STATE OF NEW HAMPSHIRE
DEPARTMENT OF STATE

IN THE MATTER OF:	)	
Local Government Center, Inc., et al.	)	C-2011000036
RESPONDENTS	)	

HEALTHTRUST'S OBJECTION TO BSR'S MOTION FOR SUMMARY JUDGMENT

HealthTrust, Inc. ("HealthTrust"), hereby objects to the motion for summary judgment filed by the New Hampshire Bureau of Securities Regulation ("BSR"). HealthTrust has addressed the BSR's arguments concerning the Settlement Agreement ("Agreement") in its own summary judgment motion, and HealthTrust incorporates the facts and arguments from those papers here. See HealthTrust Memorandum in Support of Motion for Summary Judgment ("HT Mem."); HealthTrust Statement of Undisputed Facts ("Statement"). This Objection will respond to particular points made in the BSR's pleadings and will also address why the penalty requested by the BSR is both unauthorized and inappropriate, in the event the Presiding Officer were to find a violation had been present until recently. Certain additional facts are set forth in HealthTrust's Statement of Additional Undisputed Facts ("Additional Statement").

RECENT DEVELOPMENT: THE TERMINATION AGREEMENT

HealthTrust and Property-Liability Trust, Inc. ("PLT") have terminated the Settlement Agreement ("Agreement") that underlies the BSR's Motion for Entry of Default Judgment. As noted in HealthTrust's summary judgment papers, in February 2014 Towers Watson provided HealthTrust with estimates of PLT's coverage obligations as of January 10, 2014 that were materially lower than prior estimates. The results of the PLT coverage lines runoff have been

favorable. In light of these changed circumstances, the sole reason for the Agreement, PLT's insolvency, is no longer present. Accordingly, on May 30, 2014, the PLT Board of Directors voted to enter a Termination Agreement proposed by HealthTrust, and on June 3, 2014, the HealthTrust Board of Directors voted to enter the Termination Agreement. The Termination Agreement was fully executed on June 3, 2014. Additional Statement ¶ 11, Second Curro Aff. Ex. 17 (the Termination Agreement).

The Termination Agreement is effective as of June 6, 2014 at 5:00 p.m. Termination Agreement ¶ B1. The Agreement is terminated at that time. Id. ¶ B2. All PLT assets transferred to HealthTrust pursuant to the Agreement, net of claim payments and other expenses incurred thereunder, will be re-transferred from HealthTrust to PLT. Id. ¶ B3. All remaining PLT liabilities that were transferred to HealthTrust pursuant to the Agreement will be re-transferred from HealthTrust to PLT. Id. ¶ B4. The PLT employees who were transferred to HealthTrust pursuant to the Agreement, and all outstanding liabilities related to their employment, will be retransferred from HealthTrust to PLT. Id. ¶ B6.[1]

Contemporaneously with these transfers, PLT will pay HealthTrust $17.1 million in complete and full satisfaction of the payment directed by the Final Order. Termination Agreement ¶ B5. Subject to the Presiding Officer's and the BSR's approval, HealthTrust will distribute the $17.1 million to its current members or another identified combination of current and former HealthTrust members as soon as practicable.[2] Additional Statement ¶ 13.

[1] Additionally, any service or lease agreement between HealthTrust and PLT that was in effect on January 10, 2014 will be reinstated on the same terms and conditions that existed on that date. Termination Agreement ¶ B8.

[2] The current members' distribution will require calculations of contributions through June. Because some members prefer contribution holidays over refund checks, HealthTrust will provide advance notice to the members of their share of the distribution and the opportunity to notify HealthTrust if the individual member prefers a contribution holiday. HealthTrust anticipates that the logistics will be completed and checks distributed or contribution holidays commenced in September. Additional Statement ¶ 13 n. 2.

In its recently filed objection to HealthTrust's motion for summary judgment, the BSR represents that "the Termination Agreement, at section D, provides for HealthTrust to lend money or obtain a line of credit for the benefit of PLT." BSR's objection, p. 9. The BSR's representation is misleading. Section D expressly provides that HealthTrust can only provide a line of credit (1) if PLT's assets prove insufficient to cover PLT's liability for coverage to its existing members through June 30, 2016, and – more importantly – (2) "[s]ubject to BSR prior approval or non-objection." Termination Agreement, Section D (emphasis added). Thus, the BSR, not HealthTrust, controls whether HealthTrust can provide a line of credit to PLT.

The BSR's Motion for Entry of Default Order ("Motion") alleged that the Agreement violated the Final Order and RSA 5-B and requested a finding of violation and an order that respondents "shall cease and desist" operating in violation of the Final Order and RSA 5-B "or be deemed not entitled to operate as N.H. RSA 5-B pools, and to claim the protections of N.H RSA § 5-B." Motion, Prayer B. The Termination Agreement terminates the Agreement such that HealthTrust and PLT are no longer arguably operating in violation of the Final Order and RSA 5-B and there is no need for a cease and desist order. The issues that underlay the Motion thus "have become academic." In re O'Neil, 159 N.H. 615, 624 (2010). Since the unusual circumstances giving rise to the Agreement are unlikely to arise again, HealthTrust suggests this matter has become moot.

ARGUMENT

I. THE AGREEMENT DID NOT VIOLATE THE FINAL ORDER'S GOVERNANCE REQUIREMENTS.

The BSR first contends that HealthTrust and PLT violated the Final Order's directive to maintain independent boards and separate bylaws. This position rests on two erroneous premises: (1) that the Agreement constituted a "third reorganization" that somehow did away

with PLT's board and bylaws, and (2) that the Final Order somehow prohibited HealthTrust from administering property-liability lines of coverage. Neither premise is correct. First, the Agreement did not affect PLT's corporate governance. PLT continues to have an independent board and bylaws. Second, the Final Order concerned the propriety of a single board of directors governing two programs (corporations) as part of a conglomerate; it did not address any question concerning operation of multiple coverage lines by a single program (corporation).

A. The Agreement Did Not Affect PLT's Corporate Governance, and PLT Continues to Have an Independent Board and Bylaws.

In its memorandum, the BSR recognizes that the "respondents" reorganized in compliance with the Final Order.[3] The BSR accepts that in November 2012, the respondent LLCs adopted separate bylaws and appointed separate governing boards, and that in September 2013, HealthTrust and PLT – each of which had its own bylaws and board of directors – accepted the transfer of the respective LLC's assets. BSR Mem. at 3-5, 7. Thus, there is no dispute that, prior to – and now subsequent to – the Agreement, HealthTrust and PLT were in compliance with the Final Order's requirement that the two programs be reorganized "into a form that provides each program with an independent board and its own set of written bylaws." Final Order p. 73, ¶ 1.

