[J-54-2022]
IN THE SUPREME COURT OF PENNSYLVANIA
MIDDLE DISTRICT

BAER, C.J., TODD, DONOHUE, DOUGHERTY, WECHT, MUNDY, BROBSON, JJ.

IN RE: SENIOR HEALTH INSURANCE COMPANY OF PENNSYLVANIA (IN REHABILITATION)	:	No. 71 MAP 2021
	:	Appeal from the Order of the Commonwealth Court at No. 1 SHP 2020 dated August 24, 2021
APPEAL OF: THE SUPERINTENDENT OF INSURANCE OF THE STATE OF MAINE, THE COMMISSIONER OF INSURANCE OF THE COMMONWEALTH OF MASSACHUSETTS AND THE INSURANCE COMMISSIONER OF THE STATE OF WASHINGTON	:	ARGUED: September 15, 2022

OPINION

DECIDED: June 20, 2023
CHIEF JUSTICE TODD **OPINION FILED: January 29, 2024**

On June 20, 2023, this Court issued a *per curiam* order affirming the order of the Commonwealth Court approving the Second Amended Plan of Rehabilitation for Senior Health Insurance Company of Pennsylvania ("SHIP") filed by the Insurance Commissioner of the Commonwealth of Pennsylvania in the capacity as the Statutory Rehabilitator of SHIP. We now set forth the rationale for our order.

I. Factual and Procedural Background

A. SHIP's Insolvency and Rehabilitation

During the last 30 years, insurance companies such as SHIP, which is a Pennsylvania domiciled insurance company, sold "long term care policies" to purchasers in a number of states, including the Commonwealth of Pennsylvania. Such policies, as a general matter, promised the purchaser that, in exchange for paying a premium, if they

became disabled and in need of long-term care in a skilled nursing facility, the cost of such care would be provided to the policyholder for the duration of their stay in such facilities.[1] However, regrettably, the premiums charged for many of these policies proved inadequate to cover the high cost of such care, and companies which wrote them, such as SHIP, began to face deteriorating financial conditions because they were paying out more under the policies which they had written than the premiums they were collecting could cover.

SHIP sold long term care policies from the 1980s until the early 2000s in 46 states, including Pennsylvania, as well as the District of Columbia and the U.S. Virgin Islands. However, in 2003, SHIP was forced into bankruptcy because of poor investments, in addition to the fact that the total outstanding liabilities on the policies it sold far exceeded its assets and ability to pay promised benefits. Under the supervision of the federal bankruptcy court, SHIP went into "run-off" status, under which it stopped selling any new long-term care policies and began to "run off" the policies it had already issued — that is to say, it attempted to pay benefit claims under the extant policies. In 2008, SHIP's ownership was formally transferred to a non-profit organization, the Senior Health Care Oversight Trust ("Trust"), which has managed the assets of SHIP and orchestrated the run-off process since that time. *In re SHIP*, 266 A.3d at 1147.

In January 2020, because SHIP's financial woes continued to mount, and because it was having great difficulty paying on the policies it had already issued, the Pennsylvania Insurance Department, through its then-Commissioner Jessica Altman, applied to the Commonwealth Court for an order of rehabilitation pursuant to Article V of "The Insurance

[1] As noted by the Commonwealth Court in its opinion in this matter, 99% of these policies have a "premium waiver" provision, under which the insurer ceases collecting a premium from the policyholder after that individual receives benefits under the policy for a specified period of time, and for as long as that individual is eligible to receive such benefits or receives specialized care. *In re Senior Health Insurance Company of Pennsylvania In Rehabilitation*, 266 A.3d 1141, 1147 n.3 (Pa. Cmwlth. 2021) (hereinafter "*In re SHIP"*).

Department Act of 1921," 40 P.S. §§ 221.1-221.63 ("Insurance Act"),[2] on the basis that SHIP was insolvent, the Trust and SHIP's directors consented to the rehabilitation.[3]

On January 29, 2020, the Commonwealth Court issued an order granting the petition and, consistent with the Insurance Act, appointed the Commissioner as "statutory rehabilitator."[4] The Rehabilitator, in turn, appointed a special Deputy Rehabilitator, Patrick Cantilo, an expert in long-term insolvency matters, to study SHIP's financial condition, to manage the overall operations of the company, and to implement corrective measures to stabilize its precarious financial state.

The case was assigned to President Judge *Emerita* Mary Hannah Leavitt of the Commonwealth Court who, sitting in a single judge capacity, has exercised and continues to exercise judicial oversight of these rehabilitation proceedings. Through evidence presented to that court, the following breakdown of SHIP's outstanding policies and liabilities, which prompted the Rehabilitator to commence the rehabilitation process, was established: As of December 31, 2020, SHIP had 39,148 outstanding active policies, almost 10 percent of which are held by Pennsylvanians (3,862). In the states represented by outside regulators — the Maine Superintendent of Insurance, the Massachusetts Commissioner of Insurance, and the Washington Insurance Commissioner, collectively "Regulators," — Maine has 316 residents with such policies, Massachusetts has 296, and Washington has 1,287.[5]

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[2] The specific provisions of this Act, relevant to our disposition of this matter, are set forth and discussed at greater length below.

[3] *See* 40 P.S. § 221.14(1), (2), and (12).

[4] See *id.* § 221.15(c) ("An order to rehabilitate the business of a domestic insurer, or an alien insurer domiciled in this Commonwealth, shall appoint the commissioner and his successors in office the rehabilitator . . . ."). For ease of discussion, and to maintain consistency with the nomenclature used by the parties and the Commonwealth Court, we will hereinafter refer to the Commissioner as the "Rehabilitator." The current Insurance Commissioner, who succeeded Jessica Altman, is Michael Humphreys, who was unanimously confirmed to that position by the Pennsylvania Senate on June 27, 2023.

[5] As explained below, Regulators were granted intervenor status by the court.

The average age of a SHIP policyholder is 86, and 47 percent of the policyholders pay no premiums because they are in the "premium waiver" status described above, or because the policyholders previously elected a "non-forfeiture" option which permitted them to discontinue paying premiums in exchange for a period of coverage that equaled the amount of premiums paid, less benefits already received. The Rehabilitator estimated that, if no action was taken, by the year 2050 the value of claims by current policyholders will rise to $3 billion, while the amount of premiums SHIP would be able to collect would only be $230 million. The Rehabilitator calculated that, at the time the application for rehabilitation was filed, SHIP's liabilities on its outstanding policies already exceeded its revenues and assets by $1.2 billion dollars, a difference the parties refer to as the "Funding Gap." *In re SHIP*, 266 A.3d at 1147-48.

The Rehabilitator submitted to the court an initial proposed rehabilitation plan on April 22, 2020. Thereafter, the Commonwealth Court issued a case management order ("CMO") which directed the Rehabilitator to advise "Interested Parties" — which the order defined, *inter alia*, as including "the insurance regulatory authorities in each jurisdiction in which SHIP issued policies that remain in effect" — of the filing of the proposed plan and the procedures to offer comments on it, and to participate in the hearing the court would be conducting to determine whether it should be adopted. *In re SHIP*, 1 SHP 2020 (Pa. Cmwlth. filed June 12, 2020) (order), at 1-2. The CMO also provided that any commenter who intended to participate in the hearing was required to apprise the court of their comments, and to file a formal application with the Commonwealth Court to intervene in the proceeding. *Id*. at 3-4. Thereafter, pursuant to Pa.R.A.P. 3775,[6] regulators from

[6] This rule establishes procedures and criteria for intervention in formal proceedings against insurers and provides:

> **(a) Intervention.** A person not named as a respondent in a formal proceeding who has a direct and substantial interest in

(continued…)

Maine and Massachusetts filed a joint application for intervention, which the court granted by order issued September 15, 2020, and regulators from the state of Washington, who

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> the administration of the insurer's business or estate may request leave of court to intervene.
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> **(b) Application to intervene.** A request for leave to intervene, generally or for a limited purpose, shall be by application and answer, if any, in accordance with Pa.R.A.P. 123 (application for relief). The application shall contain a concise statement of the interest of the applicant and the purposes for which the applicant seeks to intervene. A copy of the document to be filed if the Court allows intervention shall be attached to the application.
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> **(c) Action on application.** Intervention in a formal proceeding shall be allowed if the proven or admitted allegations of the application establish a sufficient interest in the proceedings, unless the interest of the applicant is already adequately represented or intervention will unduly delay or prejudice the adjudication of the rights of the parties.
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> (1) *General intervention.* When the applicant demonstrates an ongoing interest in the administration of the insurer's business or estate, the Court may grant the applicant general intervention. The general intervenor shall remain on the master service list until the formal proceeding is completed.
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> (2) *Limited intervention.* When the applicant's interest involves a discrete controversy relating to the administration of the insurer's business or estate, the Court may grant the applicant limited intervention to participate as a party in the discrete controversy. The limited intervenor shall not be placed upon the master service list unless the Court orders otherwise.
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> **(d)** Upon grant of an application to intervene, the document attached to the application to intervene, that is, the application for relief under Pa.R.A.P. 3776 or complaint under Pa.R.A.P. 3783, shall be deemed filed, and the Court shall direct the time for filing a response.

Pa.R.A.P. 3775.

had filed a separate application for intervention, were joined with them as intervenors, via an order issued September 18, 2020.[7]

Other entities and persons which applied for and were granted intervenor status by the court are Appellees, a coalition of health insurers including, *inter alia*, Anthem, parent of Highmark Insurance, United Health Care, and Blue Cross Blue Shield of New Jersey (collectively, "Health Insurers"), the National Organization of Life and Health Guaranty Associations ("NOLHGA"), and an individual, James Lapinski, who is both a SHIP policyholder and insurance agent. All intervenors submitted both formal and informal comments on the proposed plan.

After reviewing these comments, the Rehabilitator ultimately filed a Second Amended Plan ("Plan") with the court on May 3, 2021. The Rehabilitator constructed this Plan based on the conclusion that there was a historic premium inequity paid by policyholders living in different states, given that some states' regulatory bodies had approved rate increases requested by SHIP during the period they were in force, whereas others had not, resulting in some policyholders paying less for the same coverage than others. *In re SHIP*, 266 A.3d at 1146. The Plan deliberately sought to modify what the Rehabilitator perceived as this discriminatory rate structure.

