IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

PENNSYLVANIA PROFESSIONAL LIABILITY JOINT UNDERWRITING ASSOCIATION,	: **No. 1:17-CV-02041-CCC**
Plaintiff,	:**(The Honorable Christopher C. Conner)**
v.	:
TOM WOLF, IN HIS OFFICIAL CAPACITY AS GOVERNOR OF THE COMMONWEALTH OF PENNSYLVANIA,	:
Defendant.	:

THE PENNSYLVANIA MEDICAL SOCIETY *AMICUS* BRIEF IN SUPPORT OF PLAINTIFF'S COMPLAINT AND MOTION FOR PRELIMINARY INJUNCTION SEEKING TO PROHIBIT THE TRANSFER OF $200,000,000 OF PLAINTIFF'S FUNDS TO PENNSYLVANIA'S GENERAL FUND

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AND NOW, comes the Pennsylvania Medical Society ("Movant" or "Medical Society"), by and through its counsel, Gordon & Rees, and hereby files this *Amicus* Brief in support of Plaintiff's Complaint and Motion for Preliminary Injunction, and sets forth as follows:

I. INTRODUCTION

On October 30, 2017, Tom Wolf, Governor of Pennsylvania, signed into law Act 44 of 2017 ("Act 44"), which amends the State's Fiscal Code,

implements the 2017-2018 budget, and appropriates certain funds, among other things. As part of its efforts to pursue a balanced state budget, Act 44 requires Plaintiff, Pennsylvania Professional Liability Joint Underwriting Association ("JUA"), to "pay the sum of $200,000,000 to the state treasurer for deposit in the General Fund", by December 1, 2017. Act 44, §1.3 (Fiscal Code as amended at Article II-D, §203-D). If Plaintiff fails to make the payment by December 1, 2017, Act 44 declares that the JUA will automatically and immediately be abolished and all of its monies and assets transferred to the Commissioner of the Pennsylvania Department of Insurance ("Commissioner"). Id. (Fiscal Code as amended at Article II-D, §207-D). As discussed more fully herein, the Legislature declared, without foundation, that the JUA maintains unappropriated surplus in excess of the $200,000,000.

Plaintiff filed a Complaint requesting a declaratory judgement and injunctive relief, prohibiting the transfer of the $200,000,000 of JUA funds, roughly 75% of its current surplus, to the General Fund of Pennsylvania, and prohibiting the abolishment of the JUA. By Order of November 8, 2017, this Court scheduled a hearing to consider Plaintiff's Motion for Preliminary Injunction for November 14, 2017.

On November 13, 2017, Movant filed a Motion for Leave to File *Amicus* Brief with a Proposed *Amicus* Brief. On November 15, 2017, this Court issued an Order granting Movant's Motion and ordering that the *Amicus* Brief be filed by November 17, 2017. Accordingly, Movant is filing this Brief in response thereto and in support of Plaintiff's Complaint and Motion for Preliminary Injunction.

Movant, and on behalf of its members that include JUA policy-holders, has significant interest in the outcome of Plaintiff's request for injunctive relief and declaratory judgment. Movant is uniquely positioned to provide the Court with input on the impact that transfer of JUA funds to the General Fund would have on JUA policy-holders, future policy-holders, and any and all Pennsylvania physicians and healthcare providers as well as on the medico-legal environment and accessibility of Pennsylvania citizens to quality patient care in Pennsylvania. Such a transfer is counter to Legislative objectives to assure Pennsylvania healthcare providers can obtain accessible and affordable medical professional liability ("MPL") insurance; to assure patient access to affordable and quality healthcare in Pennsylvania; and to prevent the next medical malpractice crisis. Further, such a transfer of private funds is inappropriate.

II. CONCISE STATEMENT OF THE MEDICAL SOCIETY, ITS INTEREST IN THIS CASE AND THE SOURCE OF ITS AUTHORITY TO FILE

Founded in 1848, the Medical Society is presently the largest physician organization in Pennsylvania, comprised of over 16,000 physicians and medical students, and governed by physician members, including a Board of Trustees. Among its services, and a top priority, is advocacy for physicians in state government and MPL insurance matters, in advancing public policy and public health measures, and for the Commonwealth's residents, patients.

The Medical Society's members include present and future JUA policy-holders, and as such, the Medical Society and its members have significant interest in the outcome of this action and the resultant funding, or de-funding, of the JUA. The JUA policy-holders have an interest in their premiums paid for MPL insurance being used and available for paying their insured liabilities. See 40 P.S. §1303.732(a)(4). The surplus funds held by the JUA are comprised of premiums paid by its policy-holders and investment income therefrom, to be used by the JUA to satisfy its statutory and contractual MPL insurance obligations. To otherwise transfer those funds to the State for purposes of balancing its budget improperly converts the funds to tax revenue.

Further, all healthcare provider members of the Medical Society and all Pennsylvania residents have a significant interest in the outcome of this case because of the negative impact that transferring $200,000,000 of the JUA's surplus, approximately 75% of its surplus, would have on the JUA and the MPL environment in Pennsylvania. The JUA has submitted actuarial analysis to the Pennsylvania Department of Insurance ("Department") which states that a reduction in the JUA's current surplus would negatively impact its ability to meet its statutory obligations.

If the funds were to be transferred, and the JUA then unable to pay its policy-holders' liabilities:

- JUA policy-holders would be personally at risk for satisfying MPL insurance settlements and awards;
- The JUA would not be available to provide MPL insurance coverage to Pennsylvania healthcare providers who are unable to secure MPL insurance coverage in the standard market;
- The cost of MPL insurance premiums across all carriers would increase;
- MPL insurance access would be reduced;
- The ability of hospitals and medical practices to recruit and retain high quality physicians would be negatively impacted; and
- Patient access to affordable and quality healthcare in Pennsylvania would be reduced.

In other words, the goals associated with the creation of present-day JUA and the MCARE Act generally would be thwarted, and put the industry at risk of another medical malpractice crisis.

The Middle District of Pennsylvania has inherent authority to permit the filing and consideration of this *Amicus* Brief. See *Amicus's* Motion for Leave to File *Amicus* Brief.

III. BACKGROUND

A. Pennsylvania's Medical Professional Liability Environment

1. Cyclical Medical Malpractice Crises

Pennsylvania has incurred cyclical medical malpractice crises since the 1970's. The 1970's crisis was largely based on a lack of available insurers; the 1980's crisis by affordability of insurance coverage; and the 1990's crisis by accessibility and affordability and a marked increase in the frequency and severity of claims. Many states in the 1970's, including Pennsylvania, created non-profit associations to provide MPL insurance to address the lack of capacity, and their strategy worked to bring an end to the 1970's crisis.

Premium rates began to sky-rocket in the 1990's/2000's. As a result, Pennsylvania healthcare providers dropped or reduced high-risk patient care, retired early, and/or left the state to practice in a more physician-friendly insurance market. As a consequence of the crises in the 1990's into 2000's,

some MPL insurers voluntarily withdrew from the Pennsylvania market (for example, Princeton Insurance Company and St. Paul Group) and several carriers became insolvent and were liquidated (for example, PHICO in 2002), reducing the number of insurance carriers writing MPL insurance policies in Pennsylvania. The reality that PHICO, one of the state's then-largest insurers, could lack sufficient funds to satisfy its claim payment obligations raised significant concerns throughout Pennsylvania and the industry, and to this day, impacts Pennsylvania's MPL insurance environment.