The BSR rests its case on the assertion that, as a result of the Agreement (which it inaccurately refers to as a "third reorganization"), "HealthTrust and PLT no longer maintained separate boards and separate bylaws." BSR Mem. at 6. The BSR's position rests solely on a citation to the Agreement, without any analysis or supporting facts. See id. at 7-8 (citing Exhibit E – the Agreement). The BSR misconstrues the Agreement. The Agreement was not a

[3] The parties here are HealthTrust and PLT, each of which has an independent board of directors. Other parts of the former Local Government Center, Inc. (now known as New Hampshire Municipal Association, Inc.) group are not parties against whom the BSR seeks relief and are not represented here.

corporate "reorganization," and PLT continues to have a separate board and its own bylaws. Statement ¶ 32.

"As a general rule, the proper interpretation of a contract is ultimately a question of law for [the courts], and [they] will determine the meaning of the contract based on the meaning that would be attached to it by reasonable persons." Lakes Region Gaming v. Miller, 164 N.H. 558, 562 (2013) (quoting Robbins v. Salem Radiology, 145 N.H. 415, 417 (2000)). "When interpreting a written agreement, [the courts] give the language used by the parties its reasonable meaning, considering the circumstances and the context in which the agreement was negotiated, and reading the document as a whole. Absent ambiguity, the parties' intent will be determined from the plain meaning of the language used in the contract." Audette v. Cummings, 82 A.3d 1269, 1273 (N.H. 2013) (quoting Czumak v. N.H. Div. of Developmental Servs., 155 N.H. 368, 373 (2007)).

As a matter of law, the Agreement did not have the effect asserted by the BSR. The Agreement did not do away with PLT's separate board of directors or separate bylaws. To maximize payment of the $17.1 million in light of PLT's then apparent insolvency, the Agreement provided for the transfer of all of PLT's assets and liabilities to HealthTrust and that HealthTrust would manage the runoff of PLT's coverage obligations using the transferred assets and the existing PLT staff. See Agreement ¶¶ D.1-D.5. It was silent as to PLT's corporate governance and structure. There was no language in the Agreement that would support the effect posited by the BSR.[4]

[4] The Gardner Affidavit does not create a factual issue. The affidavit does not present any facts concerning PLT's Board of Directors but only observations as to what the Agreement "appears to allow." Gardner Affidavit ¶ 6. The interpretation of a contract, however, is a matter of law. See Orr v. Goodwin, 157 N.H. 511, 518 (2008) (plaintiffs' assertion as to their interpretation of contract not "availing").

The BSR's position is belied by the undisputed facts concerning PLT and its board while the Agreement was operational. PLT continued to have a Board of Directors and separate bylaws. See Statement ¶ 32; Additional Statement ¶¶ 1-2. The six directors of PLT were elected or re-elected by the PLT members at the PLT annual meeting in December 2013. Additional Statement ¶ 1. PLT's Board monitored HealthTrust's compliance with the Agreement, and the Board met to discuss the status of the runoff on March 4 and May 30, 2014. Statement ¶¶ 33-34; Additional Statement ¶ 1. The Chair of PLT's Board and PLT's counsel were among those who met with the BSR on February 4, 2014. Additional Statement ¶ 6. PLT sought a meeting with the New Hampshire Department of Labor by letter dated February 19, 2014. Additional Statement ¶ 8. PLT requested quarterly updates of HealthTrust's runoff of the PLT coverage lines by letter dated April 23, 2014. Additional Statement ¶ 2.

HealthTrust's runoff of the PLT coverage line obligations did not resemble the corporate governance structure (a single parent entity and board over two subsidiary pooled risk management programs) prohibited by the Final Order. The Presiding Officer should reject the BSR's contention that HealthTrust and PLT violated the corporate governance directive of the Final Order that each program have its own independent board and separate bylaws.

B. The Final Order Concerned Programs, Not Lines of Coverage, and It Did Not Prohibit HealthTrust from Running-off Property-Liability Coverages.

The BSR contends that HealthTrust's "operat[ion] [of] the property-liability and workers' compensation lines of coverage" violated the Final Order. See BSR Mem. at 7-8. It is not clear if the BSR is asserting some alleged violation beyond its erroneous assertion that PLT no longer has a separate board and bylaws. It is clear, however, that the Final Order did not contain directives about the operation of lines of coverage. It required that separate programs – which

RSA 5-B:5, I(a) requires "[e]xist as a legal entity" – have separate boards and bylaws. Final Order p. 73, ¶ 1. As set forth in HealthTrust's memorandum, the Final Order's governance analysis concerned programs, not lines of coverage. See HT Mem. at 23-26. The Final Order does not address the lines of coverage administration issue apparently presented by the BSR.

In applying the Final Order, the Presiding Officer must look to its plain meaning. The rules of interpretation of a prior order are well-established. "In construing a court order, we look to the plain meaning of the words used in the document." In re Salesky, 157 N.H. 698, 703 (2008). "Neither what the parties thought the judge meant nor what the judge thought he or she meant, after the time for appeal has passed, is of any relevance. What the decree, as it became final, means as a matter of law as determined from the four corners of the decree is what is relevant." Edwards v. RAL Automotive Group, Inc., 156 N.H. 700, 705 (2008) (quoting Universal Assurors Life v. Hohnstein, 500 N.W.2d 811, 814 (Neb. 1993)).

The BSR does not identify any Final Order language that prohibited HealthTrust from administering runoff of the PLT coverage lines.[5] It is not surprising that the Final Order does not contain language prohibiting administration of multiple coverage lines because the 2012 administrative hearing did not concern such an issue. See Salesky, 157 N.H. at 703 ("As a general matter, a court decree or judgment is to be construed with reference to the issues it was meant to decide."). Instead, the hearing concerned the governance of the two separate programs that were at that time part of a "conglomerate" and had no boards or bylaws of their own. See Final Order at 8-24. The Presiding Officer's rulings in the Final Order were directed to the absence of separate boards and bylaws governing the separate programs and the conflicts the

[5] The assertions concerning the meaning of the Supreme Court's decision, the Final Order, and statutes and what the Agreement "appears to allow" or "may also be used to facilitate" in the Gardner Affidavit ¶¶ 5-6 constitute "legal conclusions and 'expression[s] of purely personal opinion'" that are insufficient to support or defeat summary judgment. See Granite State Management & Resources v. City of Concord, 165 N.H. 277, 290 (2013) (quoting Brown v. John Hancock Mut. Life Ins. Co., 131 N.H. 485, 490-91 (1989)).

"parent/subsidiary" structure presented for the single LGC, Inc. board responsible for all the various subsidiary legal entities in the "conglomerate." See Final Order at 6, 15.