B. Rehabilitation Plan

The Plan has three phases:

Phase I

In this phase, policyholders currently paying premiums below what is termed the "If Knew" premium rate are required to choose among five options involving different

[7] The Commonwealth Court did not indicate in its order that it was granting only limited intervention, *see In re SHIP*, 1 SHP 2020 (Pa. Cmwlth. filed September 15, 2020) (order); thus, pursuant to Pa.R.A.P. 3775, this order must be construed as a grant of general intervention.

premium prices and levels of coverage. As explained by the Commonwealth Court, the "If Knew" premium is set according to an actuarially justified methodology which:

> determines the premium an insurer would charge had it known when the policy was issued what it knows today, *i.e.*, that it would experience lower returns on investments, lower mortality rates, lower lapse rates, and higher claim incidence rates. The If Knew Premium assumes a 60% lifetime loss ratio from inception of a policy, *i.e.,* the use of 60% of expected premium to pay benefits to policyholders. The other 40% of expected premium is used to pay salaries, administrative overhead, premium taxes, federal taxes and profit for the insurer. The goal of the lifetime loss ratio is to establish a premium level that is reasonable in relation to the benefits paid.

Id. at 1159-60. The "If Knew" premium rates are intended to ensure that, going forward, policies are priced adequately on a lifetime basis; however, this pricing methodology does not attempt to recoup the insurer's past losses due to inadequate pricing, nor does it consider the policyholder's age and current medical condition in setting the premium rates. *Id.* at 1149.

The options available to such policyholders under Phase I are:

--Option 1 permits policyholders to reduce their benefits to the level of coverage the premiums they are currently paying would yield on an "If Knew" basis.

--Option 2 and 2A allows policyholders to select more limited coverage than they currently have. They could pay an "If Knew" rate for a policy that caps the maximum benefit period at either 4 years or 5 years. Under Option 2, the 4-year plan has a maximum $300.00 daily benefit and 1.5% inflation protection, whereas under Option 2A, which has a higher premium, the 5-year plan has a more generous daily benefit with a 2% inflation rider. Policyholders who choose either of these plans will be guaranteed no further rate increases or benefit reductions in Phase II of the Plan.

--Option 3 allows policyholders to choose a fully paid up "reduced" policy for the premiums they have already paid, which is an overall package of much more limited

benefits, but ones which the Rehabilitator calculated are more generous than those offered in the industry. As this is essentially a "lump sum" benefit package, the purchaser will be charged no more in the way of premiums, but, instead, will receive a fixed amount of benefits no matter how long he or she lives.

--Option 4 allows policyholders to keep their exact same policies and coverage, but pay the "If Knew" rate for that coverage going forward, which the Rehabilitator projected may result in substantial premium increases. *Id.* at 1149-50.

Phase II

Phase II will apply to all policyholders who selected Options 1 and 4, given that those are the only policyholders who will continue to pay premiums. Those who selected Options 2 and 3 will have foregone further premiums in exchange for a fixed or "frozen" amount of defined benefits. The Plan's method of implementation of Phase II anticipates "achieving a self-sustaining premium for every policy" and has as its goal "to eliminate any Funding Gap not eliminated in Phase [I]." *Id.* at 1150. The amount of benefit reductions or premium increases will, thus, be dependent on the Rehabilitator's determination of the financial condition of SHIP after implementation of Phase I.

Phase III

In this phase, the Rehabilitator will "run off" all remaining long-term care policies still in effect, meaning the policies will expire of their own volition according to their terms. *Id.*

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Under the Plan, the Commonwealth Court is the entity which will have the ultimate authority to approve or disapprove the relevant "If Knew" premium rates and the nature of any reduced coverage determined by the Rehabilitator to be necessary.

Given that the Plan will effectuate benefit modifications and rate adjustments for residents of other states who currently hold policies issued by SHIP, the Plan contains a mechanism for other state insurance regulatory bodies to choose to accept or reject the benefit and rate structures contemplated by the Plan for policyholders in their states. Accordingly, the Plan allows other states to affirmatively opt out of it, what the court termed the "Issue State Rate Approval Option."[8] *Id.* at 1157. If those states affirmatively fail to opt out of the Plan by filing a notice with the Rehabilitator in accordance with a deadline specified by the Plan, then they are deemed under the Plan to have opted into it. *See* Plan, 5/3/21, at 109.

In states that opt out of the Plan, for all SHIP policies which are not subject to premium waiver and which have premiums priced below the "If Knew" rate level, the Rehabilitator is required by the Plan to file a request for approval with those states' regulatory bodies to raise those policies' premiums to the "If Knew" level. Such rate applications will be filed by the Rehabilitator on a *seriatim*, *i.e.*, policy by policy, basis. If a rate request is not acted on in 60 days by those states' regulatory agencies, it is deemed denied. *In re SHIP*, 266 A.3d at 1157 n.9.

If the request is denied automatically, or not granted in full by the other states' regulatory agencies, then the Rehabilitator will afford the individual policyholders in those states the following benefit and premium options: The policyholders can: (1) pay the reduced premium approved by their state's regulatory body and have benefits proportionally reduced to actuarially match it; (2) have their benefits downgraded to actuarially match the premium they are currently paying; (3) accept a lump sum "non-

[8] We refer to this aspect of the Plan as the "ISRA option."

forfeiture" benefit package similar to that offered in Option 3 of the Plan, but with less generous benefits; or (4) pay the "If Knew" rates, as determined by the Commonwealth Court, for their current level of benefits. *Id.* at 1157.

The Commonwealth Court held hearings on the Plan from May 17, 2021 through May 21, 2021, during which the parties offered the testimony of several witnesses and introduced other evidence. Notably, during these hearings, Regulators "expressly disavowed that they were appearing in a *parens patriae* or other representative capacity for policyholders in their states." *Id.* at 1181 (citing N.T., 5/19/21, at 541-47).[9]

At the conclusion of the hearings on May 21, 2021, the Commonwealth Court issued a ruling from the bench granting the Rehabilitator's oral motion for judgment in the nature of a directed verdict against Regulators as to the Plan's ISRA option. Regulators filed an application for reconsideration. Regulators also raised a number of other challenges to the Plan, which form the basis of the issues they raise in their current appeal to our Court, and the parties submitted post-hearing briefs to the court detailing their respective positions. Intervenor Health Insurers supported the Plan, and Intervenor NOLHGA did not formally support or oppose the Plan. Although Intervenor Lapinski raised questions regarding the data used in the actuarial calculations of SHIP's Funding Gap and expressed his desire that SHIP's financial condition be addressed swiftly, he did not oppose the Plan.

C. Commonwealth Court Opinion

[9] As our Court has explained, "*Parens patriae* is 'a doctrine by which a government has standing to prosecute a lawsuit on behalf of a citizen, esp. on behalf of someone who is under a legal disability to prosecute the suit.'" *Commonwealth v. Chesapeake Energy Corporation*, 247 A.3d 934, 938 n.3 (Pa. 2021) (quoting *Parens Patriae*, Black's Law Dictionary (11th ed. 2019)).

On August 24, 2021, Judge Leavitt issued a single-judge opinion and order approving the Plan in relevant part. In her meticulous and comprehensive 87-page opinion, she concluded that: (1) the Plan served a rehabilitative purpose and was within the discretion of the Rehabilitator; (2) liquidation, as opposed to rehabilitation, could not achieve the Plan's goals; and (3) the Plan met the legal standards for confirmation. *See generally Id.* at 1167-81. Regarding the seven issues Regulators raise in this appeal, Judge Leavitt addressed each.

First, the court addressed Regulators' complaint that the Plan should not have been approved because it was not feasible, *i.e.*, it did not restore SHIP to solvency. The court opined that there was no statutory requirement under the Insurance Act that a rehabilitation plan must be "feasible," *i.e.*, "reasonably likely to succeed in restoring the company to solvency" in order to be approved. *Id.* at 1181. To the contrary, the court observed that our Court, in the leading case on the standards a rehabilitation plan must meet, *Foster v. Mutual Fire and Marine*, 614 A.2d 1086 (Pa. 1992) ("*Mutual Fire"*), held that, "[s]o long as the rehabilitation properly conserves and equitably administers 'the assets of [the insolvent company] in the interest of investors, the public and others (with) the main purpose being the public good' the plan of rehabilitation is appropriate . . . [but] does not have to restore the company to its exact original condition." *In re SHIP*, 266 A.3d at 1180 (quoting *Mutual Fire*, 614 A.2d at 1094)). Thus, the court rejected the assertion of Regulators that a return to solvency meant the company needed to return to the exact status it had prior to entering bankruptcy, namely, a company which was an active participant in the selling of policies in the insurance marketplace. The court found that the Plan "if successful, will restore SHIP to what it was pre-receivership, *i.e.*, an insurer winding down its long-term care insurance business and able, as a going concern,

to continue coverage and pay the claims of its existing policies." *In re SHIP*, 266 A.3d at 1180.

The court also found that the Plan would "materially reduce" the Funding Gap and therefore "significantly improve" its financial condition. *Id*. Moreover, the court observed that our Court also noted in *Mutual Fire* that rehabilitation where possible is the "preferred course," and that liquidation was a remedy of last resort. *Id.* at 1181 (citing *Mutual Fire*, 614 A.2d at 1094). Thus, in its view, the Plan met both criteria for approval, as it sought to return SHIP to solvency, while avoiding its liquidation.

With respect to Regulators' second issue, in which they assert that the Plan is contrary to law because it operates to improperly disadvantage the financial interests of the individual policyholders — due to the fact that it fails to take into account that guaranty association[10] coverage is available in the event of liquidation, which would, according to Regulators, result in the policyholders being left in a superior financial position — the court rejected these contentions. The court concluded that adoption of the Plan was superior to liquidation in protecting the financial interests of the policyholders for four reasons.

First, the court found that liquidation would not address the Funding Gap caused by what it regarded as the historical inequity in pricing the individual policies. *Id.* at 1168.

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[10] A "guaranty association" is a nonprofit entity created by state statute which has, as its purpose, to act as a "guarantor" to take over insurance policies and protect policyholders in the event the company which issued the policies is unable to pay claims thereunder. Coverage in such instances is limited by statute to $300,000 in total benefits. Guaranty associations recoup the costs of providing such "backup" coverage by assessing the insurance companies which comprise its membership an amount proportional to the volume of business which those companies do within a state. In some states, the insurers are permitted to offset what they pay on the policies of the bankrupt insurer by deducting the amounts from their own premium taxes, imposing surcharges directly on all of the policyholders of the members of the guaranty association, or seeking general rate increases or permission to reduce benefits from state regulators. *See generally* 1 Couch on Insurance, §§ 6:27, 6:28 (3d ed. 2000).