2. Impacting the 1990's/2000's medical malpractice crisis in Pennsylvania

In 2002, the Pennsylvania Legislature passed Act 13 of 2002 ("MCARE Act") in efforts to try to again alleviate a medical malpractice crisis. Its provisions, in relevant part, were designed to assure affordable and accessible MPL insurance and thereby positively impact the affordability and accessibility of health care in Pennsylvania. 40 P.S. §1303.102. In addition, the MCARE Act endeavored to assure that patients injured in Pennsylvania receive prompt and fair compensation. Id. Relevant reform provisions of the MCARE Act include:

- Requiring Pennsylvania physicians to maintain certain basic MPL insurance coverage, currently $500,000, 40 P.S. §1303.711(a);

- Creating the MCARE Fund to provide a secondary layer, or excess layer, of MPL insurance coverage to Pennsylvania physicians to pay for claim liabilities, currently $500,000, see 40 P.S. §§1303.711, 712; and

- Creating the present-day JUA to afford MPL insurance policies to Pennsylvania healthcare providers who cannot conveniently obtain MPL insurance, through ordinary methods, at rates not in excess to those of applicable similarly-situated healthcare providers. 40 P.S. § 1303.732(a).

These provisions were enacted in efforts to satisfy the goals of the MCARE Act. While requiring $1 million of MPL insurance coverage, the MCARE Act minimized the cost to Pennsylvania healthcare providers by requiring them to purchase $500,000 of that coverage from a Pennsylvania MPL insurer rather than a full $1 million of coverage. The remaining $500,000 of coverage would come from the MCARE Fund that was, and is, funded by fee assessments to Pennsylvania healthcare providers. In all, the cost to the healthcare providers for $1 million in total coverage is less than what they would pay for the full $1 million of coverage all from one MPL insurer. Further, by establishing the present-day JUA, qualified healthcare providers have access to affordable MPL insurance which is unavailable to them in the standard MPL insurance market. Without the JUA option, otherwise qualified healthcare providers would cease practicing certain needed high risk procedures and specialties; and/or retire or leave the state, as occurred in the 1990's/early 2000's.

Around the same time, alternative risk financing entities, risk retention groups ("RRGs"), emerged, really penetrating the Pennsylvania market around 2004. Because of the Federal Liability Risk Retention Act of 1986, an RRG can be licensed or domiciled in one state, Vermont for example, but be permitted to sell MPL insurance in all 50 states. In Pennsylvania such an RRG must simply register with the Department; there is no oversight of the RRG by the State or Department (they are overseen by the relevant department in the state of domicile). These RRGs were attractive to healthcare providers who wanted more control over their insurance destiny, as they are traditionally governed by a board of physician-insured directors. They provided another option from which Pennsylvania healthcare providers could purchase their statutorily-required MPL insurance coverage.

3. Pennsylvania's Current MPL Insurance Environment

The MPL insurance industry is currently in a "soft" market, awaiting the historically inevitable "hard" market. In a "hard" market, insurance premiums rise, underwriting criteria are more strict, high-risk specialist's coverage is dropped or non-renewed, capacity is reduced, and there is less competition among insurance carriers; in other words, decreased accessibility and affordability of MPL insurance for Pennsylvania healthcare providers. While

this is historically one of the longest soft market periods, there is concern in the industry that when the market does turn, it will result in a very significant crisis, given the current status of MPL insurers' finances and the current market. Market factors exist now that are also correlated to a hardening market. They include:

- Increase in loss ratios of MPL insurers;
- Reduction in reserves of MPL insurers;
- An increase in premium-to-surplus ratios for non-traditional carriers;
- Decreased market share of the traditional MPL insurers; and
- Consolidation of MPL insurers.

Loss Ratio is one indicator of how well an MPL insurer is doing. It is a ratio of the MPL insurer's incurred losses, paid claims, compared to the premiums earned. The higher the loss ratio, the more indicative it is that the insurer may not be financially sound. The Premium-to-Surplus Ratio measures the financial strength of the insurer; the ability of the MPL insurer to absorb above-average losses; and the ability of the MPL insurer to underwrite new policies. A high Premium-to-Surplus Ratio is indicative of an insurer having lower capacity.

These two factors and others led the Department in 2017 to conclude, again, that Pennsylvania's MPL insurance industry lacks sufficient insurer capacity to increase the primary insurance coverage limit that healthcare providers must purchase from MPL insurance carriers from $500,000 to $750,000.[1] See Attachment "A", Memo from Jessica K. Altman, Acting Insurance Commissioner, to All Interested Parties, dated 9/11/2017. Her conclusions were based on, among other things, a Capacity Study performed by Deloitte Consulting, LLP.

The Deloitte Study noted that MPL RRGs have increased market share in the Pennsylvania market at 37% in 2016, up 8% since 2008. In 2015, the Commissioner also recognized the large market share that RRGs have acquired in Pennsylvania's MPL insurance market. See Attachment "B". She explained then that the innate limitations that RRGs have on raising capital was one factor in her determination that Pennsylvania lacked capacity to increase the primary insurance coverage layer for years 2016 and 2017. Id.

[1] The MCARE Act provides that the MCARE Fund's excess coverage would be phased out in a step-wise fashion as the industry gained capacity to cover the full $1,000,000 of required provider MPL insurance coverage. That is, the individual healthcare provider would be required to obtain $1,000,000 of primary insurance coverage from the insurers authorized to provide such insurance in Pennsylvania. 40 P.S. §1303.711(d)(3). The Commissioner is tasked with evaluating and determining whether capacity exists, every two years. For every evaluation year since 2006, the Commissioner has concluded that capacity does not exist.

Despite the increased market share, many of these RRGs today are facing challenges in the current environment, including difficulty competing in a “soft” market where the traditional insurers are able to use their surplus to reduce provider policy premiums. To compete, or to simply retain current insureds, these RRGs must meet or exceed the premium reductions being offered by their competitors. This means the RRGs and the standard market insurers may not collect enough premium to cover liabilities or they might use surplus to cover the difference. Either way, it would impact the financial ratios discussed above. For example, just in the last 4 months, the MPL insurance market lost two MPL RRGs.

On August 10, 2017, Doctors and Surgeons National Risk Retention Group IC, Inc., a previously-registered Pennsylvania RRG, was placed into liquidation; the ordering court (where the RRG is domiciled) determined that further efforts at rehabilitation would not be productive but rather substantially increase the risk of loss to policy-holders and others. See Order, Attachment “C”. On September 21, 2017, Oceanus Risk Retention Group was placed into liquidation after being declared insolvent. See Order, Attachment “D”.

When an MPL insurer writing insurance in Pennsylvania is placed into liquidation, policy-holder liabilities of occurrence-based policies are taken on by Pennsylvania's Property and Casualty Insurance Guaranty Association ("PPCIGA"), providing $300,000 in claim coverage ($200,000 less than the primary insurance coverage requirement). Plus, RRG policy-holders in such situations do not have access to PPCIGA because the RRG is not regulated by the State.

Given the history and the present market factors, now is an inappropriate time to remove Legislative strategies that have proven to positively impact the market and that can mitigate the effects of a "hard" market or malpractice crisis.

B. Pennsylvania Legislature's Attempts to Transfer $200,000,000 from the JUA to the General Fund.

1. <u>Act 85 of 2016</u>

In 2016, the Pennsylvania Legislature passed Act 85 of 2016 ("Act 85"). It included directed Plaintiff to transfer $200,000,000.00 from its funds to Pennsylvania's General Fund, so that the State could balance its budget for the year 2016-2017.[2] Act 85 §1726-C(6). Specifically it states:

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[2] The Pennsylvania Constitution requires that Pennsylvania have a balanced budget. PA. CONST. art. VIII, §§ 12, 13.

> Notwithstanding Subchapter C of Chapter 7 of the act of March 20, 2002 (P.L.154, No.13), known as the Medical Care Availability and Reduction of Error (Mcare) Act, the sum of $200,000,000 shall be transferred from the unappropriated surplus of the Pennsylvania Professional Liability Joint Underwriting Association to the General Fund. The sum transferred under this section shall be repaid to the Pennsylvania Professional Liability Joint Underwriting Association over a five-year period commencing July 1, 2018. An annual payment amount shall be included in the budget submission required under section 613 of the act of April 9, 1929 (P.L.177, No.175), known as The Administrative Code of 1929.