The Supreme Court recognized that this was the basis for the Final Order. The Court summarized the Presiding Officer's organizational findings as follows:

> The presiding officer first found that the respondents violated RSA 5-B:5, I(b) and (e). He construed those provisions to require that each pooled risk management program be governed by its own board of directors and by its own bylaws. See RSA 5-B:5, I(b), (e). Accordingly, he found that the 2003 reorganization, which resulted in LGC transferring the assets of its pooled risk management programs to itself and abolishing the separate boards that had previously governed such programs, violated those provisions.

Appeal of Local Government Center, slip op. at 6. The Court then summarized the Presiding Officer's rationale, which focused exclusively on the implications of LGC's failure to respect the RSA 5-B mandated governance for each program:

> The presiding officer explained that "by abolishing each program's respective board and substituting the LGC . . . board of directors, the political subdivision members of each pooled risk management program were deprived of the governance previously maintained for their benefit," as required by statute. The post-2003 reorganization "result[ed] in a conglomerate imbued with conflicts of interest adverse to the required standards for operation of each pooled risk management program." "The influences and interest that would be limited to considerations of a single program and its members [became] subject to other influences and interests within the LGC . . . conglomerate related to other subsidiary business entities all governed by one board."

Id. (quoting the Final Order at 6, 19, 21).

The BSR's position confuses programs and lines of coverage. A "program" is not a line or group of lines of coverage but a legal entity, and the governance requirements apply to those legal entities. The statute expressly distinguishes between programs and coverages. See RSA 5-B:5, I(a) ("Each program shall . . . [e]xist as a legal entity organized under New Hampshire law."); RSA 5-B:3, III (Programs "may provide any or all of the following coverages . . . .").

In the Final Order, the Presiding Officer recognized that the requirements of a governing board and bylaws attach to the legal entity that is the program:

> The organizational violations . . . result from [LGC's] failure to meet and maintain standards required by this statute to operate each pooled risk management program at all times consistent with a governing board and governing by-laws of a legal entity organized under New Hampshire law.

Final Order at 6. See id. at 10, 11. Consistent with the statute, the Final Order applied the governance requirements to the legal entity programs. Indeed, the Presiding Officer recognized that the formerly separate property-liability and workers' compensation programs had been combined by a merger of LLCs in 2007 (Final Order at 13 & n. 14), and he applied the corporate governance requirements to that single "combined" program, not to the separate property-liability and workers compensation lines of coverage. Final Order at 23, 73. See Appeal of Local Government Center, slip op. at 4 (noting 2007 merger), 10 (noting remedy).

The Final Order provided for the proper governance of each corporate entity that constitutes a program, and it did not address any issues concerning the administration of the runoff of lines of coverage written by one program by another. The administration of the runoff of a program's coverage obligations pursuant to contract did not present a corporate governance issue. Corporate governance is distinct from such operational issues. Insurance companies and pooled risk management programs enter into contracts with third party administrators ("TPAs") to handle claims under their policies and otherwise administer their business, but that does not mean their boards of directors do not continue to exist or have responsibilities with respect to the administered business. (For example, HealthTrust has long engaged Anthem to administer its medical plan claims. Additional Statement ¶ 15). Similarly, insurance companies and programs reinsure their business or certain "blocks" of business with other insurers, but that does not render their boards of directors a nullity or constitute a corporate "reorganization."

The BSR's position ultimately is a policy view that property-liability lines of coverage should not be managed alongside health lines of coverage. However, RSA 5-B expressly permits programs to offer "any or all" of the enumerated coverage lines, including property, casualty and health lines. RSA 5-B:3, III. The BSR is attempting to establish a policy not found in the statute through the administrative process. The attempt is not proper because "[a]n agency may not add to, change, or modify the statute by regulation or through case-by-case adjudication." Appeal of Local Government Center, slip op. at 17 (quoting In re Jack O'Lantern, Inc., 118 N.H. 445, 448 (1978)).[6]

C. The Agreement Did Not Require Member Consent.

The BSR asserts in passing that political subdivisions did not provide "the necessary resolution or consents" for the Agreement. BSR Mem. at 8-9. However, the BSR does not advance any basis for requiring individual member consent. The Agreement was, of course, approved by the boards who are the elected representatives of the HealthTrust and PLT members. Statement ¶¶ 18, 21. As set forth in HealthTrust's memorandum, RSA 5-B:3 does not require members consent. HT Mem. at 26-28. The BSR does not identify any language in the statute that could support a contrary conclusion.[7]

II. THE AGREEMENT DID NOT "PRECLUDE" THE RETURN OF THE $17.1 MILLION TO HEALTHTRUST BUT FACILITATED IT.

The BSR asserts that the Agreement violated the Final Order because it allegedly allowed PLT to avoid paying the $17.1 million and deprived HealthTrust's members of any refundable

[6] The DOL appears not to share this view, as it issued an Administrative Order allowing HealthTrust to administer the runoff of PLT's workers' compensation coverages pursuant to the Agreement. See Curro Aff. Ex. 10.

[7] The BSR suggests that HealthTrust members were exposed to risks "associated" with the property-liability coverage lines. BSR Mem. at 8. However, there was no realistic exposure. At the time the Agreement was executed, PLT had approximately $12.2 million of net assets above its reserves for coverage obligations to act as a buffer before HealthTrust would have absorbed any PLT liabilities. See Statement ¶ 24. Based on the April 30, 2014 pro forma financial statements, it now appears that there will be $18.6 million after runoff of the PLT coverage obligations. Additional Statement ¶ 9.

excess. BSR Mem. at 9. This ignores both the situation at the time the Agreement was entered and the operation of the Agreement. Any shortfall would have been a consequence of PLT's insolvency, not the Agreement. As more fully set forth in HealthTrust's summary judgment papers, it appeared in the fall of 2013 that PLT would be insolvent if the $17.1 million repayment obligation was affirmed. That fact and the consequent inability of PLT to pay all its creditors meant that PLT could not pay HealthTrust but instead would need to make a bankruptcy filing, which would both delay the partial payment and reduce it due to the costs of bankruptcy proceedings. HT Mem. at 4-6, 13; Statement ¶¶ 5-16.[8] The Agreement addressed this situation by providing for PLT to transfer all its assets and liabilities (that is, everything it had) to HealthTrust, Agreement ¶ D.1, and further provided for HealthTrust to administer the runoff of PLT's coverage obligations, which would minimize the costs of the runoff (and thus increase the amount realized by HealthTrust compared to a bankruptcy) and would have allowed HealthTrust to determine when it may appropriately collect and distribute PLT assets (as opposed to having the payment governed by the bankruptcy court). Agreement ¶ D.3.