The court noted that the Rehabilitator had found that liquidation was not in "the public good," as that term was used in *Mutual Fire*, since the guaranty associations would pass on the cost of absorbing the coverage through tax offsets or increased premiums to their own policyholders, which would be adverse to the interests of the public as a whole. *Id.* at 1169. The court observed that it was within the Rehabilitator's discretion to make such a finding, and, thus, it was entitled to deference. *Id.*

Second, the court found that liquidation would merely perpetuate the inequitable premium rate structure, given that the guaranty associations would be requesting rate increases based on the already existing inequitable premiums, as they typically requested rate increases based on a cohort of policy holders, not on an individual, serialized basis as the Rehabilitator would under the Plan. *Id.* As NOLHGA's actuary admitted in his testimony in the hearings, this would result in some policyholders paying more than the "If Knew" premium rate of the Plan after liquidation. *Id.* Moreover, guaranty associations are required to request rate increases from the state which issued the policy, not where the policyholder resides, and the approval of such increases when previously requested by SHIP has varied widely between those states — ranging from an 11% approval rate in Maine to a 90% approval rate in Washington. *Id.* The court did not perceive any reason from the evidence presented which persuaded it to believe that this inconsistent and widely varying approval rate among the states would change after liquidation. *Id.*

Third, the court, relying on testimony of the NOLHGA actuary, Matthew Morton, as well as Vincent Bodnar, an insurance industry expert in long term care insurance, found that the liquidation process would take much longer, with a minimum of two years to obtain requested rate adjustments, if they are in fact granted, which is by no means a certain proposition given the experience of SHIP in having such requested increases partly or mostly denied by the various state regulatory bodies. *Id.* By contrast, the court found

that, under the Plan, the Rehabilitator will know within 8 months of its implementation how much of the Funding Gap will be eliminated, as, by then, the policyholders will have had the opportunity to review the benefit and premium election packages the Rehabilitator has prepared and make their selections. *Id.* at 1170. The court observed that this will enable the Rehabilitator to proceed immediately to Phase II, if necessary, or consider other alternatives, depending on how much of the Funding Gap has been eliminated by the implementation of the first phase. In this regard, the court reminded that the Rehabilitator will be providing it with reports and further recommendations as to Phase II, and, thus, the court will have more flexibility than it would in liquidation.

Lastly, the court determined that policyholders would have fewer choices available under liquidation. The court referred to the experience of the liquidation of a long-term care insurer in *Consedine v. Penn Treaty*, 63 A.3d 368 (Pa. Cmwlth. 2012) ("*Penn Treaty*"), *affirmed Consedine v. Penn Treaty*, 119 A.3d 313 (Pa. 2015) (upholding Commonwealth Court's decision to override the decision of the insurance commissioner to liquidate an insolvent insurer, and instead order rehabilitation). The court noted that the final outcome for the insurer in that case, which was liquidation after the rehabilitation attempt failed, resulted in policyholders receiving significantly fewer benefits than those available to policyholders under the Plan. The court highlighted the fact that NOLHGA's actuary admitted that the final coverage options available to policyholders in a liquidation of SHIP would not include the coverages available under options 2, 2A, 3, and 4 of the Plan; thus, the court reasoned that the individual policyholders would have more meaningful policy modification alternatives under the Plan than they would in liquidation. *In re SHIP*, 266 A.3d at 1170.

Regarding Regulators' third issue in which they claim that the Plan denies them due process in violation of the 14th Amendment of the United States Constitution,[11] as well as impairs their existing policies in violation of the Contracts Clause of the United States Constitution,[12] and thereby contravenes *Neblett v. Carpenter*, 305 U.S. 297 (1938) (holding that there is no due process violation under the Fourteenth Amendment, nor an unconstitutional impairment of a contract, when a rehabilitation plan for a defunct insurer offers holders of insurance contracts issued by the defunct insurer the same monetary value that total liquidation of the defunct insurer would provide), the court rejected those assertions. The court applied the test our Court adopted in *Mutual Fire* to determine whether a rehabilitation plan impaired the contractual rights of individual policy holders such that they would be in a worse position than in liquidation: (1) does the plan impair existing contract rights; and, if so, (2) is there a legitimate and significant public purpose which justified the impairment, and (3) are the contractual adjustments reasonable and appropriate to effectuate that purpose? *In re SHIP*, 266 A.3d at 1778 (citing *Mutual Fire*, 614 A.2d at 1094). Under this test, referred to as the *Carpenter* test, a rehabilitation plan should be confirmed if the creditors/policyholders will fare at least as well under the plan as they would in liquidation. *Mutual Fire*, 614 A.2d 1093-94. The court noted that, in applying this test, even if a particular policyholder is found to fare worse under a rehabilitation plan, and the plan significantly impairs the policyholders' contractual rights, the plan will, nevertheless, be upheld if "the Rehabilitator has acted for a legitimate and significant public purpose and the contractual modification is reasonable and appropriate to that public purpose." *In re SHIP*, 266 A.3d at 1178.

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[11] "No State . . . shall . . . deprive any person of life, liberty, or property, without due process of law." U.S. Const. amend. XIV, § 1.

[12] "No State shall . . . pass any Law impairing the Obligation of Contracts." U.S. Const. art. I § 10.

In the instant case, the court found that, even assuming the Plan impairs the contractual rights of its existing policyholders, the testimony of Deputy Rehabilitator Cantilo established a legitimate and significant public purpose for the Plan to do so. According to Cantilo, the Department determined that it did not serve the public interest to have taxpayers absorb the costs of allowing those who paid less than they actuarily should have for the identical coverage by reliance on guaranty association coverage. In Cantilo's view, the Plan avoided this by "right siz[ing]" the policies and enabling the existing policyholders to get basic fundamental long-term care coverage, but also requiring them to pay rates the rest of the taxpaying public would ordinarily pay for such coverage. *Id.* at 1179.

The court rejected Regulators' assertion that the proper metric to assess whether individual policyholders are better off under liquidation than rehabilitation was the net present cash value of the benefits the policyholders would receive under the two approaches, what is commonly termed the *Carpenter* value. The court opined that the true value of continued coverage under the Plan "cannot be reduced to dollar amounts." *Id*. The court relied on actuarial testimony of Cantilo and Bodnar that, in its view, demonstrated that a purchaser of long term care insurance makes such a buying decision based on his or her unique personal goals and objectives – *e.g.*, protecting personal assets in the event of admission into a nursing home – and not on the liquidated dollar value of the coverage purchased.

As to Regulators' fourth issue, in which they claim that the Plan does not serve a legitimate public purpose justifying the impairment of individual policyholders' contracts because the attendant economic harm to them is unreasonable, given that the Plan does not ultimately restore SHIP to solvency, the court rejected that argument. The court found that the goals of the Plan — to "materially reduce the Funding Gap" and "significantly

improve SHIP's financial condition" — served legitimate public purposes justifying the making of such policy modifications, inasmuch as it would enable SHIP to avoid liquidation and "run-off its long-term care insurance business." *Id.* at 1180-81.

Concerning Regulators' fifth issue — that the Plan is unlawful because it does not treat policyholders in different states equally — the court found it to be meritless. The court first observed that Regulators lacked standing to assert such a claim, in light of their express disavowal that they were acting in either a *parens patriae* or a representative capacity for the individual policyholders within their states. *Id.* The court also found that Regulators presented no evidence which would establish that the policyholders in their states would be unfairly treated by eliminating the current inequitable rate structure whereby those who are paying greater than average premiums are effectively subsidizing the lower-than-average premiums paid by other policyholders for the same coverage. The court noted that "[t]he Plan will require similarly situated policyholders to pay the same premium for the same coverage," *id.*, no matter which state the policies were originally issued in, or where the policyholders currently reside.

With respect to Regulators' sixth issue — their claim that the Rehabilitator's statutory authority under Article V of the Insurance Act in carrying out a plan of rehabilitation does not include the authority to change the rates and terms of the policies of out-of-state policyholders without approval of those states' regulatory bodies — the court found that this challenge lacked merit. The court noted that the Rehabilitator has broad authority under Section 221.16(b) of the Insurance Act to "take such action as [he] deems necessary or expedient to correct the condition that caused the need for rehabilitation." *Id.* at 1171 (quoting 40 P.S. § 221.16(b)) (internal quotation marks omitted). In the court's view, this statutory authority — allowing the Rehabilitator to "correct the condition" leading to the need for rehabilitation — includes the authority to

approve a combination of benefit modifications and premium increases as called for by the Plan. The court considered this grant of legislative authority to be consistent with the principles our Court set forth in *Mutual Fire*, wherein we recognized the Rehabilitator's expansive discretionary right, conferred by the General Assembly, to carry out the intent of the rehabilitation statutes, which includes the right of the Rehabilitator to impair the contractual rights of some policyholders in order to minimize the harm to all affected parties. *Id.* The court regarded the Plan's ultimate goal of maintaining coverage for the policyholders by setting actuarially justified rates as being within the scope of the Rehabilitator's broad powers. *Id.* at 1172. The court reminded that the rate setting and benefit reductions would be subject to its review during the course of the rehabilitation proceedings. *Id.*

The court rejected Regulators' argument that the Rehabilitator is not statutorily empowered to impose this rate structure on out-of-state policyholders. The court noted that, under Section 221.15(a) of the Insurance Act, the Commonwealth Court is authorized to rehabilitate the business of any insurer domiciled in Pennsylvania, and, as a general principle of insurance law, the state of domicile of a bankrupt insurer "has an overriding interest in assuring that the rehabilitation, if possible, is effectuated." *Id.* (quoting *Matter of Mutual Benefit Life Insurance Company*, 609 A.2d 768, 777 (N.J. Super. 1992)). Consequently, any decree issued by a court "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." *Id.* (quoting 1 Couch on Insurance 3d § 531).

Moreover, the court reminded that Regulators' states — Maine, Massachusetts, and Washington — adopted the model Uniform Insurance Liquidation Act ("UILA"), approved by the National Conference of Commissioners on Uniform State Laws, and

Pennsylvania adopted a similar piece of model legislation, the Insurer's Supervision and Model Rehabilitation Act promulgated by the National Association of Insurance Commissioners ("Model Act"). The court highlighted that both model statutes have as enumerated goals "a single, cohesive, uniform handling of [a bankrupt insurer's] rehabilitation through a single state." *In re SHIP*, 266 A.3d at 1173. Therefore, allowing Pennsylvania to assume primacy over the receivership was, in the court's view, consistent with Regulators' states' statutory framework governing rehabilitation of bankrupt insurers, which also designate the insurance commissioner of the state in which the bankrupt insurer is domiciled to be the receiver for the insurer. Based on all of these factors, the court concluded that "Regulators have presented no reason to set aside Pennsylvania's primacy in SHIP's receivership." *Id.* at 1173.

