Hooper's testimony explained why the rates cannot be meaningfully reviewed without knowing the methodology the Company uses to calculate the premium differences for these rating factors, and without knowing whether these are the only applicable rating characteristics. "E.g." is not a lawful rating factor. Furthermore, Ms. Hooper testified that even though gender rating, with proper actuarial support, is not prohibited by law for long-term care insurance, a decision whether to approve the use of gender rating would have to depend on whether or not the policies in question are currently gender rated. This information is not in the Company's Pennsylvania rate filing.[17] This information vacuum puts the Bureau in the difficult position of not knowing if female policyholders bought policies in reliance on a promise that they would not be charged a

[17] Similar issues would be raised if the Company proposed to change its existing issue-age rating structure.

higher premium because of their gender. If that were the case, this is an example of the fine points of state regulation that the Plan disregards.

In addition to treating similarly situated policyholders differently, the Plan also charges the same premiums to policyholders who are in very different situations. The lifetime guarantee of renewability is a fundamental element of long-term care coverage. Insurers design long-term care programs with level premium structures under which policyholders pay premium for many years with very little expectation of receiving benefits until later in life. This builds value that allows policyholders to keep their coverage at an established premium when they are older.[18] The insurer may not take this accumulated value away from the policyholder by terminating or involuntarily reducing coverage.[19] Yet this is the principal mechanism by which the Company seeks to reduce or eliminate its deficit. The Rehabilitator's calculations show that these transactions would be highly profitable for the Company, and those profits would come at the expense of the policyholders.

The Company's Challenge to the Superintendent's Jurisdiction

At the hearing, I ruled that the Company's assertion that the Superintendent lacks jurisdiction is in the nature of a motion to dismiss, and that if the Company had appeared and filed a proper motion to dismiss, I would have denied the motion. I will now explain the basis for that ruling more fully.

The Company observes that it is the subject of pending litigation in Pennsylvania, and that Superintendent Cioppa, in his official capacity as Maine's chief insurance regulator, is "a party in that proceeding over whom the Pennsylvania Court thereby gained personal jurisdiction."[20] The Company asserts that "Under the circumstances, it is our position that the State of Maine and its Bureau of Insurance do not have jurisdiction over the matters (and parties) addressed in the [Emergency Cease and Desist Order]."

The Company has not explained how or why these "circumstances" deprive the State (or the Superintendent) of jurisdiction over the Company's activities in Maine. The issue is not whether Pennsylvania courts have personal jurisdiction over the Superintendent, but whether the Superintendent and the Maine courts have personal jurisdiction over the Company. It is possible for both of these things to be true, but only one is relevant to this proceeding. The Company has unquestionably submitted to personal jurisdiction in Maine when it requested and obtained its

[18] It must be kept in mind, however, that there is a difference between a level premium design and a guaranteed level premium. Although rates are set with the expectation that increases will not be necessary for the life of the policyholder, there are mechanisms to approve and implement rate increases if an insurer can prove that its initial assumptions are no longer valid.

[19] If a policyholder agrees to a voluntary reduction in coverage, the terms of the transaction must fairly reflect the years that the policyholder has prepaid for a policy with richer benefits.

[20] The Company asserts further that the Bureau of Insurance is also, separately, a party to the Pennsylvania proceeding. That is not accurate, but the inaccuracy is not relevant unless the Company is conceding the Superintendent's jurisdiction to decide this matter but challenging Bureau Staff's authority to prosecute it.

license to do business in Maine, subject to the Maine Insurance Code and the Superintendent's regulatory authority.[21] The Company reaffirmed Maine's jurisdiction over it when the Rehabilitator consented to the Superintendent's order suspending its Maine certificate of authority while requiring the Company to "continue to make required filings."