The BSR's position relies on disregard of these realities. While the Final Order required that PLT pay $17.1 million to HealthTrust for ultimate distribution to its members, that assumed that PLT had the means to do so. Based on the then opinions of its independent actuaries and its financial statements, it did not. In the circumstances, PLT complied with the Final Order by paying – transferring – everything it had to HealthTrust, and HealthTrust complied by accepting the transfer on conditions that maximized its return and gave it control over the timing of the distribution of PLT assets to HealthTrust members. The logic of BSR's position is that the Final

[8] In addition to the authorities cited in the HealthTrust memorandum concerning directors' duties to treat creditors fairly, see: 3A Fletcher Cyclopedia of the Law of Corporations § 1035.60 at 35-36 (2011 rev. vol.) ("In most jurisdictions, when a corporation becomes insolvent, officers and directors of a corporation owe a fiduciary duty to the corporation's creditors."); Peterson v. John J. Reilly, Inc., 105 N.H. 340, 346 (1964) (assets of an insolvent corporation are a "trust fund" for its creditors).

Order required PLT to file for bankruptcy. However, that was not the intent of the Final Order, which directed the distribution of PLT "excess surplus" and the repayment of $17.1 million to HealthTrust. Among other things, it would have unnecessarily harmed the members of PLT (as PLT's coverage obligations to claimants and members would not be paid in full) and the members of HealthTrust (who would receive less in distributions from PLT assets at later dates as determined by the bankruptcy court). Statement ¶¶ 15-16. Entering a workout agreement to maximize payment of the $17.1 million and avoid the "collateral damage" of a PLT bankruptcy did not violate the Final Order.

The BSR incorrectly asserts that the purpose of the Agreement was "to extinguish" the debt for less than $17.1 million. BSR Mem. at 9, 10. The Agreement accepted the transfer of PLT's assets and liabilities in complete satisfaction of PLT's obligation because of PLT's apparent insolvency, Agreement ¶ D.2, but that transfer was of everything that PLT had. It did not "extinguish," "compromise" or "forgive" the obligation, nor did it "subsidize" PLT. HealthTrust's collection of less than the full amount would have only been a result of PLT's insolvency, not the Agreement. If it turned out that PLT had more than the $12.2 million anticipated in the fall of 2013 (see Statement ¶ 24), then HealthTrust would have collected more. In fact, it now appears that PLT's assets are sufficient for HealthTrust to collect the full $17.1 million, which HealthTrust would have been able to do under the Agreement. See Statement ¶ 30. Instead, HealthTrust will collect the full amount under the Termination Agreement. Additional Statement ¶ 13. Thus, the BSR's claim that the Agreement "extinguished" the debt is factually incorrect.

The BSR's assertion that the Agreement would have delayed distribution from PLT assets to HealthTrust members is similarly flawed. Any delay would have resulted from PLT's

insolvency, not the Agreement. The Agreement allowed HealthTrust – and not a PLT bankruptcy court – to determine when to make a distribution from the PLT assets, and HealthTrust need not have awaited the conclusion of the PLT runoff. In fact, the HealthTrust Board, on April 1, 2014, approved a distribution of $13.9 million from those assets to HealthTrust members, subject to the Secretary's consent or express non-objection. Statement ¶ 35. HealthTrust requested consent on April 8, 2014, but the Secretary has to date declined to consent or non-object. Id. ¶ 36. Given the Termination Agreement, it is anticipated that the full $17.1 million will be distributed to HealthTrust members as soon as practicable, subject to approval by the BSR and the Presiding Officer. Additional Statement ¶ 13.

The Agreement thus did not "preclude" collection of the $17.1 million but facilitated it. Today, HealthTrust and its members stand to receive the full amount, and a substantial distribution already had been approved under the Agreement.

III. THE RELIEF SOUGHT BY THE BSR IS NOT AUTHORIZED AND IN ANY EVENT IS UNWARRANTED AND DISPROPORTIONATE.

In the Motion, the BSR requested that the Presiding Officer order HealthTrust and PLT to cease and desist operating in violation of the Final Order or be deemed not entitled to the protections of RSA 5-B:6. Motion, Prayer B. Now, the BSR in its summary judgment motion requests only that the Presiding Officer issue an order finding the Respondents may no longer claim the protections of RSA 5-B:6. BSR Motion for Summary Judgment, Prayer D. The BSR thus seeks to disestablish HealthTrust as a pooled risk management program by depriving it of the tax and regulatory exemption intended to allow such programs to benefit political subdivisions. See RSA 5-B:1; RSA 5-B:6, I.[9] This corporate "death knell" penalty sought by the BSR is not authorized. While

[9] RSA 5-B:6, I, provides: "Any pooled risk management program meeting the standards required under this chapter is not an insurance company, reciprocal insurer, or insurer under the laws of this state, and administration of any activities of the plan shall not constitute doing an insurance business for purposes of regulation or taxation."

it never was warranted, it is particularly unjustified because HealthTrust and PLT have terminated the Agreement. In other words, as sought by the BSR in the Motion, HealthTrust and PLT have "ceased and desisted."

A. The Statute Does Not Authorize the Secretary to Terminate a Program's Statutory Exemption from State Taxation and Insurance Regulation.

RSA 5-B does not contain language granting the Secretary or Presiding Officer the power to deprive programs of the statutory exemptions from state insurance laws and state taxation. The absence of such language indicates that the Legislature did not see fit to confer such power. "Administrative tribunals . . . have only the authority that is 'expressly granted or fairly implied by statute.'" In re Chase Home for Children, 155 N.H. 528, 533 (2007) (quoting Appeal of Public Serv. Co. of N.H., 130 N.H. 285, 291 (1988)). The courts "interpret legislative intent from the statute as written and will not consider what the legislature might have said or add words that the legislature did not include." Id. at 534.

The authority of the Secretary – and thus of the Presiding Officer – to impose penalties is set forth in RSA 5-B:4-a. That section contains three subsections concerning penalties.[10] First, it authorizes the Secretary to impose "penalties for violations of this chapter, including but not limited to: (1) Fines. (2) Rescission, restitution, or disgorgement." RSA 5-B:4-a, I(b). Second, it authorizes the Secretary to recover "the costs of the investigation, and any related proceedings, including reasonable attorney's fees, in addition to any other penalty under this chapter." RSA 5-B:4-a, V. Third, it provides that "[t]he following fines and penalties may be imposed" and specifies "an administrative fine not to exceed $2,500" and "an order for rescission, restitution or disgorgement." RSA5-B:4-a, VII.

[10] The Secretary also has the power to issue an order requiring a person "to cease and desist from violations of this chapter." RSA 5-B:4-a, VI.

There are thus a number of penalties potentially available to the Presiding Officer in the event he finds a violation. RSA 5-B does not, however, authorize the Secretary or a Presiding Officer to abolish the status and the statutory exemption from insurance regulation and state taxation provided by RSA 5-B:6, I.