The court was similarly unpersuaded by Regulators' assertion, which is also reiterated in its brief to our Court: that Pennsylvania is required by the Full Faith and Credit Clause of the United States Constitution[13] to apply the rate laws of Regulators' states in establishing the "If Knew" rate to be used under the Plan. The court observed that the United States Supreme Court has described the fundamental purpose of this constitutional provision as reflective of an intent to strip states of their status as independent, foreign sovereigns which could "ignore obligations created under the laws or by the judicial proceedings of [other states], and to make them integral parts of a single nation throughout which a remedy upon a just obligation might be demanded as of right, irrespective of the state of its origin." *Id.* at 1173 (quoting *Baker by Thomas v. General*

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[13] This clause mandates:

> Full Faith and Credit shall be given in each State to the public Acts, Records, and judicial Proceedings of every other State. And the Congress may by general Laws prescribe the Manner in which such Acts, Records and Proceedings shall be proved, and the Effect thereof.

U.S. Const. art. IV, § 1.

Motors, 522 U.S. 222, 232 (1998)). However, the court noted that the United States Supreme Court has also distinguished between a state court's obligation under the Full Faith and Credit Clause with respect to a final judgment rendered by courts of other states, and the substantive laws of those states. The court underscored that the high Court has held that, while the Full Faith and Credit Clause compels a state court to recognize the judgments entered by courts of sister states, a state court remains free to "lawfully apply either the law of one state or the contrary law of another [state]." *Franchise Tax Board of California v. Hyatt*, 538 U.S. 488, 496 (2003) ("*Hyatt*"). Thus, while the Full Faith and Credit Clause forbids a court from applying public policy considerations of its own state to avoid recognizing the judgment of a court of a sister state, a court is not barred by this constitutional provision from following the public policy embodied in the statutes of its own state when determining which law to apply in adjudicating a particular controversy.

In accordance with these principles, the Commonwealth Court observed that, in *Hyatt*, the high Court upheld a Nevada court's application of a Nevada statute which exempted state agencies from immunity against suits for intentional torts, to allow intentional tort claims to be maintained against a California franchise tax board, even though the board was immune from such suits under California law. The Commonwealth Court noted that the high Court emphasized that a state is not required "to apply another state's law that violates its 'own legitimate public policy.'" *In re SHIP*, 266 A.3d at 1174 (quoting *Hyatt*, 538 U.S. at 497). Because the choice of law made by the Nevada court "did not exhibit a policy of hostility to the Public Acts of a sister State," and because the Nevada court had "rel[ied] on the contours of Nevada's own sovereign immunity from suit [statute] as a benchmark for its analysis," the high Court found no violation of the Full

Faith and Credit Clause. *Id.* at 1174 (quoting *Hyatt*, 538 U.S. at 499) (internal quotation marks omitted).[14]

Applying these principles to the case at bar, the Commonwealth Court found that the use of the "If Knew" methodology, which assumes a loss ratio of 60% for the lifetime of the policy, is the "benchmark for a premium rate increase in Pennsylvania and most other states." *Id.* at 1175. Thus, because this methodology is routinely used in the rate setting process by Regulators' states, in the court's view, it cannot be regarded as discriminatory or unreasonable.

The court acknowledged that the Plan "does not follow the ordinary rate review process for a solvent insurer." *Id.* at 1176. However, the court described the effect of the rate review process set forth in the Plan as merely changing the forum for the determinations of policyholders' premiums from Regulators' states to Pennsylvania — the state which is responsible for rehabilitating SHIP. Because the court perceived this to be a procedural conflict regarding the proper forum for such determinations, and not a conflict in substantive law, the court found it was not required to defer to the forum choice of those states.

The court denied that automatic imposition of the rate and benefit structures under the ISRA option of the Plan, triggered if Regulators' states opted out of the Plan, was coercive, given that, in its view, Regulators' states still had a meaningful way to control the mix of benefit reductions and premium increases when the Rehabilitator applied for rate increases in those states. Crucially, however, the court stressed that this mechanism prevents those states from interfering with Pennsylvania's overall ability to rehabilitate SHIP. The court found, based on the testimony of Cantilo, that forcing the Rehabilitator to use the normal rate settling processes established by the statutes in Regulators' states

[14] We discuss *Hyatt* more fully below.

would be time consuming and cumbersome, taking an average of 6-12 months for preparation of the rate request, as well as additional lengthy review periods, and it would not solve the previous problem of those states' regulatory bodies granting varying levels of the requested premium adjustments. The court concluded this delay would serve to undermine Pennsylvania's own legitimate and dominant public policy interest, reflected in Section 221.1(c) of the Insurance Act, to rehabilitate a domestically domiciled insurance company by restoring it to financial solvency in an expeditious fashion.

Moreover, the court found that the states of Maine, Massachusetts, and Washington had a common policy interest with Pennsylvania to ensure that insurance rates paid by policyholders "are not excessive, unfairly discriminatory, or unreasonable to the benefits provided," which the court concluded the Plan would further. *Id.* at 1177.

Consequently, the court determined that, because the Plan did not reflect a policy of hostility to the insurance regulatory statutes of Maine, Massachusetts, or Washington, and properly relied on the contours of Pennsylvania insurance law as "a benchmark for its analysis," it rejected Regulators' Full Faith and Credit Clause claim. *Id*. (quoting *Hyatt*, 538 U.S. at 499).

With respect to Regulators' final issue presented to us and which they raised in their motion for reconsideration of the directed verdict entered below — that the ISRA option in the Plan did not ameliorate the Plan's interference with Regulators' authority to set rates for the policyholders in their states because it was "coercive and provides them with no meaningful review of the rate filings," *id.* at 1184 — the court found these claims devoid of evidentiary support. The court pointed out that, though Regulators claimed that the requirement that they act within 60 days to review rate filings and to consider them on a *seriatim* basis was inconsistent with their own state practices, they presented no evidence of record to support this claim. The court also noted that, while Regulators

claimed the ISRA option harmed their interests, only 2,000 of the 39,000 policyholders lived within Regulators' states.

Having rejected these various objections, the court formally approved the Plan. Its order directed the Rehabilitator to prepare an actuarial memorandum in support of the "If Knew" rates to be used in Phase I of the Plan and to submit it to the Insurance Department for review and approval. The order additionally instructed the Rehabilitator to designate a deputy insurance commissioner to review the actuarial memorandum and submit it to the court for its approval.

Regulators filed a direct appeal from the Commonwealth Court's order to our Court.[15]

II. Analysis

A. Issues

As discussed above, Regulators present seven issues for our consideration:

> 1. Whether the Commonwealth Court erred as a matter of law in holding that the Plan is not required to be feasible and in approving the Plan that the Rehabilitator acknowledges is not reasonably likely to restore SHIP to solvency[?]
>
> 2. Whether the Commonwealth Court erred as a matter of law in approving the Plan as within the Rehabilitator's discretion based on a "legitimate and significant public purposes" standard rather than the classic test of the best financial interest of policyholders in that the Plan places the entire $1.224 billion insolvency on the remaining policyholders and avoids triggering guaranty associations that would provide $837 million in additional support?
>
> 3. Whether the Commonwealth Court erred as a matter of law in approving the Plan where it does not provide policyholders

[15] Regulators simultaneously filed an application for a stay pending appeal in the Commonwealth Court, which denied the request. *See In re SHIP*, 1 SHP 2020 (Pa. Cmwlth. filed Nov. 4, 2021) (order). After this denial, Regulators filed an application with our Court for a stay pending appeal, which we denied. *In re SHIP*, 71 MAP 2021 (Pa. filed Jan. 31, 2022) (order).

> with a value in rehabilitation at least equal to the value in liquidation as required by the Due Process and Contracts Clauses of the United States Constitution and the Supreme Court's decision in *Neblett* v. *Carpenter*, 305 U.S. 297 (1938)?
>
> 4. Whether the Commonwealth Court erred as a matter of law in approving the Plan where it substantially impairs policyholders' contract rights without a legitimate public purpose, since it is unlikely to restore SHIP to solvency, and thereby unreasonably imposes economic harm on policyholders in violation of the Contracts Clause?
>
> 5. Whether the Commonwealth Court erred as a matter of law in approving the Plan where it does not treat policyholders in all states equally as required by 40 P.S. § 221.44 and § 221.61 and *Neblett v. Carpenter*, 305 U.S. 297 (1938)?
>
> 6. Whether the Commonwealth Court erred as a matter of law in approving the Plan where it violates the Full Faith and Credit Clause of the United States Constitution and exceeds the statutory authority of 40 P.S. § 221.15 and § 221.16 by seeking to set rates in States other than Pennsylvania and supersede the authority of insurance regulators in other States?
>
> 7. Whether the Commonwealth Court erred as a matter of law in holding that the "issue state rate approval" provision cures the Plan's improper attempt to supersede the authority of insurance regulators in other states and in granting the Rehabilitator's motion "in the nature of directed verdict" on this issue?

Regulators' Brief at 4-5.

B. Standard of Review

As our Court has previously emphasized, insurance is a "highly specialized industry." *Mutual Fire*, 614 A.2d at 1092. As a result, "the skill, judgment and expertise of the Insurance Commissioner are statutorily recognized and deferred to, resulting in a broad scope of discretionary powers." *Id.* Due to the Commissioner's considerable proficiency and intensive involvement in the field of regulation and supervision of

insurance companies that transact business within this Commonwealth, generally, as well as the Commissioner's extensive past particularized experience in overseeing the business affairs of insolvent insurers, judicial review of the actions of the Commissioner in developing a plan of rehabilitation for an insolvent insurer is circumscribed, and is deferential to the numerous factual and public policy determinations made by the Commissioner in developing the plan. *Id.* at 1091. We are also mindful of the critical supervisory role the Commonwealth Court plays in the rehabilitation process, as required by the Insurance Act, to work closely with the Commissioner in overseeing the implementation of the rehabilitation plan:

> [T]he Insurance Commissioner and the Commonwealth Court are obligated to interact in order to supervise, implement and regulate equitably the process engaged to rehabilitate an insolvent or financially hazardous insurer. As a result of these specific assignments, it is not the function of the courts to reassess the determinations of fact and public policy made by the Rehabilitator. Rather, the involvement of the judicial process is limited to the safeguarding of the plan from any potential abuse of the Rehabilitator's discretion.

Id.; *see also* Couch on Insurance, § 5.23 (acknowledging that, while courts have a role in controlling an insurance commissioner's exercise of his or her powers, a court "may not, however, use its supervisory role as a means of substituting its judgment for that of the commissioner").