Furthermore, the Pennsylvania Commonwealth Court has granted the Company an exemption from compliance with Maine law, and I have before me a petition to enforce Maine law. The question here is which tribunal has subject matter jurisdiction over the Company's premium rates and policy benefits, not which parties are subject to personal jurisdiction. Unquestionably, 24-A M.R.S. §§ 2736 through 2736-B grant the Superintendent the authority to review and approve or disapprove premium rates and the jurisdiction to adjudicate premium rating disputes, subject to the appeal rights provided by the Maine Administrative Procedure Act. It is also beyond question that Pennsylvania has the same powers when a Maine insurer does business in Pennsylvania. The Pennsylvania order is void for lack of subject matter jurisdiction because it purports to preempt Maine law and to apply Pennsylvania law extraterritorially to its domestic insurer – acts over which the Pennsylvania Court has no legal authority.

Under the federal system of the United States, a corporation's internal affairs are governed by its state of domicile, but when the corporation requests permission to do business in another state, it agrees to submit to the laws and regulatory authority of that state. There is no "rehabilitation exception" releasing a foreign corporation from those obligations if bad luck or mismanagement have left the corporation in dire financial circumstances. In the exercise of its *in rem* jurisdiction over the Company, Pennsylvania may invest a receiver with powers to take extraordinary measures to prevent the Company's insolvency, but these powers do not include the power to usurp the authority of other states to regulate the Company's activities, at the expense of non-Pennsylvania residents, in those states, no matter how much the Company might wish.

Likewise, a state does not have the power to impose its laws extraterritorially to shield its citizens or its domestic corporations from the consequences of their actions outside the state borders. For example, all states, including Maine, have agreed to recognize the validity of out-of-state drivers' licenses. If a driver we would consider unfit holds a valid out-of-state license, we defer to the home state and respect that license even if a Maine license would have been revoked based on the same history of illegality or incompetence. But the validity of that license does not allow such drivers to follow their home state laws extraterritorially while they are in Maine. If they are stopped by our police while driving on our roads, their blood alcohol levels must comply with Maine law even if a higher level would be permissible in the driver's home state.

[21] By contrast, Bureau Staff have not asserted personal jurisdiction over the Rehabilitator or Special Deputy Rehabilitator, who have not been named as parties to this proceeding.

There is a difference between the ability to take an action and the right to take that action. That is why so much of the justice system is devoted to remedial measures after a wrongful act has already been committed. The Superintendent and other intervening State Regulators have tried, unsuccessfully so far, to prevent the Commonwealth Court from exceeding its jurisdiction. However, the Commonwealth Court's order approving the Plan did not resolve the present conflict, but rather created the conflict. Even if the Superintendent had the power to grant the Company an exemption from its obligations under Maine law, the Superintendent did not do so. The Superintendent has never conceded Pennsylvania's power to apply its laws extraterritorially and allow the Company to violate Maine law. Quite the opposite: the Superintendent has openly and consistently challenged that power from the beginning. That is the foundation of the State Regulators' intervention in the Pennsylvania proceeding. The Superintendent intervened in the Pennsylvania proceeding for the limited purpose of challenging the legality of the Plan. The application to intervene did not include any express or implied agreement to be bound by any orders of the Pennsylvania courts that they lacked jurisdiction to issue. The Commonwealth Court approved the application but did not condition it in any way on the Superintendent's waiver of regulatory authority or on the Superintendent's consent to be bound by any order purporting to abrogate that authority. The Company, by contrast, has always operated, from the day it began doing business in Maine and continuing through its receivership, under a Maine certificate of authority that is conditioned on its ongoing obligation to conduct its Maine operations in compliance with Maine law.

Conclusions

For these reasons, I conclude that Staff has proven that the Company has:

1. failed to comply with its obligation to file its proposed premium rates for review by the Superintendent in accordance with 24-A M.R.S. § 2736. This requirement is not a mere procedural formality ,because the minimal information the Company has provided through other means strongly suggests that the proposed rates are both excessive and unfairly discriminatory. It is true that these rates are below the level the Company needs to meet its obligations, but that does not make them fair and lawful. If the Company does not have the funds to keep its promises while charging reasonable premiums, the remedy is not to shift the burden of the Company's insolvency to the policyholders through excessive premiums, but to recognize that the Company is insolvent and enable the guaranty associations to step in to protect the policyholders;

2. violated both 24-A M.R.S. §§ 2736 and 5084(2) by stating that it will implement the proposed rates even if they are not approved;