The BSR might contend that the phrases "penalties . . . including but not limited to" in RSA 5-B:4-a, I(b) and "any other penalty provided for under this chapter" or "any other penalty provided for by law" in RSA 5-B:4-a, V and VII support its claimed authority. However, the references to other penalties "provided for under this chapter" or "by law" do not grant the Presiding Officer power to order the extraordinary sanction sought by the BSR because the abolition of status and statutory exemption is not found in RSA 5-B or elsewhere. The phrase "including but not limited to" is similarly insufficient. "The principle of *ejusdem generis* provides that, where specific words in a statute follow general ones, the general words are construed to embrace only objects similar in nature to those enumerated by the specific words." State v. Beauchemin, 161 N.H. 654, 658 (2011) (quoting State v. Breed, 159 N.H. 61, 65 (2009)). The penalties authorized by RSA 5-B:4-a, therefore, must be similar to the listed penalties of fines, rescission, restitution or disgorgement. The "death knell" sanction sought by the BSR is quite unlike the enumerated penalties. It does not remedy a specific transaction or impose a monetary loss but instead destroys the ability of the program to operate by removing statutory exemptions. It is thus not authorized.

The BSR might also contend that the sanction is a power "reasonably implied in order to perform the substantive responsibilities imposed by this chapter." RSA 5-B:4-a, II. However, the Secretary has no substantive responsibilities as to the exemption of programs from insurance regulation or taxation. The exemptions are legislatively declared benefits intended to benefit the

political subdivisions who are members of pooled risk management programs. See RSA 5-B:1, :6, I. The Legislature charged the Insurance Commissioner with the "rights, powers, and duties pertaining to the enforcement and execution of the insurance laws of this state." RSA 400-A:3. Thus, only the Insurance Commissioner is empowered to determine who is subject to the insurance laws, including the premium tax. See RSA 400-A:32.

The BSR essentially assumes that the Secretary has the power of a licensing agency to revoke a regulated entity's authority to do business (here, by revoking the application of statutory exemptions that allow the program to do business). However, the Legislature has not provided the Secretary with such powers over pooled risk management programs in RSA 5-B. The BSR is attempting to add words to the statute that the Legislature did not see fit to include, contrary to the established principles of statutory construction. See Appeal of Local Government Center, slip op. at 12.

The Legislature knows how to grant the authority to issue and revoke licenses. It has provided that broker-dealers, issuer-dealers, agents and investment advisers may not do business without a license from the Secretary, RSA 421-B:6, :7, and authorized the Secretary to revoke such licenses in certain circumstances. RSA 421-B:10. Similarly, it has required that insurance companies obtain licenses from the Insurance Commissioner, RSA 402:10, and authorized the Commissioner to suspend or revoke those licenses for specified reasons. See, e.g., RSA 400-B:12; RSA 417:13. However, the legislature did not grant the authority to create RSA 5-B pooled risk management programs or to approve or revoke the related exemptions to the Secretary. Accordingly, the Presiding Officer may not lawfully issue such an order. See Appeal of Somersworth School Dist., 142 N.H. 837, 841 (1998) ("Although the PELRB may issue cease and desist orders, the statute does not give it the power to grant all equitable remedies.")

(citations omitted); Appeal of Land Acquisition, LLC, 145 N.H. 492, 498 (2001). In the absence of legislation, the agency "cannot confer jurisdiction upon itself." In re Campaign for Ratepayers' Rights, 162 N.H. 245, 250 (2011) (quoting Fullerton v. Administrator, 911 A.2d 736, 742 (Conn. 2006) (brackets omitted)).

B. The Sanction Sought by the Secretary Is Disproportionate and Excessive.

Even if there had been a violation of the Final Order and the sanction requested by the BSR were permissible, the Presiding Officer should not deprive HealthTrust of its exemptions from state taxation and insurance regulation. In the Final Order, the Presiding Officer provided respondents with prior opportunity to cure the violations found, Final Order p. 73, ¶ 2, and the same type of measured approach would be warranted here. The proposed sanction would sound a death knell for HealthTrust. It is grossly disproportionate and excessive to any violation. See In re AlphaDirections, Inc., 152 N.H. 477, 486 (2005) (administrative penalty may be set aside "if it is so harsh or excessive as to be unreasonable"). "All penalties ought to be proportioned to the nature of the offense." N.H. Const., pt. 1, art. 18. Especially now that the Agreement has been terminated, the sanction is plainly unwarranted.

Removing the exemptions would effectively disable HealthTrust's business to the detriment of its member political subdivisions by (1) preventing HealthTrust from offering coverage to its members, (2) creating uncertainty about the validity of HealthTrust's in-force coverages and its ability to legally handle claims and runoff its past business, and (3) causing HealthTrust to increase its rates – if it eventually could write coverage as an insurer – to account for potential premium and other state taxes applicable to insurance. HealthTrust potentially would have to stop writing coverage and might not even be able to conduct a runoff. Even if it could eventually resume business, its prices would be higher. As a practical matter, the program

that has benefitted political subdivisions for over thirty years would be disabled to the detriment of the very political subdivisions HealthTrust serves. Additional Statement ¶ 14.

Even if the Agreement had violated the Final Order or RSA 5-B, such a sanction is not a necessary or appropriate remedial measure. The penalty of rescission would have been available, RSA 5-B:4-a, I(b)(2), but even that is now unnecessary. Since HealthTrust and PLT have already terminated the Agreement, no penalty is appropriate. The death knell sanction is so extreme that it could only be warranted if a program repeatedly committed serious, unmistakable and continuous violations and was clearly uninterested in working with regulators to achieve compliance. That is simply not the case here.

The Final Order does not address the question of the ability of one program to administer the runoff of another's coverage obligations. Its directives concern corporate governance – the statutory requirements that a program be a legal entity with a board of directors and bylaws. If the Final Order were construed to address issues of administration, it would be inappropriate and disproportionate to penalize HealthTrust for conduct that has not previously been identified as a violation.[11] At this point, the issue need not be addressed as, in light of the Termination Agreement, PLT will administer its coverage lines.