In fidelity to these principles, our Court's review of an order of the Commonwealth Court with respect to a plan of rehabilitation presented by the Commissioner is limited to three specific areas:

> (1) examination of whether the Commonwealth Court exceeded its statutory authority to approve, disapprove or modify the rehabilitation plan; (2) determin[ation] [of] whether the Commonwealth Court substituted any of its own beliefs

> into the rehabilitation process; and (3) if so, whether the exercise of such discretion was for the prevention of further abuse by the Rehabilitator, and not to change the substance of the plan.

Mutual Fire, 614 A.2d at 1092. Where a rehabilitation plan reflects the "considered exercise of judgment on behalf of the Insurance Commissioner in her capacity as Rehabilitator," and where the plan will be "thoroughly supervised and implemented with the capable assistance of the Commonwealth Court, as provided by statute, we cannot interfere with those findings or determinations made below, absent an abuse of discretion." *Id*. at 1093.

C. Standing

Initially, we address the Rehabilitator's argument that Regulators lack standing to challenge the Plan as unlawful or an abuse of discretion, inasmuch as a party seeking judicial resolution of a controversy "must establish as a threshold matter that he [or she] has standing to maintain the action." *Fumo v. City of Philadelphia,* 972 A.2d 487, 496 (Pa. 2009). In Pennsylvania, unlike the federal system, in which courts "derive their standing requirements from Article III of the United States Constitution, standing for Pennsylvania litigants has been created judicially." *Johnson v. American Standard*, 8 A.3d 318, 329 (Pa. 2010) (citation omitted). Our doctrine of standing "stems from the principle that judicial intervention is appropriate only where the underlying controversy is real and concrete, rather than abstract." *Firearm Owners Against Crime v. Papenfuse*, 261 A.3d 467, 481 (Pa. 2021). This doctrine therefore serves "to protect against improper plaintiffs," *Application of Biester*, 409 A.2d 848, 851 (Pa. 1979), as well as ensures that our courts are not called upon to issue "advisory or abstract opinions," *Markham v. Wolf*, 136 A.3d 134, 140 (Pa. 2016). A "person who is not adversely affected in any way by the

matter he seeks to challenge is not aggrieved thereby and has no standing to obtain a judicial resolution to his challenge." *Johnson*, 8 A.3d at 329 (citation and internal quotation marks omitted).

The Rehabilitator first asserts that, though Regulators claimed that they were appearing in their capacity as Regulators, in reality "many of their arguments are directed to issues related to the impact on policyholders." Rehabilitator's Brief at 15. Indeed, the Rehabilitator emphasizes that Regulators "concede that they do not speak for or represent any of SHIP's policyholders," given that "they expressly disavowed acting in a representative capacity for even the policyholders in their own respective states." *Id.* Thus, the Rehabilitator contends that any argument Regulators make regarding the impact of the Plan on individual policyholders "should be disregarded as a mere difference of opinion." *Id.* at 16.

The Rehabilitator further argues that Regulators failed to adduce any evidence which demonstrated that the Plan caused harm to their rights as regulators. The Rehabilitator notes that even Regulators' own witness testified only to his opinion of the more negative effect the Plan's implementation, compared to a liquidation, would allegedly have on *policyholders*; moreover, Rehabilitator points out that, as the Commonwealth Court found, that witness did not address why the Plan's ISRA option "was deficient in some way." *Id.* at 17 (quoting *In re SHIP*, 266 A.3d at 1183).

In response, Regulators characterize Rehabilitator's contentions regarding standing as "late . . . [and] inconsistent with the established process for review of the Plan and the statutory role of insurance regulators in protecting policyholders by enforcing insurance laws generally and reviewing rates in particular." Regulators' Reply Brief at 24.

Regulators note that they "are the public officials charged with regulating the insurance industry to protect policyholders in their states." *Id.* at 26. They contend that the Plan "seeks to fundamentally change the relationship between SHIP, an insurer doing business in their states, and its policyholders in their states by reducing benefits and increasing rates." *Id.* Regulators claim that these impacts of the Plan on their policyholders' contracts and rates gives them standing to contest the Plan's legality.

As for the harm which they purportedly will suffer in their capacity as public officials charged with enforcing the insurance laws of their states, Regulators assert that they need not demonstrate actual harm to have standing, inasmuch as alleged violations of the statutes they are charged with enforcing is considered to be, *per se,* contrary to the public interest, which gives them standing to challenge the conduct giving rise to the violation. They further maintain that there was sufficient evidence produced at the hearings, both from the Rehabilitator and themselves, which showed both how the policyholders contract rights were reduced, and the manner in which their states' rate review process was displaced by the Plan's singular control over rates on a nationwide basis. *Id.* at 28.

Issues concerning a party's standing present pure questions of law. *Johnson*, 8 A.3d at 326. Accordingly, our standard of review is *de novo* and our scope of review is plenary. *Id.*

Even though Regulators were granted Intervenor status by the Commonwealth Court, they nevertheless must demonstrate standing as to the particular issues that they wish to raise on appeal. *See Citizens Against Gambling Subsidies, Inc. v. Pennsylvania Gaming Control Board*, 916 A.2d 624, 628 (Pa. 2007) ("Standing to appeal generally

requires both status as a party and aggrievement."). To do so, they must demonstrate they are aggrieved, which requires a showing that

> the litigant has a substantial, direct, and immediate interest in the matter. To have a substantial interest, the concern in the outcome of the challenge must surpass the common interest of all citizens in procuring obedience to the law. An interest is direct if it is an interest that mandates demonstration that the matter caused harm to the party's interest. Finally, the concern is immediate if that causal connection is not remote or speculative. The keystone to standing in these terms is that the person must be negatively impacted in some real and direct fashion.

Markham, 136 A.3d at 140 (citations and internal quotation marks omitted).[16]

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[16] To the extent that Regulators' averment that the Rehabilitator's standing arguments are "late," Regulators' Reply Brief at 24, can be construed as a contention that they are waived for purposes of this appeal, we reject it. We note that the Rehabilitator challenged Regulators' lack of standing in the Commonwealth Court. *See* Rehabilitator's Pre-Hearing Rebuttal Memorandum, filed in *In re SHIP*, 1 SHP 2020 (Pa. Cmwlth.), 4/19/21, at 27-31 (arguing, *inter alia*, that Regulators failed to demonstrate harm to their own interests or the interests of policyholders in Regulators' states; and that an entity has no standing to obtain judicial relief unless adversely affected by matter at issue); Rehabilitator's Post-Hearing Submission, filed in *In re SHIP*, 1 SHP 2020 (Pa. Cmwlth.), 6/14/21, at 57 (proposing conclusion of law that "Regulators have not established any interest such that they should remain involved in the implementation of the Plan"); Rehabilitator's Brief in Response to Post-Hearing Submissions, filed in *In re SHIP*, 1 SHP 2020 (Pa. Cmwlth.), 6/29/21, at 2-4, 7-10 (explaining that Regulators have no real interest in outcome of proceedings and failed to establish harm to themselves or policyholders, and contending that Commonwealth Court should reject Regulators' arguments in their entirety for failure to demonstrate the threshold requirement of injury to Regulators).

The Commonwealth Court did not specifically rule on the Rehabilitator's standing challenge to each of the claims Regulators currently present for appellate review, except to conclude that Regulators lacked standing to raise the argument embodied in their fifth issue — that the Plan is allegedly unlawful because it does not treat all policyholders in different states equally — because Regulators had expressly disavowed that they were acting in either a *parens patriae* or representative capacity for the individual policyholders within their states. *In re SHIP*, 266 A.3d at 1181. Nevertheless, the court proceeded to address that issue on the merits.

Subsequently, in a memorandum opinion accompanying its order denying Regulators' motion for a stay pending appeal, the Commonwealth Court opined that Regulators' "lack of standing to assert claims on behalf of policyholders" was an (continued…)

A review of Regulators first five issues compels us to conclude that they do not assert therein a harm to a "direct interest," which they themselves possess, and which can be avoided through a judicial resolution. In those issues, Regulators assert various detrimental impacts which they contend will be inflicted on the financial interests of individual SHIP *policyholders*, as well as to those policyholders' personal interests in maintaining the long-term care coverage they purchased, due to the Plan's restructuring of the rates and coverages; but Regulators do not assert impacts on themselves.

In their first issue, Regulators assert that the Commonwealth Court erred in approving the Plan because the Plan is not "feasible," *i.e*., not "reasonably likely to succeed in restoring the company to solvency." Regulators' Brief at 25. They argue that a "feasibility requirement protects policyholders," and that implementing the Plan, which they contend "will lead to permanent reductions in policy benefits," *id*. at 27, when it is not feasible will result in policyholders receiving less in the inevitable liquidation which will follow, *id.* at 28. In their second issue, Regulators assert that the Plan "disregard[s] the best financial interest of policyholders and the statutory guaranty association system." *Id*. at 29 (capitalization omitted). Regulators submit that the Plan contravenes Article V of the Insurance Act and state guaranty association statutes, which seek to protect policyholders and honor their contractual rights by reducing those policyholder rights and advancing the Rehabilitator's and Commonwealth Court's own "policy views at the expense of policyholders." *Id*. at 30. In their third and fourth issues, Regulators argue

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"impediment to . . . Regulators' case on appeal." *In re SHIP*, 1 SHP 2020 (Pa. Cmwlth. filed Nov. 4, 2021), slip op. at 4.

In any event, because the Rehabilitator raised its standing claims below, they are properly preserved for our review. *See* Pa.R.A.P. 302(a).

that the Plan "fails to satisfy the constitutional standard that [the Plan] place policyholders in at least as good a position as liquidation," *id.* at 37 (capitalization omitted), as required by *Neblett, supra,* and that the Plan substantially impairs policyholders' contract rights without a legitimate public purpose, violating the Contracts Clause of the United States Constitution, *id.* at 42-44. Finally, in their fifth issue, Regulators claim that the Plan unlawfully treats policyholders in different states unequally, in violation of Article V of the Insurance Act and *Neblett*, "by reducing benefits or increasing premiums more in some states than others." *Id*. at 45.

As this summary illustrates, each of these five issues concern the Plan's alleged harm *only* to the personal interests of SHIP's policyholders, not to Regulators. Yet, because Regulators expressly disavowed that they were representing the interests of SHIP policyholders in the proceedings in the Commonwealth Court, either directly or in a *parens patriae* capacity, and because Regulators have failed to identify any other substantial, immediate, and direct harm that they would personally suffer flowing from the Commonwealth Court's rulings that are the subject of these five challenges, we conclude that Regulators lack standing to raise them in this appeal. *See Hospital & Healthsystem Association of Pennsylvania v. Department of Public Welfare*, 888 A.2d 601, 607 (Pa. 2005) ("[W]here a person is not adversely affected in any way by the matter challenged, he is not aggrieved and thus has no standing to obtain a judicial resolution of that challenge." (quoting *William Penn Parking Garage v. City of Pittsburgh*, 346 A.2d 269, 280 (Pa. 1975)); *Citizens Against Gambling Subsidies*, *supra* (where intervenors could not demonstrate harm to any direct personal interest in the outcome of casino licensing

proceedings they were challenging, they lacked standing to challenge the lower tribunal's ruling on appeal).