Id.

On May 18, 2017, the JUA filed suit in the United States District Court for the Middle District of Pennsylvania, requesting a declaratory judgment prohibiting the transfer of JUA funds.[3] That case is currently pending and assigned to the Honorable Christopher Conner. *Amicus* here similarly filed an *Amicus* brief in that case, providing input on the negative impact and risks that might occur by permitting the transfer of $200,000,000 of JUA funds to the General Fund, under the circumstances presented by Act 85.

2. ACT 44 of 2017

Act 44 of 2017 and Act 85 of 2016 have the same intent and purpose: To use JUA funds to balance the State budget; the latter for the 2016-17 year

[3] Case No. 1:17-cv-00886-CCC.

and the former for the current 2017-18 year. Under Act 44, however, the Legislature has changed its approach:

1. Instead of an interest free loan, Act 44 does not require that the State repay the JUA; thus, the JUA and its policy-holders are deprived of $200,000,000 and related additional investment income that could accrue;

2. If the JUA fails to make the payment deadline, the JUA is abolished and its money must be transferred to the Commissioner; and

3. If abolished,
   - the Commissioner must transfer $200,000,000 of the JUA's money to the State treasurer for deposit in the State's General Fund;

   - the JUA's remaining money will be placed into a Department account to be used and administered by the Department which would take over the JUA functions; and

   - the Department must annually thereafter transfer deemed "surplus" to the State's General Fund.

Act 44, §1.3 (Fiscal Code, as amended, Article II-D, §§ 203-D and 207-D). In either scenario, policy-holder premium and investment therefrom are transferred to the State's General Fund; the abolishment scenario additionally requires an annual transfer of any "surplus". This raises concerns that even if the JUA would transfer the funds requested by December 1, 2017, there is no guarantee that the State would not seek to transfer JUA funds to balance the State budget in future years.

The Legislature attempted to justify the JUA-related Fiscal Code amendments by making certain "findings", including:

- There is a decline in the need for the MPL insurance policies offered by the JUA.
- The JUA has excess money beyond which is required to fulfill its statutory mandate.
- JUA funds, while consisting of premiums and investment income, do not belong to JUA members or insureds, but belong to the State.
- The transfer of JUA funds to the State's General Fund is in the best interest of the Commonwealth's residents so that the State's 2017-2018 budget can be balanced.

Act 44 §1.3 (Fiscal Code, as amended, Article II-D §201-D(1)-(5)).

The Legislature's findings lack sufficient foundation or evidence; and importantly, the evidence that does exist directs contrary conclusions: There is a continued need for the JUA; the JUA does not have excess funds; the JUA funds do not belong to the State; and it is not in the best interest of the State's residents to transfer JUA funds to balance the State budget.

IV. DISCUSSION – THE STATE'S "FINDINGS" ARE INCORRECT

A. The Need for MPL Insurance Policies Offered by the JUA

In today's present environment, and in the future, inevitable hard market, the JUA's purpose of providing insurance coverage to those Pennsylvania healthcare providers that are unable to obtain coverage or affordable coverage elsewhere remains vital to achieving the goals of the MCARE Act: accessibility and affordability of MPL insurance coverage for Pennsylvania healthcare providers; accessibility and affordability of high quality patient care; and compensating injured patients.

While the Legislature declared that there is a decline in the need for JUA MPL insurance policies, without any reference, see Act 44 §1.3 (Fiscal Code as amended Article II-D §201-D(1)), Pennsylvania's Acting Insurance Commissioner, with reliance on the Deloitte Capacity Study, concluded that the Commonwealth continues to lack sufficient insurer capacity. See Attachment "A". That is, in the opinion of the Commissioner, there is *not* a sufficient number of insurers available in the state with capacity at this time to cover Pennsylvania healthcare provider MPL insurance policies with coverage limits of even $750,000 (the first step-wise phase-out provision), let alone the ultimate goal of coverage of $1,000,000, for the 2018-2019 years.[4]

[4] If the Commissioner should ever determine that sufficient insurer capacity does exist, the JUA will need to be able to provide MPL insurance coverage at higher primary limits; and its surplus is important to being able to do so without significantly increasing premium rates at such time.

The Legislature's "finding" is in direct contradiction to the analysis performed by Deloitte and the conclusion reached by the Commissioner.

The Deloitte study set forth several factors identified as indicative of a marketplace that may not have the financial capacity to withstand an increase to the primary limits, including a decrease in the MPL insurance market share for Pennsylvania's traditional MPL insurance carriers, an increase in the market share of MPL RRGs, an increase in premium-to-surplus ratios for the RRGs, and an increase in loss ratios among all carriers. See id. These same factors identified by Deloitte also indicate a potential hardening of the market.

Given the historical volatility of the MPL insurance market and the identification of factors in existence that are indicative of a potential hard market, the JUA must remain viable. It plays a vital role in such circumstances – providing insurance coverage to those that are unable to obtain coverage elsewhere, at a time when insurers become selective and historically deny coverage to providers, particularly including those practicing in high-risk specialties such as obstetrics and neurology. The JUA needs to be viable and appropriately funded in order to satisfy its statutory obligations to provide affordable insurance coverage to those unable to obtain it in the standard market and to pay for the defense of an insured's claims and any resultant awards.

Depletion of JUA surplus due to a transfer of its funds to the General Fund would threaten JUA viability and threaten the JUA's ability to satisfy its statutory and contractual obligations. A fund transfer would also result in increased premiums for JUA policy-holders (due to the lack of surplus) and/or non-JUA policy-holders (if member assessments are increased). See Plaintiff's Complaint at ¶¶ 42, 51, 55; see also Wisconsin Med'l Soc'y v. Morgan, 787 N.W.2d 22, 64-65 (Wis. 2010).

Even if one were to conclude that this particular transfer does not threaten the viability of the JUA, the precedent of permitting the transfer of funds could. See Wisconsin Med'l Soc'y, 787 N.W.2d at 63. There is no guarantee or any reason to believe that if the JUA were to make the $200,000,000 transfer by December 1, 2017, that it would be the one and only time that the State would seek to transfer JUA surplus to its General Fund to balance the State budget.

Finally, the fact that the Department would take on the functions of the JUA if the JUA does not make the $200,000,000 payment by December 1, 2017, gives validation to the need for the services provided by the JUA.

B. The JUA Does not Have Excess Funds Beyond that Required to Meet its Statutory Obligations.

The Legislature declared that the JUA "has money in excess of the amount reasonably required to fulfill its statutory mandate". Act 44, §1.3 (Fiscal Code, as amended, Article II-D §201-D(1)). The JUA is not aware of any regulator that has conducted a study nor that has concluded that the JUA has excessive surplus. See Plaintiff's Complaint at ¶¶52-53.

In contrast, the JUA commissioned an actuarial study to evaluate its surplus needs. On May 1, 2017, the JUA reported to the Department that the JUA's surplus was determined to not be excessive and that divestiture of any of its surplus could adversely affect its ability to meet its obligations to policy-holders. See Plaintiff's Complaint at ¶¶54-55. Accordingly, this actuarial study contradicts the Legislature's declaration and further corroborates the Movant's concerns that transfer of any of JUA's surplus could adversely impact the JUA and its ability to pay JUA policy-holder liabilities.

C. The JUA Funds Consist of Premium and Investment Income and do not Belong to the State.

Even if one were to conclude that the JUA has excess surplus, those funds are comprised of premiums paid by current or past Pennsylvania healthcare providers to obtain their statutorily-required primary MPL insurance layer of coverage and investment income from those premiums. In fact, all parties agree that the JUA's funds at issue are comprised of JUA policy-

holder premiums and investment income. In Act 44, the Legislature states: "Funds under the control of the Joint Underwriting Association consist of premiums paid on the policies issued under subchapter B of chapter 7 of the MCARE Act and income from investment." Act 44, §1.3 (Fiscal Code, as amended, Article II-D §201-D(2)).