The BSR has attempted to portray HealthTrust as violating paragraph 1 of the Final Order so as to bring the automatic sanction of paragraph 2 into play. However, the BSR now concedes that the respondents complied with paragraph 1 of the Final Order by reorganizing the programs into HealthTrust and PLT, each of which is a New Hampshire legal entity with a separate board

[11] Indeed, without an opportunity to cure, a penalty based on an application of the Final Order to prohibit HealthTrust from administering the runoff of property-liability coverage lines pursuant to contract would violate HealthTrust's right to due process under N.H. Const. Part 1, Arts. 12 and 15. Such a use of the Final Order would be improper because the order does not reasonably advise of a prohibition on administration. So construed, it would be impermissibly vague because it "fails to provide people of ordinary intelligence a reasonable opportunity to understand what conduct it prohibits." N.H. Dept. of Environmental Servs. v. Marino, 155 N.H. 709, 716 (2007) (quoting State v. Porelle, 149 N.H. 420, 423 (2003)).

of directors and bylaws. It is undisputed that HealthTrust and PLT are still New Hampshire legal entities with separate boards and bylaws. The boards of those two entities were faced with a possible PLT insolvency if the $17.1 million obligation were affirmed. They sought to address the significant problems that would follow insolvency in a reasonable way that would maximize value to HealthTrust and otherwise avoid adverse consequences to their respective members. HealthTrust did not give up the right to obtain the $17.1 million for its members. If the Agreement entailed a violation, it was a new violation resulting from sincere efforts to deal responsibly with an unprecedented situation. It would not warrant harsh punishment.

Importantly, HealthTrust and PLT have sought regulatory guidance. In 2013, PLT requested BSR approval of a 90% confidence level, but received no response. Additional Statement ¶ 3. HealthTrust requested the BSR to delay PLT's distribution of $3.1 million in light of PLT's potential insolvency, but was rebuffed. Statement ¶ 8. (The BSR sought to control HealthTrust's and PLT's implementation of the Final Order by a proposed Memorandum of Understanding calling for the Secretary's representative to control them to the exclusion of their boards for purposes of implementing the Final Order. Additional Statement ¶ 4; Second Curro Aff. Ex. 11, Arts. I, III.)

Since the Supreme Court upheld the $17.1 million repayment, HealthTrust and PLT have repeatedly sought the BSR's comments and offered to modify the Agreement, without substantive response from the BSR. The BSR was not able to meet to discuss the Agreement until February 4, 2014. When the meeting requested by HealthTrust took place, the BSR asked few questions and did not comment on the Agreement. Additional Statement ¶ 6. The BSR filed the Motion on February 7, 2014, before it asked for information on February 11, 2014. In its responses, HealthTrust reiterated its willingness to work with the BSR to address any concerns

and requested suggestions as to modifications to the Agreement and the runoff. The BSR made no substantive response. Additional Statement ¶ 7. (The BSR also declined requests for multi-party meetings with the Department of Labor, which is charged with supervising workers' compensation matters. See RSA 281-A:11. Additional Statement ¶ 8.)

HealthTrust proposed to PLT on March 4, 2014, that the Agreement should be terminated in light of the positive developments concerning the financial prospects for PLT's coverage lines runoff. Additional Statement ¶ 9. More recently, on May 20, 2014, the HealthTrust Board of Directors advised the BSR of its willingness to rescind the Agreement. The Board noted that the sole reason for the Agreement – the consequences to HealthTrust of a potential PLT insolvency – is no longer present in light of updated actuarial reports and the current financial statement for the PLT coverage lines runoff. The Board accordingly proposed to resolve the situation by rescinding the Agreement, with the $17.1 million being paid to HealthTrust for it to distribute to its members. Id. ¶ 10. HealthTrust and PLT agreed to terminate the Agreement in the Termination Agreement, and HealthTrust will distribute the $17.1 million subject to BSR and Presiding Officer approval. Id. ¶ 13.

In this context, if a violation were found, the Presiding Officer should decline to order any penalty.

CONCLUSION

For the reasons set forth above and in its own summary judgment papers, HealthTrust requests that the Presiding Officer dismiss this matter as moot or deny the BSR's motion for summary judgment and grant summary judgment to HealthTrust denying the BSR's Motion for Entry of Default Order in its entirety.

Respectfully submitted,

HEALTHTRUST, INC.

By Its Attorneys,

Dated: June 4, 2014

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CERTIFICATE OF SERVICE

I certify that I have forwarded copies of this pleading to counsel of record via email.

/s/ Michael D. Ramsdell
Michael D. Ramsdell

243 Neb. 359
Supreme Court of Nebraska.

UNIVERSAL ASSURORS LIFE INSURANCE COMPANY, Appellee,
v.
Bertha HOHNSTEIN, Appellant,
and
Elizabeth A. Halstead, Appellee.

No. S-91-047. | April 29, 1993.

Following death of decedent, decedent's mother and decedent's former wife both sought residual proceeds under three separate certificates of life insurance. Insurer paid proceeds into court and was dismissed from action. On motions for summary judgment, the District Court for Scotts Bluff County, Alfred J. Kortum, J., sustained former wife's motion for summary judgment. Mother appealed. The Supreme Court, Caporale, J., held that: (1) dissolution decree does not change dissolution party's liability to creditor, and (2) decedent and former wife were co-owners of the certificates, and, thus, decedent could not change beneficiary except by joint act with wife.

Affirmed.

West Headnotes (18)

[1] **Divorce**
Construction and operation in general

After time for appeal has passed, meaning of dissolution decree is determined as matter of law from its language; neither what the parties thought decree meant nor what judge intended is of any relevance.

7 Cases that cite this headnote

[2] **Divorce**
Operation and effect

Dissolution decree does not change dissolution party's liability to creditor.

Cases that cite this headnote

[3] **Divorce**
Operation and effect

Former wife remained personally liable to creditor following dissolution of marriage for marital indebtedness.

Cases that cite this headnote

[4] **Appeal and Error**
Review Dependent on Whether Questions Are of Law or of Fact

Statutory interpretation is matter of law in connection with which an appellate court has obligation to reach an independent, correct conclusion notwithstanding determination made by trial court.

6 Cases that cite this headnote

[5] **Insurance**
By beneficiaries

Phrase "person holding policy" in statute allowing any such person holding life insurance policy to sell and surrender policy without consent of beneficiary unless appointment of beneficiary is revocable, describes owner of policy. Neb.Rev.St. § 44-370.

1 Cases that cite this headnote

[6] **Insurance**
Right to change; consent

Right to change beneficiary statute grants owner of life policy right to change beneficiary unless appointment of beneficiary was made irrevocable. Neb.Rev.St. § 44-370.

1 Cases that cite this headnote

[7] **Insurance**
Life Insurance

Owner of life policy need not be insured, that is, person whose death obligates insurer to pay under policy.

Cases that cite this headnote

[8] **Judgment**
Existence or non-existence of fact issue

Summary judgment is properly granted only when record discloses that there is no genuine issue concerning material fact or ultimate inferences deducible from such fact or facts and that movant is entitled to judgment as matter of law.

Cases that cite this headnote

[9] **Judgment**
Presumptions and burden of proof

Judgment
Weight and sufficiency

Movant for summary judgment makes prima facie case by producing enough evidence to demonstrate that movant is entitled to judgment if evidence is uncontroverted at trial; at that point, burden of producing evidence shifts to party opposing motion.