Turning to Regulators' remaining two issues, they allege that the Commonwealth Court erred in approving the Plan because it unlawfully exceeds the statutory authority conferred on the Rehabilitator and the Commonwealth Court by the Insurance Act, given that, in their view, it allows those entities to set rates in Regulators' states, thereby improperly superseding Regulators' exclusive statutory authority to do so. They maintain this exercise of power also violates the Full Faith and Credit Clause of the United States Constitution. Finally, they contend that neither of these violations are cured by the ISRA option of the Plan. Regulators' Brief at 50-56. These particular issues manifestly relate to the Plan's impact on Regulators' ability to carry out their statutory duties regarding the approval of rates charged for insurance policies issued within their respective states.

With respect to the question of the standing of an administrative agency to be a litigant in adjudicative proceedings, we have held:

> when the legislature statutorily invests an agency with certain functions, duties and responsibilities, the agency has a legislatively conferred interest in such matters. From this it must follow that, unless the legislature has provided otherwise, such an agency has an implicit power to be a litigant in matters touching upon its concerns. In such circumstances the legislature has implicitly ordained that such an agency is a proper party litigant, *i.e.,* that it has "standing."

Commonwealth, Pennsylvania Game Commission v. Commonwealth, Department of Environmental Resources, 555 A.2d 812, 815 (Pa. 1989); *accord In re T.J.*, 739 A.2d 478, 482 (Pa. 1999).

In the case *sub judice*, Regulators are the public officials responsible under the laws of their respective states tasked by their states' legislatures with the duty to regulate

rates an insurer like SHIP may charge for long-term care policies. *See*, *e.g.*, Me. Stat. 24-A § 211; Mass. Stat. 175 § 3A; Wash. Rev. Code §§ 48.01.020, 48.02.060. Accordingly, because the final two challenges by Regulators to the Plan are based on their assertions that it affects their statutory functions, duties, and responsibilities regarding the setting of insurance rates within their own states, we conclude that they have standing to pursue these issues in this appeal. *Pennsylvania Game Commission; In re T.J.* Consequently, we will address the substantive merits of these claims.

D. Whether the Plan Unlawfully Displaces the Insurance Regulatory Authority of Other States[17]

Regulators contend that, because a state may constitutionally regulate insurance companies doing business within its borders, which includes the right to require rate approvals, the regulation of premium rates is an activity which is committed to the authority of individual states, and each of their states has statutorily granted to them the right to review and approve the rates an insurer charges for long-term care policies for their state's residents. *See* Regulators' Brief at 49 (citing, *e.g.*, Me. Stat. 24-A § 2736; Mass. Stat. 175 §§ 108, 108(8)A; Wash. Rev. Code § 48.19.010(2)). Additionally, Regulators highlight that their rate-making decisions are subject to review by the courts of their respective states. Regulators aver that, because the Plan increases rates for affected policyholders within their jurisdiction without their approval, it strips Regulators and their state courts of their statutory roles and thus violates their states' statutory frameworks.

[17] Because Regulators' arguments that the opt-out provision fails to cure what they characterize as the Plan's improper attempt to supersede their regulatory authority are intertwined with this issue, we will consider them in our discussion insofar as they are relevant.

Regulators further argue that the Commonwealth Court erred by finding that the Rehabilitator possessed authority under Article V of the Insurance Act to supersede their states' regulatory authority over insurers. Regulators note in this regard that, while the Insurance Act permits a rehabilitator to "take possession of the assets of the insurer . . . and to administer them," 40 P.S. § 221.15(c), as well as to "take such action as he deems necessary or expedient to correct the condition or conditions which constituted the grounds for the order of the court to rehabilitate the insurer," *id.* § 221.16(b), these statutory provisions do not provide authority to the Rehabilitator "beyond [that possessed by] the insurer itself." Regulators' Brief at 50.

Likewise, according to Regulators, other provisions of Article V, such as 40 P.S. § 221.5(b) (granting a receiver the right to "apply to any court outside of the Commonwealth" for injunctions and orders relating to assets and activities of the insurer) and Section 221.17(a) (directing a rehabilitator to "immediately consider all litigation pending outside this Commonwealth and . . . petition the courts having jurisdiction over that litigation for stays whenever necessary to protect the estate of the insurer"), provide evidence that Article V was intended to recognize the authority of other states during the rehabilitation process.

Regulators acknowledge that 40 P.S. § 221.1(a) (providing that Article V "shall not be interpreted to limit the powers granted the commissioner by other provisions of the law") grants the commissioner as rehabilitator broad regulatory authority during the rehabilitation process, including rate review authority; nevertheless, they assert that this provision cannot be read to limit their authority as regulators in the setting of policy

premium rates. They contend that "[a]n insurer in rehabilitation is subject to rate regulation like any other insurer." Regulators' Brief at 52.

Regulators dispute the Commonwealth Court's finding that Pennsylvania, as the domiciliary state of SHIP, has an "overriding interest" in the conduct of the rehabilitation process. *Id.* (quoting *In re SHIP*, 266 A.3d at 1172). Regulators proffer that Rehabilitator's control over the physical assets and the business affairs of an insolvent insurer does not also encompass the right to "displace the roles of regulators in other [s]tates under their own laws concerning business transacted in their [s]tates." *Id.* at 52. Additionally, Regulators argue that uniform insurance laws like the UILA and the Model Act do not contain provisions altering the normal rate-setting authority during the rehabilitation process. Regulators reject the Commonwealth Court's assertion that this is merely a "procedural" issue, and instead characterize it as an attempt by the Rehabilitator and the Commonwealth Court to "project [their] policy preferences into other [s]tates," thereby interfering with those states "exclusive responsibility to protect their residents by reviewing rates to be charged." *Id.* at 53.[18]

The Rehabilitator responds by pointing out that the Commonwealth Court has been given original jurisdiction under the Judicial Code "of all civil actions or proceedings . . . [a]rising under Article V of the [Insurance Act]." 42 Pa.C.S. § 761(a)(3). Rehabilitator avers that, when this provision is read in conjunction with the specific statutory powers

[18] *Amici*, the Insurance Regulators of the states of Alaska, Arizona, Arkansas, Connecticut, Idaho, Indiana, Iowa, Louisiana, Maryland, Mississippi, Montana, New Hampshire, New Jersey, New Mexica, North Carolina, North Dakota, Ohio, Oklahoma, Rhode Island, South Carolina, South Dakota, Utah, Vermont, West Virginia, Wisconsin, and Wyoming, and the District of Columbia, have filed a brief in support of Regulators, and their position on this issue aligns with Regulators' position.

afforded him under Article V, 40 P.S. § 221.15(a) (authorizing the insurance commissioner to apply for an order of rehabilitation, of an insurer domiciled in Pennsylvania); *id.* § 221.15(c) (appointing the insurance commissioner rehabilitator and empowering him or her to "take possession of the assets of the insurer . . . and to administer them under the orders of the court"); the stated purpose of Article V, *see id.* § 221.1(c) ("The purpose of this article is the protection of the interests of insureds, creditors, and the public generally, with minimum interference with the normal prerogatives of the owners and managers of insurers, through . . . equitable apportionment of any unavoidable loss . . . ."); and Article V's requirement that the Commonwealth Court give final approval to any plan of rehabilitation, *id.* § 221.16(d), these provisions establish that Pennsylvania courts have exclusive jurisdiction with respect to the distribution of the assets of an impaired insurer. Rehabilitator's Brief at 44.

The Rehabilitator stresses that the need for giving one state the exclusive jurisdiction over delinquency proceedings involving an insurer which conducts business in multiple states has been well-recognized by various courts, which have held that the court with jurisdiction over the insurer's assets during those proceedings may modify or qualify the insurer's existing obligations to policyholders. *Id.* at 45-46 & n.23 (citing, *e.g.*, *Carpenter v. Pacific Mutual Life Insurance Company*, 74 P.2d 761, 776 (Cal. 1937), *affirmed sub nom. Neblett v. Carpenter*, *supra* (observing that California insurance company in the normal conduct of its business is prohibited by the contract and due process clauses of the United States Constitution from modifying existing policies; however, when the company is the subject of a rehabilitation proceeding, the rehabilitator, may, as a valid exercise of the state's police power, do so without offending those

constitutional strictures); *Kentucky Central Life Insurance Company v. Stephens*, 897 S.W.2d 583, 587 (Ky. 1995) (holding that, because the state has an important and vital interest in the reorganization of a financially troubled insurer, policyholders' contracts are "subject to a reasonable exercise of state police power" as part of the reorganization process); *In re Ambac Assurance Corporation*, 841 N.W.2d 482, 509 (Wis. Ct. App. 2013) ("[I]t is axiomatic that the commissioner, in the reasonable exercise of the state's police power, may structure a rehabilitation plan that has the potential to adversely affect the interests of individual policyholders when the plan advances the broader interests of the policyholders, the creditors, and the public as a whole.")). The Rehabilitator argues that Pennsylvania courts have likewise recognized that policyholder contracts may be restructured in a rehabilitation proceeding "so long as those modifications satisfy the governing test for impairment of contracts." *Id.* at 46 (citing *Koken v. Legion Insurance Company*, 831 A.2d 1196, 1241 (Pa. Cmwlth. 2003) (observing that, in a rehabilitation proceeding, "Article V authorizes reformation and novation where appropriate to avoid prejudice to policyholders") (emphasis omitted); *Grode v. Mutual Fire Insurance Company*, 572 A.2d 798, 805 (Pa. Cmwlth. 1990) (holding that "contractual impairments that are insubstantial and reasonably necessary to implement a rehabilitation plan cannot be deemed unlawful")).

The Rehabilitator contends that the real crux of Regulators' contention is that the policy modifications which the Plan makes are not required to comply with their state laws and regulations which govern insurance policies during the ordinary course of an insurer's business; however, the Rehabilitator points out that, because this is a rehabilitation proceeding, courts are not required to strictly uphold policyholder contracts, and that

reformation and repricing of such contracts to modify policyholder premiums and benefits are within the power of the rehabilitation court. *Id.* at 46-47 (citing *Penn Treaty*, 63 A.3d 368, 459 (Pa. Cmwlth. 2012) (rejecting contention that Commonwealth Court lacked authority to modify policyholder benefits as part of an approved rehabilitation plan as, in a rehabilitation, existing policies may be "reformed and repriced")).