3. violated 24-A M.R.S. § 5084(1) by sending policyholders a rate increase notice that fails to state that the rate is subject to regulatory approval; fails to inform them of their right to request a hearing; fails to inform them of their right to provide written comments on the proposed rate increase to the Bureau of

Insurance; and fails to provide the Bureau's contact information. The Company has also violated 02-031 C.M.R. ch. 420, § 8 by failing to provide notice at least 90 days before the proposed effective date of the rate increases;

4. violated 24-A M.R.S. §§ 2152, 2153, and 2154, which prohibit unfair and deceptive practices; misrepresentation of the financial condition of an insurer or the terms of an insurance policy or the benefits and advantages promised thereby; and untrue, deceptive, or misleading advertisements or announcements. The witnesses who had to decipher the election packages testified that they were confusing and overwhelming. Misleading statements in the election package include, without limitation, the following:

   - AS was warned that her policy would be subject to "mandatory future premium increases or benefit reductions" in Phase Two unless she chose an option involving substantial benefit reductions, but she was also assured that her policy was "Fully Covered" and therefore exempt from Phase Two. Only one of those statements can be true.

   - The statement that the "Plan's principal goal is to correct the Company's financial condition through policyholder modifications with a focus on protecting policyholder interests" is contradicted by the Company's own calculations. The Plan is designed to push policyholders away from the Options most favorable to the policyholder and into the options most favorable to the Company.

   - As part of the effort to encourage the "Basic Policy" Options 2 and 2a, the Company overstates the benefits provided by these options.[22] The statement that these options "aim to strike a balance between Option 1 [downgrade policy to keep current premium] and Option 4 [keep current policy]" is false. For most policyholders, Options 2 and 2a provide less coverage than Option 1, which is why the Plan predicts that they will be more effective at shrinking the Company's deficit.

   - The statement that Options 2 and 2a have "an added safety net where your benefits will not be reduced below coverage levels provided in liquidation" is confusing and misleading. It appears to refer to the feature that ensures that the **<u>maximum possible benefit</u>** will not be reduced unless it exceeds the guaranty association limit ($300,000) in Maine. But that is very different from saying the benefits themselves will not be reduced. For example, AS has

[22] The Phase One rate calculations indicate that for typical policyholders, Options 2 and 2a provide less than half the actuarial value of their current policy. Even the policyholder who testified, who already has a "right-sized" policy with a maximum lifetime benefit of $146,000 (less than half the guaranty association limit) would see her actuarial value reduced to about 62% of its current value if she accepted Option 2.

a policy with a maximum lifetime benefit of $146,000. Because it is "fully covered," there would be no loss of benefits if she kept her present policy and the Company were liquidated. By contrast, she would incur a significant loss of benefits if she accepted the offer to downgrade to Option 2 – the expected value of the policy as calculated by the Company would decrease by 38%. The so-called "added safety net" ensures that her "Option 2" would have the same $146,000 maximum benefit, but it would be significantly less likely that the policy would actually pay that amount.

- Likewise, it is confusing and misleading to assure the policyholder: "Under the Rehabilitation Plan you have at least one option that provides coverage greater than or equal to coverage you would receive in liquidation from the Guaranty Associations." This appears to be another attempt to encourage the false impression that "coverage" is the same as the maximum lifetime benefit.[23]

- "Step 3" in AS's policyholder guide states, accurately, that the coverage election form must be postmarked by March 15, but it is accompanied by an illustration of a form that has a February 28 response deadline. This is confusing, and a policyholder might feel rushed to make a response by February 28 just in case.

  Even with the March 15 response date, the process is already too rushed, and some policyholders were given deadlines of March 11, and possibly earlier. It smacks of classic high-pressure sales tactics to require the policyholder to make irrevocable elections of coverage on short notice, without adequate information, before the Superintendent has even been given the opportunity to review the choices the Company has offered. The policyholder notice is headed, in large. boldface type: **"IMMEDIATE ACTION REQUIRED."** But the only reason immediate action is required is because the Company has chosen to require it. This scare tactic is unnecessary and unfair. The effect on the Company of delaying rate increases a few more months is inconsequential compared to the size of the Company's deficit, especially when the Company has acknowledged in its Plan that 25% to 40% of its policyholders are already paying "If Knew" premiums that are adequate by the Company's own assumptions, Moreover, if prompt rate approvals were really a matter of urgency for the Company, the Rehabilitator could have developed and filed rate increases with the Superintendent and other state regulators in 2020.