2 Cases that cite this headnote

[10] **Insurance**
Intention

Insurance policy is to be construed as any other contract to give effect to parties' intention at time contract was made.

Cases that cite this headnote

[11] **Insurance**
Plain, ordinary or popular sense of language

When terms of insurance contract are clear, they are to be accorded their plain and ordinary meaning.

Cases that cite this headnote

[12] **Insurance**
Ambiguity in general

When clause in insurance contract can be fairly interpreted more than one way, there is ambiguity.

Cases that cite this headnote

[13] **Appeal and Error**
Review where evidence consists of documents

Construction of contract is matter of law in connection with which an appellate court has an obligation to reach an independent and correct conclusion notwithstanding determination made by trial court.

6 Cases that cite this headnote

[14] **Insurance**
Persons covered

Former husband and former wife were joint insureds under certificates providing for joint decreasing life insurance; husband and wife were joint debtors who purchased decreasing life insurance, and master policy provided that when decreasing life insurance-joint debtor was provided, the debtors would be "joint insured" debtors.

Cases that cite this headnote

[15] **Insurance**
Right to change; consent

Former husband and former wife, who were joint insureds under certificates providing for joint decreasing life insurance, were also joint owners of insurance provided, and, thus, beneficiary could not be changed except by joint act of both owners; bank was named as irrevocable creditor beneficiary on joint debt of husband and wife, and premium for coverage was single. Neb.Rev.St. § 44-370.

Cases that cite this headnote

[16] **Insurance**
Reasonable persons

Resolution of ambiguity in policy of insurance turns not on what insurer intended language to mean, but what reasonable person in position of insured would have understood it to mean at time contract was made.

Cases that cite this headnote

[17] **Insurance**
Favoring coverage or indemnity; disfavoring forfeiture

In case of ambiguity in an insurance contract, construction favorable to insureds prevails so as to afford coverage.

Cases that cite this headnote

[18] **Insurance**
Persons covered

Former husband and former wife were insureds under certificate providing level life, joint debtor life insurance and were co-owners of insurance created by certificate, notwithstanding inconsistencies in master policy definitions; husband and wife paid premiums for joint coverage, foreclosing insurer from denying joint coverage. Neb.Rev.St. § 44-370.

Cases that cite this headnote

**812 *Syllabus by the Court*

*359 1. **Divorce: Intent: Appeal and Error.** After the time for appeal has passed, the meaning of a dissolution decree is determined as a matter of law from its language; neither what the parties thought the decree meant nor what the judge intended is of any relevance.

2. **Divorce: Liability: Debtors and Creditors.** A dissolution decree does not change a dissolution party's liability to a creditor.

3. **Statutes: Appeal and Error.** Statutory interpretation is a matter of law in connection with which an appellate court has an obligation to reach an independent, correct conclusion irrespective of the determination made by the trial court.

4. **Insurance: Contracts: Words and Phrases.** As used in Neb.Rev.Stat. § 44-370 (Reissue 1988), the phrase "person holding a policy" describes the owner of the insurance policy.

5. **Insurance: Contracts.** Neb.Rev.Stat. § 44-370 (Reissue 1988) grants the owner of a life insurance policy the right to change the beneficiary unless the appointment of the beneficiary was made irrevocable.

6. **Insurance: Contracts.** The owner of a life insurance policy need not be the insured, that is, the person whose death obligates the insurer to pay under the policy.

7. **Summary Judgment.** Summary judgment is properly granted only when the record discloses that there is no genuine issue concerning any material fact or the ultimate inferences deducible from such fact or facts and that the movant is entitled to judgment as a matter of law.

813 *360 8. **Summary Judgment: Evidence. A movant for summary judgment has made a prima facie case by producing enough evidence to demonstrate that the movant is entitled to a judgment if the evidence were uncontroverted at trial; at that point, the burden of producing evidence shifts to the party opposing the motion.

9. **Insurance: Contracts: Intent.** An insurance policy is to be construed as any other contract to give effect to the parties' intentions at the time the contract was made.

10. **Insurance: Contracts.** When the terms of an insurance contract are clear, they are to be accorded their plain and ordinary meaning.

11. **Insurance: Contracts.** When a clause in an insurance contract can be fairly interpreted in more than one way, there is ambiguity.

12. **Contracts: Appeal and Error.** The construction of a contract is a matter of law in connection with which an appellate court has an obligation to reach an independent correct conclusion irrespective of the determination made by the trial court.

13. **Insurance: Contracts: Intent.** The resolution of an ambiguity in a policy of insurance turns not on what the insurer intended the language to mean, but on what a reasonable person in the position of the insured would have understood it to mean at the time the contract was made.

14. **Insurance: Contracts.** In the case of ambiguity in an insurance contract, a construction favorable to the insured prevails so as to afford coverage.

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HASTINGS, C.J., and BOSLAUGH, WHITE, CAPORALE, SHANAHAN, FAHRNBRUCH, and LANPHIER, JJ.

Opinion

CAPORALE, Justice.

I. STATEMENT OF CASE

The death of the decedent, David A. Halstead, obligated the plaintiff-appellee interpleader, Universal Assurors Life Insurance Company, to pay benefits under the provisions of three separate certificates of credit life insurance it had issued in favor of First State Bank, Scottsbluff, Nebraska, and others. Both the decedent's mother, the defendant-appellant claimant, Bertha Hohnstein, and the decedent's former wife, the defendant-appellee claimant, Elizabeth A. Halstead, demand the residual proceeds, that is, the amount of benefits exceeding *361 the sums Universal remitted to the bank. Having paid the residual proceeds into court, Universal was dismissed from the action, and the cause then proceeded to adjudication upon the reciprocal motions for summary judgment filed by the two claimants. The district court overruled the mother's motion and sustained the former wife's motion. The mother's three assignments of error merge to assert that the district court erred in so ruling. We affirm.

II. FACTS

On August 10, 1988, the decedent and the former wife indebted themselves to the bank and, for a single premium, purchased the three aforementioned certificates of insurance, which were issued under and pursuant to an agreement between Universal and the bank entitled "Debtor-Creditor Group Master Policy Single Premium Term Life Insurance-Non-Participating." The master policy provides, in pertinent part:

> [Universal] will pay, subject to all terms and conditions of this policy, to the [bank] the amount of insurance in force hereunder on the life of such Debtor at the time of such death, to reduce or extinguish the unpaid indebtedness and where the amount of insurance exceeds the unpaid indebtedness, the excess amount will be paid to a beneficiary other than the [bank], if living, named by the insured Debtor or to the estate of the insured Debtor.