Moreover, Rehabilitator argues that Regulators cannot rely on their states' regulations governing policy modifications and pricing as justification for limiting the Rehabilitator's own authority to modify policies, given that those state regulations do not apply, generally, to rehabilitation proceedings, and, regardless, do not give authority to Regulators to control the rehabilitation of SHIP by the Commonwealth Court, which has statutorily been given exclusive jurisdiction over the distribution of its assets.[19] [20]

As our Court has recognized, "the regulation of insurance companies both solvent and insolvent has been conceded to the states." *Mutual Fire*, 614 A.2d at 1101 n.12; *see also* McCarran-Ferguson Act, 15 U.S.C. § 1012(a) ("The business of insurance, and every person engaged therein, shall be subject to the laws of the several [s]tates which relate to the regulation or taxation of such business."). In Pennsylvania, the General Assembly has provided that our Commonwealth's regulatory power over insurance companies, whatever their financial condition, and the overall conduct of the insurance industry,

[19] In their brief filed with our Court, Health Insurers align with and endorse Rehabilitator's arguments on this question.

[20] In his *pro se amicus* brief, James Lapinski states that he and his wife are owed approximately $150,000, and, because they desire that the rehabilitation commence quickly, they oppose liquidation. He also attacks what he characterizes as the costly intervention of Regulators, pointing out that they represent only three out of 50 states in which policyholders reside, and he expresses the view that the money spent on legal fees related to their challenges could better be spent on paying policyholders.

generally, is to be exercised in the manner specified by the comprehensive statutory framework of the Insurance Act.

As our Court explained in *Mutual Fire*:

> The General Assembly, in recognition of the specialized complexities involved in insurance generally, and in the regulation of this industry in particular, assigned the task of overseeing the management of that industry, in this Commonwealth, to the Insurance Department, the agency having expertise in that field. 40 P.S. § 41, *et seq.* The Insurance Commissioner, an appointed position pursuant to 40 P.S. § 42 is, therefore, afforded broad supervisory powers to regulate the insurance business in this Commonwealth, including the power to protect "the interests of insureds, creditors, and the public generally...." 40 P.S. § 221.1(c). Accordingly, the delegation of such caretaking authority necessarily includes exercising a direct role in the rehabilitation of insolvent insurers. Subsection (c) of Section 515 of the Insurance Act, 40 P.S. § 221.15, authorizes the Insurance Commissioner in her capacity as Rehabilitator "to take possession of the assets of the insurer ... and to administer them under the orders of the court."
>
> Upon petition by the Commissioner to the Commonwealth Court for an Order authorizing him or her to rehabilitate an insurer pursuant to 40 P.S. § 221.15(a) and once such a rehabilitation plan has been ordered, the Rehabilitator is charged to "*take such action as [s]he deems necessary or expedient to correct the condition or conditions which constituted the grounds for the order of the court to rehabilitate the insurer*." 40 P.S. § 221.16(b).

Mutual Fire, 614 A.2d at 1091 (emphasis added).

Furthermore, the Commonwealth Court is the sole tribunal with the responsibility to "supervise and review the activities and proposals of the Insurance Commissioner while she undertakes the rehabilitation of an insolvent insurer," as well as having the ultimate power to approve the final plan of rehabilitation. *Id.*; 40 P.S. §§ 221.4(a), (d), 221.16(d). The Commonwealth Court reviews the rehabilitation plan to ensure that it does

not constitute an abuse of discretion by the Rehabilitator, and it will be deemed an appropriate exercise of the Rehabilitator's statutory powers if it

> best effectuates the [Insurance Act's] legislatively stated purpose (of) the protection of the interest of insureds, creditors and the public generally and the equitable apportionment of any unavoidable loss through *inter alia,* improved methods for rehabilitating insurers.

Mutual Fire, 614 A.2d at 1094 (internal quotation marks and citations omitted).

The General Assembly, through the enactment of Section 221.16(b), has given the Rehabilitator a sweeping and unqualified power to "take such action as he deems necessary or expedient to correct the condition or conditions which constituted the grounds for the order of the court to rehabilitate the insurer." 40 P.S. § 221.16(b). The plain import of this statutory language is that the Rehabilitator may, based on his careful consideration of the particular circumstances giving rise to the insolvency of an insurer, take *any* action necessary or expedient to rehabilitate the insurer "in order to effectuate equitably the intent of the Rehabilitation statutes, *i.e*., to minimize the harm to *all* affected parties." *Mutual Fire,* 614 A.2d at 1094 (emphasis original); *see also* 40 P.S. § 221.1 (b), (c) (providing that rehabilitation provisions of the Insurance Act "shall be liberally construed to effect the purpose [of, *inter alia*] the protection of the interests of insureds, creditors, and the public generally").

In the case at bar, the Rehabilitator determined that "the condition . . . which constituted the grounds for the order of the court to rehabilitate the insurer," 40 P.S. § 221.16(b), was SHIP's insolvency, due to the chronic Funding Gap between its premium revenues and the amount of benefits that it was paying under the policies it had written. This deficiency the Rehabilitator determined was caused, in large measure, by the

differences in premiums — for the same coverage — paid by policyholders living in different states, due to the varying degree to which other states' regulatory bodies had historically approved rate increases requested by SHIP during the life of the policies.[21] The Rehabilitator also found that this premium disparity resulted in an inequitable situation in which some policyholders now pay less for the same coverage than others, thereby resulting in policyholders who pay greater premiums effectively subsidizing those paying less.

The Rehabilitator determined, based on the actuarial analysis of insurance industry experts, which was not refuted during the proceedings in the Commonwealth Court, that these conditions have led to SHIP's current precarious financial predicament in which it is simply impossible to pay benefits at the level which it originally promised, at the originally contracted for rates, to the remaining policyholders. This, the Rehabilitator concluded, raised the significant risk that many policyholders would not receive any coverage at all at a time in their lives when they need it most, even though they already paid premiums throughout their lifetime to receive such coverage.

The Rehabilitator determined that, in order for SHIP to be able to meet its obligations to its remaining policyholders, it was necessary to restructure the benefit and premium structure of the outstanding policies. Hence, the Rehabilitator crafted the Plan, based on his actuarial analysis, so that it would best serve the interests of current policyholders and give them what the Commonwealth Court termed "meaningful options."

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[21] As noted by the Commonwealth Court, Deputy Rehabilitator Cantilo testified that, from 2009 to 2019, SHIP lost an estimated $312-$371 million dollars in actuarially justified premiums as a result. *In re SHIP*, 266 A.3d at 1152.

In re SHIP, 266 A.3d at 1168. Under the Plan, policyholders can choose to preserve their current coverage by paying an actuarially justified "If Knew" premium. Alternatively, these policyholders may opt to reduce their current level of coverage to avoid, or reduce, the amount of increased premiums they would pay going forward. *Id*.

Critically, though, the Plan corrects SHIP's discriminatory premium rate structure by giving all policyholders, regardless of the state in which the policy was originally issued, the same menu of coverage options, with all premiums being calculated on an individualized basis. Thus, under the Plan, similarly situated policyholders who make the same coverage selections will pay the same premium regardless of the state in which their policy was first issued, and without being required to pay any additional amounts to compensate for any past underpricing of their policies.

The Plan therefore constitutes a reformation of the existing insurance contracts between SHIP and its policyholders, which is "legitimately designed to ameliorate a financial hazard for the good of all involved." *Mutual Fire*, 614 A.2d at 1095. Such contractual modifications are well within the broad power vested in the Rehabilitator under Section 221.16(b) to take any action "necessary or expedient" to correct the conditions which led to SHIP's insolvency.

Section 221.16(b), by its plain terms, did not require the Rehabilitator to submit the corrective action taken by the Plan to the regulatory bodies of Regulators' states for their approval in order for it to become effective. Indeed, neither this section, nor any other statutory provision in Article V, mandates any involvement of the state regulatory agencies of other states in the rehabilitation process. Rather, Section 221.16(d) requires

only that the Rehabilitator apply to the Commonwealth Court for approval in order for it to become effective, which the Rehabilitator did.

Nevertheless, the Plan, through its use of the ISRA option, does not, as Regulators suggest, unilaterally seek to displace or supersede their regulatory authority with respect to an insurance company in rehabilitation. Given that the Plan effectuates modifications only to policies of insurance the Rehabilitator has determined are necessary for SHIP's rehabilitation, this is not a situation where the Rehabilitator is claiming the authority to underwrite or issue new policies of insurance, nor are the modifications being sought by a solvent insurer; thus, the normal approval processes attendant to rate-setting and policy modification in Regulators' states are ill-suited for use in this rehabilitation. As the Commonwealth Court found, based on the unrefuted testimony of Deputy Rehabilitator Cantilo, if the Rehabilitator is required to use the normal rate-setting processes established by the state statutes of Regulators' states, a lengthy and burdensome process would ensue, which would ultimately not assure that those states' regulatory bodies will consistently grant the requested premium adjustments necessary to rectify SHIP's present financial straits. The court concluded this delay would serve to undermine the overall goal of the rehabilitation process, which is to expeditiously restore SHIP's ability to provide long-term care benefits to its remaining policyholders. As this conclusion is amply supported by the evidence of record, we see no basis upon which to disturb it.

Moreover, and critically, however, under the Plan, Regulators *do* retain the ultimate authority to approve any rate increases the Rehabilitator may seek from them under the Plan. If other states affirmatively opt-in to the Plan, then the rate and benefit structures of the Plan will apply to SHIP policies held by their residents, just as they will for policies

held by Pennsylvania residents. Yet, Regulators' states may elect to opt out of the Plan altogether. *In re SHIP*, 266 A.3d at 1175. If a state opts out, then the Rehabilitator *cannot* automatically and unilaterally raise the rates on policyholders within that state. Instead, he is obligated under the Plan to file an application with the regulators from those states to increase rates on the SHIP policies for their residents to the "If Knew" premium level. *Id.* at 1176. If the application is not fully approved, then the benefits payable under the affected policies will be adjusted – based on those policyholders' choice of options available to them under the Plan – to reflect the premiums as approved. As the Commonwealth Court found, this furnishes those states "with a meaningful way to control the mix of benefit reductions and premium rate increases." *Id*. Thus, Regulators retain their ultimate authority to choose a course of action in approving rates and corresponding levels of coverage which they deem best suited to fulfill their obligations to protect the interests of their residents, but within the overall constraints created by SHIP's insolvency.