Despite this, Act 44 goes on to declare that the funds do not belong to any of the members of the JUA nor JUA policy holders. Id. Even further, Act 44 declares that the JUA funds belong to the State. Id. (Fiscal Code, as amended, Article II-D §201-D(3)). The State of Pennsylvania has never contributed money to the JUA. The State of Pennsylvania does not take on the JUA liabilities, including debt, nor can the JUA liabilities be charged against the General Fund. MCARE Act §1303.731(c). The JUA funds are purely private funds. See Tuttle v. New Hampshire Med'l Malpractice Joint Underwriting Ass'n., 159 N.H. 627, 992 A.2d 624 (2010) (a JUA fund for the payment of medical malpractice awards could not be used to supplement the state's General Fund; the JUA funds were entirely private funds and the JUA was not a state agency).

The past and present JUA policy-holders have an interest in having any MPL awards or settlements be paid by the JUA pursuant to their insurance

contract. The MCARE Act requires that the JUA ensure that the MPL insurance it offers, among other things, provides "sufficient coverage for a healthcare provider to satisfy its insurance requirements under section 711 on reasonable and not unfairly discriminatory terms." MCARE Act, §1303.732(b)(4).

If it cannot do so because of lack of funds and/or surplus, or any other reason, the result is (1) the JUA policy-holder's personal assets are at risk; and/or (2) the claimant does not get paid. The State does not take on such JUA liabilities. MCARE Act § 1303.731(c).

Further, if valid actuarial analysis would determine that the JUA has "excessive" surplus, that surplus would not be transferred to the State's General Fund. The surplus monies should go to the benefit of the policy-holders that paid premiums to the JUA. Such benefit might be, for example, a return of money to the policy-holders or reduced premiums.

D. It is in the Best Interest of the State's Residents to Prohibit the Transfer of the JUA Funds to the General Fund to Balance the State Budget.

The intent and goal of Act 44 is to implement and balance the 2017-2018 State operating budget. See Act 44, §1. In accord, it is the intent of the

Legislature to use the JUA funds to balance the State budget. Id. at §§1 & 1.3 (Fiscal Code as amended Article II-D §§201-D(5); 203-D).

The JUA, its members, and policy-holders as well as all Pennsylvania residents have legitimate interests in assuring the viability of the JUA. As discussed in-depth above, the nature of Pennsylvania's MPL insurance industry and healthcare environment have historically led to periods of high insurance premium costs and the inability of some healthcare providers particularly those in high-risk specialties to obtain affordable insurance. As a result, these healthcare providers stop performing high-risk procedures and/or stop practicing high-risk specialties, retire early and/or leave the state to practice elsewhere. This reduces residents' access to healthcare and to affordable healthcare. Under such circumstances, an entity like the JUA becomes vital to the market, providing a coverage option for physicians and healthcare providers, who otherwise, are not able to obtain coverage or who lose coverage at renewal.

The MCARE Act with its various reform measures has an important role in staving off the next hard insurance market and/or mitigating these known impacts to the insurance and healthcare markets. The establishment of the present-day JUA is one such measure intended to ensure that medical care is

available in Pennsylvania through a comprehensive and high-quality health care system with access to a full spectrum of hospital services and highly-trained physicians in all specialties throughout Pennsylvania. 43 P.S. §1303.102. To meet that objective, the JUA's purpose is to "offer medical professional liability insurance to health care providers … who cannot conveniently obtain medical professional liability insurance through ordinary methods at rates not in excess of those applicable to similarly situated health care providers…." 40 P.S. §303.732(a).

It is in the best interest of Pennsylvania residents therefore to maintain the viability of the JUA and prohibit the transfer of JUA funds. Any interest of the State in balancing its budget is outweighed by (1) the interest of JUA policy-holders to have their premiums, and interest therefrom, being used to satisfy its MPL claim liabilities; (2) the public interest in assuring parties to a contract of insurance meet their contractual obligations; and (3) the public interest in access to and affordability of high quality healthcare services. See Plaintiff's Motion for Temporary Restraining Order and Preliminary Injunction, at ¶¶8-10; see also Dominguez v. Schwarzenegger, 596 F.3d 1087, 1098 (9th Cir. 2010) (stating that individuals' interests in access to healthcare

outweighs a state's interest in balancing its budget), *vacated on other grounds by* Douglas v. Indep. Living Ctr. of S. Cal., Inc., 132 S. Ct. 1204 (2012).

Further, any transfer of JUA funds would result in impermissibly converting JUA funds to tax revenue. The JUA was not created for purposes of generating tax revenue for the State. The JUA was created for the purpose of providing insurance coverage to those Pennsylvania healthcare providers that are unable to obtain coverage elsewhere; it was not created nor ever intended that its premiums collected and/or investment income therefrom would be used to fill a gap in the State budget.

V. CONCLUSION

Regardless of whether the situation is the JUA's transfer of $200,000,000 of its surplus to the General Fund or if after December 1, 2017, the Commissioner transfers $200,000,000 of the JUA's surplus to the General Fund with annual transfers thereafter, those monies consist of premium paid by JUA policy-holders and investment therefrom. The monies are private and are not the property of the State.

Further, actuarial analysis has concluded that the JUA's surplus is not excessive and any divestiture of it could adversely affect the ability of the JUA to fulfill its obligations to provide accessible and affordable MPL insurance

coverage to those Pennsylvania healthcare providers who, for whatever reason, cannot obtain such insurance at reasonable rates in the standard market. Should it ever be determined that the JUA is holding "excessive" surplus, the excessive surplus would not go to the State, but rather be used to the benefit of JUA policy-holders. For example, return of money to policy-holders or reductions in premiums.

There remains a valid need for the insurance coverage offered by the JUA. The Commissioner has concluded, based on independent, third-party analysis, that insurer capacity in the State is not yet sufficient to sustain an increase in the healthcare provider's primary insurance limit. The JUA plays a vital role in filling a gap that permits quality healthcare providers to obtain MPL insurance and continue to practice in the state. The JUA also plays a vital role in stability of the market and addressing consequences of a hard market.

The Legislature's attempt to justify the transfer of JUA funds by declaring certain "findings" is disingenuous. As above, the findings lack sufficient evidence or foundation, and further, data and actuarial analyses have concluded inapposite.

For all the reasons set forth herein, the Medical Society, on behalf of its members, support a preliminary injunction to prevent the transfer of JUA

funds and to prohibit the abolishment of the JUA and Movant supports Plaintiff's request for a declaration that Act 44's JUA-provisions are unconstitutional and an order entered accordingly.

Respectfully Submitted,

GORDON & REES

BY /s/ Maggie M. Finkestein, Esquire
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CERTIFICATE OF WORD COUNT

I, Maggie Finkestein, Esquire, hereby certify that the foregoing Amicus Brief contains 5,263 words.

Dated: November 16, 2017

/s/ Maggie Finkelstein, Esquire

Maggie Finkestein, Esquire

CERTIFICATE OF SERVICE

AND NOW, 16th day of November, 2017, I, Maggie M. Finkelstein, Esquire, hereby certify that I did serve a true and correct copy of the foregoing via the Middle District Electronic Filing System:

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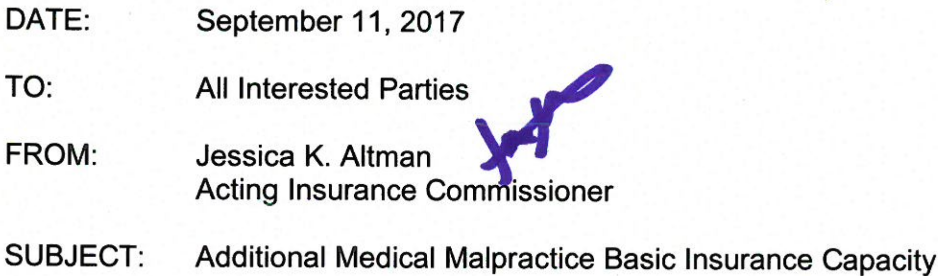
pennsylvania
INSURANCE DEPARTMENT



DATE: September 11, 2017

TO: All Interested Parties

FROM: Jessica K. Altman
Acting Insurance Commissioner

SUBJECT: Additional Medical Malpractice Basic Insurance Capacity

Under Pennsylvania's Act 13, the Medical Care Availability and Reduction of Error Act ('Fund' or 'MCARE'), basic primary professional liability insurance limits could potentially be increased in 2018 from $500,000 to $750,000 per claim. The increase is subject to an evaluation and analysis of the basic medical malpractice insurance coverage market capacity. A determination that additional capacity is not available would result in primary and Fund coverage limits for 2017 remaining in effect until such capacity is available in the future. The Department has previously undertaken reviews of the basic insurance coverage market capacity six times. To date, none of the prior reviews resulted in a change in the Fund coverage levels.