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[23] Alternatively, it is tautological that **<u>any</u>** policy "provides coverage greater than or equal to" the coverage that same policy would provide in liquidation. But that is not a distinguishing feature of this Plan, only another way of saying that liquidation might limit benefits but does not add new benefits that were not already in the policy.

> It is also an unfair practice for the Company to make a reduction in benefits the “default option” for the majority of policyholders, imposing it involuntarily on policyholders who have never requested it or who “do not clearly mark only one election,”[24] and for the Company to make its obligation to renew its customers’ existing policies depend on the customer’s agreement to submit to open-ended “self-sustaining” rate increases in Phase Two. The Company is forcing policyholders to sign a statement acknowledging that their choice is voluntary, but a choice made under these conditions cannot be voluntary.

Order

Therefore, pursuant to 24-A M.R.S. § 12-A(2-A)(D), the order issued by Superintendent Cioppa on February 8 is hereby REAFFIRMED and remains in effect unless vacated or modified by the Superintendent or a Maine court of competent jurisdiction:

Except as provided below, the Company and its principals, employees, and agents shall halt disseminating, implementing, or enforcing in this State the “Coverage Election Package” or otherwise interfering with the rights of the Company’s Maine policyholders or violating the insurance laws and regulations of this State, including, but not limited to, notifying Maine policyholders of proposed rate or benefit modifications under Maine policies or requesting that Maine policyholders select rates or benefits different under Maine policies from those authorized by the Maine Superintendent and called for under the terms of the contract, charging additional premium, or withholding, delaying or encumbering benefits in whole or in part, until such time as otherwise ordered by the Maine Superintendent.

This Order does not prohibit the Company from filing a premium increase request, or a proposed schedule of rates for proposed voluntary policy modifications, for review by the Superintendent in the manner prescribed by Maine law with sufficient supporting information to enable the Superintendent to determine whether the requested rates are inadequate, excessive, or unfairly discriminatory. This Order does not prohibit the Company from sending notices of any such filings to policyholders if the notices have been reviewed by the Superintendent for accuracy and compliance with Maine law, and have not been disapproved.

In addition to the relief ordered on February 8, it is further ORDERED:

The Company shall provide all policyholders who have already made elections, or who make elections while this Order remains in force, with a meaningful opportunity to reconsider their decisions without penalty, The Company shall not treat any election to reduce benefits as binding unless it is the policyholder’s affirmative choice and has been made after all options offered by the Company and their corresponding premium rates have been approved by the

[24] This might even include policyholders who return an election but mark it as submitted under protest.

Superintendent, and after the Company has provided full and accurate notice in compliance with this Order and with Maine law, together with a reasonable time to make a decision.

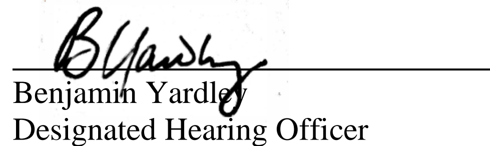
The Company shall also provide the Superintendent with a list of all policyholders to whom a coverage election form was mailed, their respective policy numbers, and their most recent contact information in the Company's records.

Notice of Appeal Rights

This Decision and Order is a final agency action of the Superintendent of Insurance within the meaning of the Maine Administrative Procedure Act. It may be appealed to the Superior Court in the manner provided by 24-A M.R.S. § 236, 5 M.R.S. §§ 11001 *et seq.,* and M.R. Civ. P. 80C. Any party to the proceeding may initiate an appeal within thirty days after receiving this notice. Any aggrieved non-party whose interests are substantially and directly affected by this Decision and Order may initiate an appeal within forty days after the issuance of this decision. There is no automatic stay pending appeal; application for stay may be made in the manner provided in 5 M.R.S. § 11004.

PER ORDER OF THE SUPERINTENDENT OF INSURANCE

March 17, 2022



Benjamin Yardley
Designated Hearing Officer