Furthermore, because Regulators have been granted intervenor status by the Commonwealth Court in the ongoing rehabilitation process, Regulators may also seek to preemptively limit the size of any future potential rate increases for their states' residents by filing objections to the actuarial memorandum the Rehabilitator has been ordered to prepare to justify the "If Knew" premium rate, as well as present their own evidence on what they consider that rate should be.[22] As both the Rehabilitator and the

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[22] We reject Regulators' assertion that the ISRA option does not permit them to meaningfully review rate request increases which the Rehabilitator might file with them if their states opted out of the Plan. As the Commonwealth Court found, Regulators did not present evidence which would establish this claim. *In re SHIP*, 266 A.3d at 1184.

Regulators also claim that the ISRA option is coercive, due to the fact that the rate and benefit structures provided in this provision automatically go into effect if the (continued…)

Commonwealth Court agree, the exact extent of any future rate increases necessary under Phase II of the Plan is, at present, uncertain and will depend on SHIP's financial condition after policyholders have made their elections under Phase 1; thus, Regulators have time to develop and present evidence to the Commonwealth Court relating to their position on those rate increases, if any. Consequently, for all of these reasons, we conclude the Commonwealth Court did not abuse its discretion in approving the Plan's ISRA provisions.

E. Whether the Plan Violates the Full Faith and Credit Clause

Finally, Regulators assert that, to the extent the Commonwealth Court is seeking to apply our Commonwealth's law to control insurance rates in other states, this violates the Full Faith and Credit Clause of the United States Constitution.[23] Regulators argue that the Plan, by dictating to other states what rates their residents will pay, violates this clause because it constitutes a unilateral substitution of Pennsylvania's laws for those states' laws governing the relations between a corporation doing business in that state

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Rehabilitator's rate applications are denied by them, which forces them to accept the requested increases, or have their policy-holding residents fare worse under the default rate and benefit structures. We find this argument unavailing, given that, as discussed, Regulators have the ability to meaningfully influence the setting of the "If Knew" rate by the Commonwealth Court prior to having to consider policy adjustments requested by the Rehabilitator using that rate, and they have full discretion to approve or reject the requested increases. The consequences of their rejection of any proposed increases are not the product of their exercise of that choice, but rather the unpleasant reality of SHIP's current dire financial circumstances. As the Rehabilitator and the Commonwealth Court have determined, based on the substantial evidence of record on this point, SHIP's financial condition would only deteriorate further without the Plan being implemented, which would inevitably result in its liquidation and their policyholders being left in a worse position than they would be under the rate and benefit structures imposed under the ISRA option.

[23] *See supra* note 13.

and its residents. It is this purported displacement which Regulators view as the violation, as it fails to properly afford credit to the policy judgments of those states protecting their residents from unjustified rate increases which are reflected in their insurance laws.

In response, the Rehabilitator proffers that, as the Commonwealth Court found, because there has been no judgment issued from the courts of sister states which Pennsylvania is bound to abide by, under the high Court's interpretation of the Full Faith and Credit Clause in *Hyatt,* Pennsylvania remains free to apply its own law in determining the appropriate rates and benefit structure necessary for the successful rehabilitation of SHIP. Indeed, according to the Rehabilitator, if Pennsylvania were forced to subordinate its own laws, which give the Commonwealth Court jurisdiction to approve rates necessary for the rehabilitation to succeed, to the rate approval authority of other states, this itself would be a violation of the Clause, as those states' rate determinations would not be providing full faith and credit to the judgment of the Commonwealth Court.

In *Hyatt*, the United States Supreme Court was asked to determine whether the Supreme Court of Nevada violated the Full Faith and Credit Clause by failing to afford a California state tax agency sovereign immunity from a suit for an intentional tort which was brought in a Nevada court. Under California law, the agency enjoyed complete immunity from tort actions, whether they were for negligent or intentional conduct, whereas under Nevada law government agencies enjoyed immunity only for torts involving negligent conduct. The Nevada Supreme Court refused to grant California complete immunity on the basis that doing so would contravene Nevada's policies and interests in protecting its citizens from intentional torts committed by a government

agency, which the Nevada Supreme Court determined outweighed California's interests in the matter.

In analyzing the claim that the Nevada court had violated the Full Faith and Credit Clause, the United States Supreme Court emphasized that the Clause does not require a state to apply the substantive laws of another state when doing so would violate its "own legitimate public policy." *Hyatt*, 538 U.S. at 497 (quoting *Nevada v. Hall*, 440 U.S. 410, 424 (1979)). Further, the high Court eschewed an analysis that balanced competing state sovereign interests. The high Court noted that such an approach had proven difficult to implement jurisprudentially. Hence, it expressly declined to endorse the adoption of a test that balances "coordinate States' competing sovereign interests to resolve conflicts of laws" to determine if the Full Faith and Credit Clause had been violated by a state which chose to apply its own law over that of a sister state in resolving a case or controversy. *Id.* at 499.

Instead, the high Court applied a more amorphous and flexible inquiry which examined whether a state, in choosing to apply its own laws instead of those of a sister state, exhibits a "policy of hostility to the public Acts" of that state. *Id.* (citation and quotation marks omitted). The high Court concluded that, because "[t]he Nevada Supreme Court sensitively applied principles of comity with a healthy regard for California's sovereign status, relying on the contours of Nevada's own sovereign immunity from suit as a benchmark for its analysis," no violation of the Full Faith and Credit Clause had occurred. *Id.*

Applying these tenets to the resolution of Regulators' claim based on the Full Faith and Credit Clause, we find that the Plan carefully follows the contours of our

Commonwealth's statutes governing the rehabilitation of an insolvent insurer, which, as we have previously emphasized, grant broad powers to the Rehabilitator "to effectuate equitably the intent of the Rehabilitation statutes, *i.e.*, to minimize the harm to *all* affected parties[;] . . . to marshall and preserve all assets of the insolvent entity[;] . . . [and] safeguard[] the public interest from the potentially innumerable consequences of [the insurer's] insolvency." *Mutual Fire*, 614 A.2d at 1094-95. We also conclude that the Plan "sensitively applied principles of comity with a healthy regard for the sovereign status" of our sister states, *Hyatt*, 538 U.S. at 499, whose interests Regulators represent, inasmuch as the Plan allows them to exercise their regulatory authority to the maximum extent which is feasible under the extraordinarily difficult circumstances created by SHIP's insolvency.

Indeed, we find no "policy of hostility," *id.*, to the insurance laws of Regulators' states exhibited by the Plan, or in the Commonwealth Court's performance of its statutory responsibility under our Insurance Act to oversee the Plan's implementation in order to achieve the objective of SHIP's rehabilitation. The practical necessity for entrusting the management of the assets of an insolvent insurance company to a single responsible person or entity, and also vesting the task of supervision of that person or entity in the allocation and distribution of those assets with a single court, serves to guarantee that any such distribution will be done in the most economical, efficient, and orderly fashion to protect the interests of the public, policyholders, creditors, and stockholders. *Motlow v. Southern Holding and Security Company*, 95 F.2d 721, 725-26 (8th. Cir. 1938); *accord Ballesteros v. New Jersey Property Liability Insurance Guaranty Association*, 530 F. Supp. 1367, 1371 (D.N.J.), *affirmed sub nom. Ballesteros v. New Jersey Property Liability Insurance Guaranty Association*, 696 F.2d 980 (3d Cir. 1982). These principles are

embodied in Article V of our Insurance Act, which, as discussed, gives the Insurance Commissioner the sole responsibility to manage and conserve the assets of an insolvent insurer domiciled in this state, and designates our Commonwealth Court as the exclusive tribunal with the responsibility to "supervise and review the activities and proposals of the Insurance Commissioner while she undertakes the rehabilitation of an insolvent insurer." *Mutual Fire*, 614 A.2d at 1091.

As noted by the Commonwealth Court, the relevant statutes governing the rehabilitation of an insolvent insurer in Regulators' states likewise designate the insurance commissioner of those states as the individual responsible for taking possession of the assets of a delinquent insurer, and they also give a single court in those states jurisdiction to administer such assets under its orders. *In re SHIP*, 266 A.3d 1173 (citing Me. Stat. 24-A § 4364; Mass. Stat. 175 § 180B; Wash. Rev. Code § 48.99.020). Additionally, as the Commonwealth Court determined, the statutes governing the setting of insurance rates in Regulators' states effectuate the same core purpose as the Plan, which is to "ensur[e] that long-term care insurance premium rates are not excessive, unfairly discriminatory, or unreasonable in relation to the benefits provided under the policy." *Id.* at 1175.

Consequently, the Plan's assignment of primary responsibility to the Commonwealth Court to conserve and administer the assets of SHIP, and the conferral on that tribunal of the corollary power to adjust policy premiums and benefits to ensure that those assets will not be unduly depleted by the payment of benefits which are both disproportionate to the premiums paid, as well as discriminatory with respect to other policyholders, is, as the Commonwealth Court found, consistent with the framework and

undergirding purposes of the statutes of Regulators' states. Thus, as there is significant harmony between the Plan and the insurance laws of Regulators' states – and not hostility born of irreconcilable conflict as Regulators suggest – we agree with the Commonwealth Court that the Plan did not violate the Full Faith and Credit Clause.

III. Conclusion

For all of the aforementioned reasons, we concluded that the Commonwealth Court did not abuse its discretion by approving the Plan; and hence entered our June 20, 2023 order.[24]

Jurisdiction relinquished.

Justices Donohue, Dougherty and Wecht join the opinion.

Justice Brobson files a dissenting opinion in which Justice Mundy joins.

The Late Chief Justice Baer did not participate in the decision of this matter.

[24] Regulators have filed an "Application for Leave to Supplement Record" ("Application") seeking: (1) to supplement the record on appeal to include a "Projected Asset Depletion (Reflecting Phase 1 Results)" exhibit from the Rehabilitator; and (2) to renew, in light of this newly available exhibit, their previously filed Application for Leave to Supplement Record with Rehabilitator's April 12, 2022 Letter Concerning Phase One Results and Effect on the Funding Gap, which this Court denied by order dated June 22, 2022. Regulators argue that the documents "demonstrate conclusively that the Plan is not feasible and liquidation inevitable." Application, 9/2/22, at 2. The Rehabilitator and Health Insurers have filed answers in opposition to Regulators' Application. Lapinski has also filed an answer, as well as a separate "Application to Supplement Policyholders [sic] September 'Answer' and His Record on Appeal" seeking leave to file a document titled "Opposition to State Insurance Regulators 'Projected Asset Depletion' and April 12, 2022 Letter." Given our disposition herein, particularly our conclusion that Regulators' lacked standing to challenge the feasibility of the Plan, Regulators' Application and Lipinski's Application are both denied.