In 2017, the Department engaged Deloitte Consulting LLP to perform a Medical Professional Liability Basic Insurance Capacity Study as of December 31, 2016. The study reviewed information from a data call by the Department and other sources. The study evaluated market share, leverage ratios and financial strength of medical professional liability insurers in Pennsylvania. The study noted that the market share of Risk Retention Groups (RRGs) has grown substantially over the past eight years, increasing from 29% in 2008 to 37% in 2016. At the same time, admitted insurers have experienced a decline in market share from 40% to 34%. The study concluded that the increased use of non-traditional insurers, coupled with information showing net premium to surplus ratios for RRGs increasing, and an increase in loss ratios across all carrier types, may be considered indicative of a marketplace that may not have the financial capacity to withstand an increase in the basic insurance limit.

The Department also solicited comments about this decision from all interested parties with a notice published in the Pennsylvania Bulletin on February 11, 2017. Health care providers raised concerns about the potential financial impact on them from an increase in basic insurance limits. If the basic insurance limits are increased, there will be a period of time during which health care providers will be required to pay both an increased premium to support the higher basic limits, an amount to cover the immediate MCARE assessment and an additional amount related to the accrued, but as of yet, unfiled claims.

In conclusion, it cannot be determined that additional basic insurance capacity is currently available for calendar year 2018. Accordingly, there will be no increase to the current basic primary limits for calendar years 2018 and 2019.

Office of the Insurance Commissioner
1326 Strawberry Square | Harrisburg, Pennsylvania 17120 | Phone: 717.783.0442 | Fax: 717.772.1969
www.insurance.pa.gov | ra-in-commissioner@pa.gov

DATE: August 18, 2015

TO: All Interested Parties

FROM: Teresa D. Miller TDM
Insurance Commissioner

SUBJECT: Additional Medical Malpractice Basic Insurance Capacity

Under Pennsylvania's Act 13, the Medical Care Availability and Reduction of Error Act ('Fund' or 'MCARE'), basic primary professional liability insurance limits could potentially be increased in 2016 from $500,000 to $750,000 per claim. The increase is subject to an evaluation and analysis of the basic medical malpractice insurance coverage market capacity. A determination that additional capacity is not available would result in primary and Fund coverage limits for 2015 remaining in effect until such capacity is available in the future. The Department has previously undertaken reviews of the basic coverage market capacity five times. To date, none of the prior reviews resulted in a change in the Fund coverage levels.

Since the passage of Act 13 in 2002, there continue to be positive changes in the marketplace. However, there are a number of challenging factors present in our marketplace which may have an effect on capacity levels. These factors include the continually changing health care landscape and the large market share of risk retention groups ("RRGs"), which has increased since 2004. Because of their structure, RRGs have a more limited ability to raise additional capital to support increased limits and therefore could be negatively impacted. Another factor is the medical malpractice market itself. Insurance carriers that previously wrote only in Pennsylvania are becoming part of larger regional or national insurance groups whose commitment to the Pennsylvania market is unproven and thus, may negatively impact capacity.

It's also worth noting the potential financial impact on health care providers. If the basic insurance limits are increased, there will be a period of time during which health care providers will be required to pay both an increased premium to support the higher basic limits, an amount to cover the immediate MCARE assessment and an additional amount related to the accrued, but as of yet, unfiled claims.

In conclusion, it cannot be determined that additional basic insurance capacity is currently available for calendar year 2016. Accordingly, there will be no increase to the current basic primary limits for calendar years 2016 and 2017.

Office of the Insurance Commissioner
1326 Strawberry Square | Harrisburg, Pennsylvania 17120 | Phone: 717.783.0442 | Fax: 717.772.1969
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VT SUPERIOR COURT
WASHINGTON UNIT
CIVIL DIVISION

2017 AUG 10 P 1:22

FILED

STATE OF VERMONT
WASHINGTON COUNTY, SS

COMMISSIONER OF THE DEPARTMENT OF FINANCIAL REGULATION
PLAINTIFF,

v.

DOCTORS AND SURGEONS NATIONAL RISK RETENTION GROUP IC, INC.
RESPONDENT.

SUPERIOR COURT
DOCKET NO. 559-916 Wncv

ORDER OF LIQUIDATION

This matter came before the Court on the Petition for Order of Liquidation for Doctors and Surgeons National Risk Retention Group IC, Inc., ("Petition") of the Commissioner of the Department of Financial Regulation ("Commissioner") as Rehabilitator of Doctors and Surgeons National Risk Retention Group IC, Inc. ("DSNRRG"), for an order of liquidation for DSNRRG pursuant to 8 V.S.A. § 7055(a). In support of the Petition, the Rehabilitator filed an Affidavit of J. David Leslie, Special Deputy Rehabilitator. Based on the evidence presented, the Court finds that further attempts to rehabilitate DSNRRG would be futile and would substantially increase the risk of loss to creditors, policyholders, or the public, and it is hereby ORDERED:

1. Appointment of Commissioner as Liquidator. Pursuant to 8 V.S.A. § 7057(a), the Commissioner, and any successor in the office of Commissioner, is hereby appointed the Liquidator of DSNRRG (the "Liquidator").

2. Liquidator to Take Possession of Assets. Pursuant to 8 V.S.A. § 7057(a), the Liquidator is directed forthwith to take possession of the assets of DSNRRG wherever located, and to administer these assets under the general supervision of this Court and pursuant to the terms of this Order and 8 V.S.A. ch. 145.

3. Title to Property and Assets. Pursuant to 8 V.S.A. § 7057(a), the Liquidator is vested by operation of law with the title to all of the property, contracts and rights of action, and to all of the books and records of DSNRRG, wherever located, as of the date of entry of this Order.

4. Accountings. Pursuant to 8 V.S.A. § 7057(e), within one year of this Order and at least annually thereafter the Liquidator shall file an accounting with the Court. The accountings shall include (at a minimum) the assets and liabilities of DSNRRG and all funds received or disbursed by the Liquidator during the current period.

5. Powers of the Liquidator. Pursuant to 8 V.S.A. § 7060:

A. The Liquidator shall have the power to:

i. Appoint a special deputy to act for the Liquidator and to determine reasonable compensation for the special deputy. The special deputy shall have all the powers of the Liquidator granted by this section. The special deputy shall serve at the pleasure of the Liquidator;

ii. Employ employees and agents, legal counsel, actuaries, accountants, appraisers, consultants, and such other personnel as may be deemed necessary by the Liquidator to assist in the liquidation;

iii. Fix the reasonable compensation of employees and agents, legal counsel, actuaries, accountants, appraisers and consultants with the approval of the Court;

iv. Pay reasonable compensation to persons appointed and to defray from the funds or assets of DSNRRG all expenses of taking possession of, conserving, conducting, liquidating, disposing of, or otherwise dealing with the business and property of DSNRRG. In the event that the property of DSNRRG does not contain sufficient cash or liquid assets to defray the costs incurred, the Commissioner may advance the costs so incurred out of any appropriation for the maintenance of the department. Any amounts so advanced for expenses of administration shall be repaid to the Commissioner for the use of the department out of the first available moneys of DSNRRG;

v. Hold hearings, subpoena witnesses to compel their attendance, administer oaths, examine any person under oath, and compel any person to subscribe to testimony after it has been correctly reduced to writing; and in connection with such proceedings, require the production of any books, papers, records or other documents which the Liquidator deems relevant to the inquiry;

vi. Audit the books and records of all agents of DSNRRG insofar as those records relate to the business activities of DSNRRG;

vii. Collect all debts and moneys due and claims, belonging to DSNRRG, wherever located, and for this purpose:

a. institute timely action in other jurisdictions, in order to forestall garnishment and attachment proceedings against such debts;

b. do such other acts as are necessary or expedient to collect, conserve or protect its assets or property, including the power to sell, compound, compromise or assign debts for purposes of collection upon such terms and conditions as the Liquidator deems best; and

c. pursue any creditor's remedies available to enforce the Liquidator's claims;

viii. Conduct public and private sales of the property of DSNRRG;

ix. Use assets of the estate of DSNRRG to transfer policy obligations to a solvent assuming insurer, if the transfer can be arranged without prejudice to applicable priorities,

x. Acquire, hypothecate, encumber, lease, improve, sell, transfer, abandon, or otherwise dispose of or deal with, any property of DSNRRG at its market value or upon such terms and conditions as are fair and reasonable. The Liquidator shall also have power to execute, acknowledge, and deliver any and all deeds, assignments, releases and other instruments necessary or proper to effectuate any sale of property or other transaction in connection with the liquidation;

xi. Borrow money on the security of DSNRRG's assets or without security and execute and deliver all documents necessary to that transaction for the purpose of facilitating the liquidation. Any such funds borrowed may be repaid as an administrative expense and have priority over any other claims in Class 1 under the priority of distribution;

xii. Enter into such contracts as are necessary to carry out this Order, and affirm or disavow any contracts to which the insurer is a party;

xiii. Continue to prosecute and institute in the name of DSNRRG or in the Liquidator's own name any and all suits and other legal proceedings, in this state or elsewhere, and abandon the prosecution of claims the Liquidator deems unprofitable to pursue further. If DSNRRG is dissolved, the Liquidator shall have the power to apply to

any court in this state or elsewhere for leave to substitute the Liquidator for DSNRRG as plaintiff;

xiv. Prosecute any action which may exist in behalf of the creditors, members, policyholders or shareholders of DSNRRG against any officer of DSNRRG, or any other person;

xv. Remove any or all records and property of DSNRRG to the offices of the Liquidator or to such other place as may be convenient for the purposes of efficient and orderly execution of the liquidation;

xvi. Deposit in one or more banks in this state such sums as are required for meeting current administration expenses;

xvii. Invest all sums not currently needed, unless the Court orders otherwise;

xviii. File any necessary documents for record in the office of any recorder of deeds or record office in this state or elsewhere where property of the insurer is located;

xix. Assert all defenses available to DSNRRG as against third persons, including statutes of limitation, statutes of frauds, and the defense of usury. A waiver of any defense by DSNRRG after a petition in liquidation has been filed shall not bind the Liquidator;

xx. Exercise and enforce all the rights, remedies, and powers of any creditor, shareholder, policyholder, or member, including any power to avoid any transfer or lien that may be given by the general law;

xxi. Intervene in any proceeding wherever instituted that might lead to the appointment of a receiver or trustee, and act as the receiver or trustee whenever the appointment is offered;

xxii. Enter into agreements with any receiver or commissioner of any other state relating to the liquidation or dissolution of DSNRRG if DSNRRG was doing business in both states; and,

xxiii. Exercise all powers now held or hereafter conferred upon receivers by the laws of this state not inconsistent with the provisions of 8 V.S.A. ch. 145.

B. The enumeration of the powers and authority of the Liquidator shall not be construed as a limitation upon the Liquidator, nor shall it exclude in any manner the Liquidator's right to do such other acts not herein specifically enumerated or otherwise provided for, as may be necessary or appropriate for the accomplishment of or in aid of the purpose of DSNRRG's liquidation.

6. Notice to Creditors and Others. Pursuant to 8 V.S.A. § 7061:

A. The Liquidator shall give or cause to be given notice of the issuance of this Order as soon as possible:

i. By first class mail and either by telecopier or telephone to the insurance commissioner of each jurisdiction in which DSNRRG is doing business;

ii. By first class mail to all insurance agents listed as agents of record on in-force policies as of October 7, 2016, at their last known address as indicated by the records of DSNRRG;

iii. By first class mail to all persons known or reasonably expected to have claims against DSNRRG, including to all policyholders at their last known address as indicated by the records of DSNRRG; and

iv. By publication in a newspaper of general circulation in the county in which DSNRRG has its principal place of business and in such other locations as the Liquidator deems appropriate.

B. The notice to potential claimants shall require claimants to file with the Liquidator their claims, together with proper proofs thereof pursuant to 8 V.S.A. § 7075 and this Order, before a date specified by the Liquidator in the notice, which must be no less than six months after the date of this Liquidation Order. All claimants shall have a duty to keep the Liquidator informed of any changes of address.

C. If notice is given in accordance with this section, the distribution of assets of DSNRRG under 8 V.S.A. ch. 145 shall be conclusive with respect to all claimants, whether or not they received notice.

7. Approval of the Plan of Liquidation. The Liquidator is authorized to implement the Plan of Liquidation attached to the Petition as Exhibit A, which is hereby found to be in the best interests of the policyholders of DSNRRG and the public.

8. Stay of Proceedings Involving Claims Defended by DSNRRG. Pursuant to 8 V.S.A. § 7033(a)(6) and (a)(11), for a period of sixty (60) days from the date of the entry of this Order for Liquidation, to the extent of the jurisdiction of this Court and the comity given to its orders, all persons are hereby enjoined from (a) the further prosecution of any action that involves a claim presently being defended by DSNRRG, and (b) any other action that might lessen the value of the insurer's assets or prejudice the rights or policyholders, creditors or shareholders, or the administration of the liquidation proceeding. Such time in necessary for the implementation of the Liquidation Plan and for the orderly transition of the defense of claims.

9. Actions By and Against Liquidator.

A. Pursuant to 8 V.S.A. § 7063, upon issuance of this Order, no action at law or equity shall be brought against DSNRRG or the Liquidator, whether in this state or elsewhere, nor shall any such existing actions be maintained or further presented after issuance of such Order. Whenever, in the Liquidator's judgment, protection of the estate of DSNRRG necessitates intervention in an action against DSNRRG that is pending outside this state, the Liquidator may intervene in the action. The Liquidator may defend any action in which the Liquidator intervenes under this section at the expense of the estate of DSNRRG.

B. DSNRRG, its officers, directors, trustees, agents, employees, and all other persons, are hereby enjoined and otherwise prevented from:

i. instituting or further prosecuting any actions or proceedings of any nature whatsoever, including matters in arbitration, against DSNRRG, its assets or the Liquidator or any Special Deputy;

ii. interfering with the Liquidator or with a proceeding under 8 V.S.A. ch. 145;

iii. causing waste of DSNRRG's assets;

iv. obtaining preferences, judgments, attachments, garnishments or liens against DSNRRG or its assets;

v. levying execution against DSNRRG or its assets;

vi. withholding from the Liquidator books, accounts, documents, or other records or information relating to the business of DSNRRG, or failing to preserve such material;

vii. any other threatened or contemplated action that might lessen the value of DSNRRG's assets or prejudice the rights of policyholders, creditors or shareholders, or the administration of the liquidation; or

viii. the setoff of any debt owing to DSNRRG; provided, however, that nothing herein shall prohibit the setoff of mutual debts or mutual credits in accordance with 8 V.S.A. § 7069.

10. Attachment, Garnishment and Levy of Execution. Pursuant to 8 V.S.A. § 7098, during the pendency in this or any other state of a DSNRRG liquidation, whether called by that name or not, no action or proceeding in the nature of an attachment, garnishment or levy of execution shall be commenced or maintained in this state against DSNRRG or its assets.

11. Effectiveness of Provisions of this Order. Each of the provisions of this Order of Liquidation shall be effective unless it is found by this Court in a proceeding expressly addressing the issue to be prohibited by 8 V.S.A. Ch. 145.

12. Retention of Jurisdiction. This Court shall retain jurisdiction for all purposes necessary to effectuate and enforce this Order.

13. Finality of Order. Notwithstanding the retention by this Court of jurisdiction under section 12 hereof, or any other provisions hereof, this is a Final Order.

14. Incorporation of Provisions of 8 V.S.A. ch. 45. To the extent that any applicable provisions of 8 V.S.A. ch. 145 are not explicitly incorporated in this Order of Liquidation, such provisions shall be deemed to be incorporated herein.

Dated at Montpelier, Vermont, this 10th day of August, 2017.

Mary Miles Teachout
Superior Court Judge

STATE OF SOUTH CAROLINA RICHLAND COUNTY	IN THE COURT OF COMMON PLEAS FIFTH JUDICIAL CIRCUIT
Raymond G. Farmer, as Director of the South Carolina Department of Insurance, Petitioner, vs. Oceanus Insurance Company, a Risk Retention Group Respondent.	Civil Action No. 2017-CP-40-05195 **ORDER COMMENCING LIQUIDATION PROCEEDINGS & GRANTING AN INJUNCTION & AUTOMATIC STAY OF PROCEEDINGS**

RICHLAND COUNTY FILED 2017 SEP 2_ PM 12: 3_ JEANNETTE W. McBRIDE C.C.P., G.S.

This matter comes before me pursuant to the South Carolina Insurers Supervision, Rehabilitation and Liquidation Act, S.C. Code Ann. §§ 38-27-10 *et seq*. Petitioner, Raymond G. Farmer, as Director of the South Carolina Department of Insurance, by and through counsel, has petitioned the Court for an Order appointing him as Liquidator of Respondent, Oceanus Insurance Company, a Risk Retention Group. The instant Petition was filed and served on Respondent on August 31, 2017. Respondent has reasonable notice of the Petition pursuant to Section 38-27-60 of the Code of Laws of South Carolina 1976, as amended; and, Respondent's Board of Directors has proffered no objection to the Petition being granted and waives hearing on this matter.

The Court, having reviewed the filings of record and otherwise being fully informed in the premises, finds:

1. This Court has jurisdiction of the subject matter and is the proper venue for this proceeding pursuant to S.C. Code Ann. § 38-27-60(b), (c) & (f) & -360 (2015).

2. Petitioner is the duly appointed Director for the State of South Carolina Department of Insurance with such powers, duties and responsibilities as are prescribed under the insurance laws of this State to that agency's director for company licensing, delinquency and receivership matters, and is specifically authorized to file a petition for liquidation pursuant to S.C. Code Ann. § 38-27-360 (2015).

3. The Department has regulatory jurisdiction over the Respondent pursuant to, *inter alia*, Chapters 3, 87 and 90 of Title 38 of the South Carolina Code of Laws 1976, as amended.

4. Respondent is a South Carolina Industrial Insured Captive (stock) Corporation formed as a risk retention group, organized and licensed pursuant to Chapters 87 and 90 of Title 38 of the South Carolina Code, and is owned and capitalized by its insured physician and physician group members.

5. Respondent was licensed on September 24, 2004 and commenced writing business with Department authorization on February 18, 2005.

6. Under Respondent's approved business plan, member-insureds are physician's groups and individual practitioners throughout the United States.

7. Respondent issues non-assessable medical malpractice professional insurance policies with primary coverage up to $1,000,000 per occurrence with $3,000,000 in the aggregate. Excess limits are provided above the primary coverage and are fully reinsured. For the 2014-2015 and 2015-2016 policy years, Respondent retains $450,000 on the primary policy and cedes the remainder to reinsurers. Retention decreases to $350,000 in 2016-2017. Respondent currently has no reinsurance for policy years prior to 2014-2015.

8. Respondent is required by the Department to maintain minimum capital and surplus of $10,000,000 on a modified GAAP basis.

9. S.C. Code Ann. § 38-27-360 sets forth the following grounds upon which an insurer may be placed into liquidation:

a. Any ground for an order of rehabilitation as specified in S.C. Code Ann. § 38-27-310 (2015), whether or not there has been a prior order directing the rehabilitation of the insurer, including the board of directors or the holders of a majority of the shares entitled to vote request or consent to liquidation;

b. The insurer is insolvent; or

c. The insurer is in such a condition that the further transaction of business would be hazardous, financially or otherwise, to its policyholders, its creditors, or the public.

10. Petitioner has alleged in its Petition that Respondent is in a condition in which the further transaction of business would be hazardous, financially or otherwise, to its policyholders, creditors, or the public and that it is insolvent as defined in S.C. Code Ann. § 38-27-50(10) (2015), both of which constitute grounds for the commencement of liquidation, as set forth in Section 38-27-360.

11. It is in the best interest of Respondent, its policyholders, its creditors and the public that the relief requested be granted.

IT IS THEREFORE ORDERED THAT:

1. PURSUANT TO S.C. Code Ann. § 38-27-370 (2015), Petitioner and his successors in office are appointed Liquidator of Respondent.

2. PURSUANT TO S.C. Code Ann. § 38-27-370(B) (2015), the rights and liabilities

of the insurer and its creditors, policyholders, shareholders, members, and other persons interested in its estate become fixed as of the date of entry of the order of liquidation, except as provided in S.C. Code Ann. §§ 38-27-380 and 38-27-560 (2015); and, any claim excepted under this provision and Section 38-27-370(B) shall be governed by Sections 38-27-380 and 38-27-560, as applicable.

2. PURSUANT TO S.C. Code Ann. § 38-27-400(a) (2015), Petitioner and his successors shall have all the powers and responsibilities set forth under that section to assist him or his designee as Liquidator, including but not limited to:

a. To appoint a special deputy to act for him and to determine the special deputy's reasonable compensation, who shall have all powers of the Liquidator granted by this section and who serves at the pleasure of the Liquidator.

b. To employ employees and agents, legal counsel, actuaries, accountants, appraisers, consultants, and other personnel he considers necessary to assist in the liquidation.

c. To fix the reasonable compensation of employees and agents, legal counsel, actuaries, accountants, appraisers, and consultants with the Court's approval.

d. To pay reasonable compensation to persons appointed and to defray from the funds or assets of the insurer all expenses of taking possession of, conserving, conducting, liquidating, disposing of, or otherwise dealing with the business and property of Respondent. In the event that Respondent's property does not contain sufficient cash or liquid assets to defray the costs incurred, the Director may advance the costs so incurred out of any appropriation for the maintenance of the Department of Insurance. Any amounts so advanced for expenses of administration must be repaid to the Director for the use of the Department out of the first

available monies of the insurer.

e. To hold hearings, to subpoena witnesses to compel their attendance, to administer oaths, to examine any person under oath, and to compel any person to subscribe to his testimony after it has been correctly reduced to writing and, in connection therewith, to require the production of any books, papers, records, or other documents which he considers relevant to the inquiry.

f. To collect all debts and monies due and claims belonging to Respondent, wherever located, and, for this purpose:

(i) To institute timely action in other jurisdictions in order to forestall garnishment and attachment proceedings against the debts.

(ii) To do other acts necessary or expedient to collect, conserve, or protect its assets or property, including the power to sell, compound, compromise, or assign debts for purposes of collection upon terms and conditions he considers best.

(iii) To pursue any creditor's remedies available to enforce his claims.

g. To conduct public and private sales of the property of Respondent.

h. To use assets of the estate of Respondent to transfer policy obligations to a solvent assuming insurer, if the transfer can be arranged without prejudice to applicable priorities under S.C. Code Ann. § 38-27-610 (2015).

i. To acquire, hypothecate, encumber, lease, improve, sell, transfer, abandon, or otherwise dispose of or deal with any property of Respondent at its market value or upon terms and conditions that are fair and reasonable. He also has power to execute, acknowledge,

and deliver any and all deeds, assignments, releases, and other instruments necessary or proper to effectuate any sale of property or other transaction in connection with the liquidation.

j. To borrow money on the security of Respondent's assets or without security and to execute and deliver all documents necessary to that transaction for the purpose of facilitating the liquidation.

k. To enter into contracts necessary to carry out the order to liquidate, and to affirm or disavow any contracts to which the insurer is a party.

l. To continue to prosecute and to institute in the name of Respondent or in his own name any and all suits and other legal proceedings, in this State or elsewhere, and to abandon the prosecution of claims he considers unprofitable to pursue further. If Respondent is dissolved under S.C. Code Ann. § 38-27-390 (2015), he has the power to apply to any court in this State or elsewhere for leave to substitute himself for Respondent as plaintiff.

m. To prosecute any action which may exist in behalf of the creditors, members, policyholders, or shareholders of Respondent against any officer of Respondent or any other person.

n. To remove any or all records and property of Respondent to the offices of the Department or to any other place convenient for the purposes of efficient and orderly execution of the liquidation, *provided* that guaranty associations and foreign guaranty associations shall have such reasonable access to the records of Respondent as is necessary for them to carry out their statutory obligations.

o. To deposit in one or more banks in this State sums required for meeting

current administration expenses and dividend distributions.

p. To invest all sums not currently needed, unless the Court orders otherwise.

q. To file any necessary documents for recording in the office of any recorder of deeds or record office in this State or elsewhere where property of Respondent is located.

r. To assert all defenses available to Respondent as against third persons, including statutes of limitation, statutes of fraud, and the defense of usury. A waiver of any defense by Respondent after a petition in liquidation has been filed does not bind the Liquidator. Whenever a guaranty association or foreign guaranty association has an obligation to defend any suit, the Liquidator shall give precedence to that obligation and may defend only in the absence of a defense by the guaranty associations.

s. To exercise and enforce all the rights, remedies, and powers of any creditor, shareholder, policyholder, or member, including any power to avoid any transfer or lien that may be given by the general law and that is not included with S.C. Code Ann. §§ 38-27-450 through 38-27-470 (2015).

t. To intervene in any proceeding wherever instituted that might lead to the appointment of a receiver or trustee and to act as the receiver or trustee whenever the appointment is offered.

u. To enter into agreements with any receiver or commissioner of any other state relating to the rehabilitation, liquidation, conservation, or dissolution of an insurer doing business in both states.

v. To exercise all powers now held or hereafter conferred upon receivers by the laws of this State not inconsistent with applicable law.

w. To audit the books and records of agents of Respondent insofar as those records relate to the business activities of the insurer.

x. Notwithstanding the powers of the Liquidator as enumerated above and granted pursuant to Section 38-27-400, the Liquidator is not obligated to defend claims or to continue to defend claims after the entry of a liquidation order.

3. PURSUANT TO S.C. Code Ann. § 38-27-400(b) (2015), the enumeration in this Order of the powers and authority of the Liquidator may not be construed as a limitation upon him; nor shall it exclude in any manner his right to do other acts not herein specifically enumerated, or otherwise provided for, that may be necessary or appropriate for the accomplishment of or in aid of the purpose of liquidation.

4. PURSUANT TO S.C. Code Ann. §§ 38-27-410, -540 & -550 (2015), the Liquidator shall provide Notice of this Order, prescribe the form of a Proof of Claim to be used by all claimants and shall set the date for submission of claims, or Bar Date, after which no claim will be allowed except as provided in Section 38-27-540; and, said Bar Date shall be no later than one-hundred and eighty (180) days from the date of entry of this Order, unless the 180th day of the period so computed is a Saturday, Sunday or a State or Federal holiday, in which event the period runs until the end of the next day which is neither a Saturday, Sunday nor such holiday.

5. PURSUANT TO S.C. Code Ann. § 38-27-370(E) (2015), the Liquidator shall submit periodic accountings to the Court, with the first such accounting to be filed no more than

180 days after the date of this Order and with subsequent accountings to be made on a semiannual basis for each calendar year.

6. Continuation and cancellation of coverage shall be governed by S.C. Code Ann. § 38-27-380(b) (2015).

7. Upon filing by the Liquidator with the office of the Secretary of State a certified true copy of the Liquidation Order, Respondent is dissolved in accordance with S.C. Code Ann. § 38-27-390 (2015).

8. Respondent is hereby officially declared insolvent as defined by S.C. Code Ann. § 38-27-50(10) (2015).

9. Petitioner's designation of Michael J. FitzGibbons of FitzGibbons and Company, Inc., 9821 N. 95th St., Suite 105, Scottsdale, Arizona 85258, as a consultant to the Liquidator and as Special Deputy Liquidator, in this matter, with such reasonable compensation as determined by the Liquidator pursuant to S.C. Code Ann. § 38-27-400(a)(1) (2015) is hereby expressly approved, and said Special Deputy Liquidator shall have all powers of the Liquidator granted by S.C. Code 38-27-400 (2015) and this Order and shall serve at the pleasure of the Liquidator.

NOTICE OF INJUNCTION AND AUTOMATIC STAY

Notice is hereby given that pursuant to S.C. Code Ann. §§ 38-7-70 & -430 (2015), the Court grants an injunction and automatic stay applicable to all persons and proceedings, other than the Liquidator, which shall be permanent and survive the entry of the Order and which prohibits:

1) The transaction of further business;

2) The transfer of property;

3) Interference with the Liquidator or with a proceeding under Chapter 27 of Title 38 of the Code;

4) Waste of the insurer's assets;

5) Dissipation and transfer of bank accounts;

6) The institution or further prosecution of any actions or proceedings;

7) The obtaining of preferences, judgments, attachments, garnishments, or liens against the insurer, its assets, or its policyholders;

8) The levying of execution against the insurer, its assets, or its policyholders;

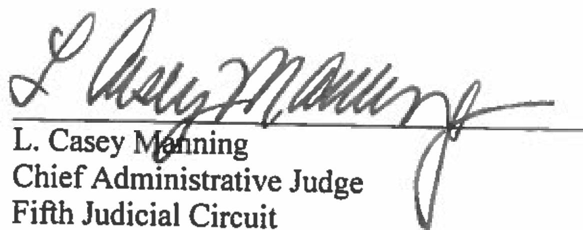
9) The making of any sale or deed for nonpayment of taxes or assessments that would lessen the value of the assets of the insurer;

10) The withholding from the receiver or books, accounts, documents, or other records relating to the business of the insurer; or

11) Any other threatened or contemplated action that might lessen the value of the insurer's assets or prejudice the rights of policyholders, creditors, or shareholders, or the administration of any proceeding under Chapter 27 of Title 38 of the South Carolina Code.

This Court retains jurisdiction of this cause for the purpose of granting such other and further relief as from time to time may be necessary and appropriate.

AND IT IS SO ORDERED.



L. Casey Manning
Chief Administrative Judge
Fifth Judicial Circuit

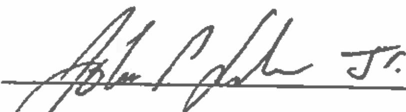
This 21 day of Sept., 2017

Columbia, South Carolina

FOR PETITIONER:

Geoffrey R. Bonham
One of the Attorneys for the Petitioner

ACKNOWLEDGED FOR RESPONDENT, OCEANUS INSURANCE COMPANY, A RISK RETENTION GROUP:



BY: John P. Seibels, Jr

ITS: Counsel of Record