**814 Each of the three certificates named the decedent as "Insured Debtor," the former wife as "Insured Joint Debtor," and the bank as "Irrevocable Creditor Beneficiary." In an area denominated "Second Beneficiary," each certificate reads:

> David A. Halstead-Beneficiary Elizabeth A. Halstead
>
> Elizabeth A. Halstead-Beneficiary David A. Halstead
>
> James D. Halstead.

The last named individual, born January 6, 1986, is the minor child of the debtors.

On November 16, 1989, the former wife filed a dissolution of marriage action which resulted in a decree of dissolution being entered on February 2, 1990. Through incorporating by reference the decedent's and the former wife's property *362 settlement agreement, the decree provides, in relevant part:

> The [former wife] and [the decedent] will keep all items of personal property currently in their respective possession. Each party will hold the other harmless from any liability upon the personal property in their possession.
>
> [The decedent] shall receive the title and possession of the [marital residence] and [the former wife] will sign a Quitclaim Deed to [the decedent] regarding said property. [The decedent] shall hold [the former wife] harmless from any liability arising from any encumbrance upon said real property.

The decree makes no specific references to the debt owed the bank or to the Universal certificates, nor does it relate the insured debt to the marital residence.

Following the entry of the dissolution decree, the decedent, on August 6, 1990, issued a notarized letter directed to Universal, which referenced the three certificates of

insurance and recited: "Because of my divorce, I hereby authorize you to change the beneficiary designations on the above [certificates] from my [former wife] to my mother...."

The decedent died August 10, 1990, as a result of injuries sustained in an accident. After Universal paid the bank the amount of the unpaid debt, there remained benefits totaling $6,067.10 due under the three certificates.

III. ANALYSIS

We begin by noting that although each certificate names the Halstead child as some sort of beneficiary, he was not made a party to this action. As a consequence, this litigation does not affect any interests he may have in the matter.

1. EFFECT OF DISSOLUTION DECREE

The decedent's mother asserts that because the marital residence was awarded to the decedent subject to the liability for any encumbrance thereon, for which liability he was obligated to hold the former wife harmless, the decedent became the sole owner of the insurance certificates and could do with them as he chose. Such, however, is not the case.

[1] In the first place, as noted in part II, the decree in no way ties the insured debt to the marital residence. In reviewing the res *363 judicata effect of dissolution decrees in later actions, we have declared:

> "[N]either what the parties thought the judge meant nor what the judge thought he or she meant, after time for appeal has passed, is of any relevance. What the decree, as it became final, means as a matter of law as determined from the four corners of the decree is what is relevant."

Metropolitan Life Ins. Co. v. Beaty, 242 Neb. 169, 173, 493 N.W.2d 627, 630 (1993). Accord *Neujahr v. Neujahr*, 223 Neb. 722, 393 N.W.2d 47 (1986).

But even if the decree were to have related the debt to the marital residence, it only orders the decedent to hold the former wife harmless from the liability; it does not, nor could it, relieve the former wife of liability to the bank.

[2] [3] Although it appears we have not heretofore been called upon to rule on the effect of a dissolution decree upon a dissolution party's liability to a creditor, we have held that a contract for the lease of school land could not be altered by a dissolution decree and made enforceable against **815 the other parties to the lease. *Kidder v. Wright*, 177 Neb. 222, 128 N.W.2d 683 (1964); *State v. Kidder*, 173 Neb. 130, 112 N.W.2d 759 (1962). Moreover, in *Baker v. Baker*, 201 Neb. 409, 267 N.W.2d 756 (1978), this court held that a dissolution court could not affect the rights of the transferees of gifts who were not before the court. We now specifically adopt the holdings of numerous other jurisdictions that a dissolution decree does not change a dissolution party's liability to a creditor. *Bourdon v. Bourdon*, 119 N.H. 518, 403 A.2d 433 (1979); *Kujawinski v. Kujawinski*, 71 Ill.2d 563, 17 Ill.Dec. 801, 376 N.E.2d 1382 (1978); *Arneson v. Arneson*, 38 Wash.2d 99, 227 P.2d 1016 (1951); *Stevenson v. Stevenson*, 680 P.2d 642 (Okla.App.1984); *Wileman v. Wade*, 665 S.W.2d 519 (Tex.App.1983); *Glasscock v. Citizens Nat. Bank*, 553 S.W.2d 411 (Tex.App.1977); *Branch Banking and Trust Co. v. Wright*, 74 N.C.App. 550, 328 S.E.2d 840 (1985) (review allowed at 314 N.C. 662, 335 S.E.2d 321; however, ex-wife withdrew her appeal as a party to the further appeal to the North Carolina Supreme Court, 318 N.C. 505, 353 S.E.2d 225). Thus, the former wife remained personally liable to the bank.

*364 2. RIGHT TO CHANGE BENEFICIARY

Neb.Rev.Stat. § 44-370 (Reissue 1988) provides:

> A life insurance company may provide that the amount to become due under a policy shall be paid in installments to a beneficiary therein named.... Any person *holding a policy* in any such company may, without the consent of the beneficiary, unless the appointment of such beneficiary be irrevocable, either sell and surrender the same to the company, or pledge or assign the same as security for a debt ... or, with the consent of the company, he may change his beneficiary unless the appointment of such beneficiary be irrevocable.

(Emphasis supplied.)

[4] The task at this point is to determine what is meant by the statutory phrase "person holding a policy." As a question of statutory interpretation, the matter is one of law in connection with which we, as an appellate court, have an obligation to reach an independent, correct conclusion irrespective of the determination made by the trial court. *State v. Saulsbury,* 243 Neb. 227, 498 N.W.2d 338 (1993); *Curry v. State ex rel. Stenberg,* 242 Neb. 695, 496 N.W.2d 512 (1993); *Northern Bank v. Federal Dep. Ins. Corp.,* 242 Neb. 591, 496 N.W.2d 459 (1993).

> The party who enters into the contract of insurance or assurance with the insurer or assurer is called the "insured" or "assured." There is some authority that the person contracting with the insurer is the "insured" while the beneficiary of the policy is the "assured." This distinction is not recognized in modern insurance law under which the terms "insured" and "assured" are regarded as synonymous except when the particular wording of the policy requires the making of such a distinction. The "insured" in a life insurance policy means the person whose life is insured and whose death matures the obligation of the insurer to pay.

2A George J. Couch, Cyclopedia of Insurance Law § 23:1 at 769-70 (2d ed. 1984).

The Kansas Supreme Court, after citing from a part of the above-quoted section in Couch's treatise, wrote:

> *365 The policies, read in their entirety, use the term *insured* to refer to both the one whose life is insured and the owner of the policy. The term is thus ambiguous where these entities are two different people. We hold [the deceased wife] purchased the policies of insurance on the life of her [deceased] husband ... for the specific purpose of preventing the proceeds of the policies from becoming a part of [his] estate. We therefore hold the [deceased wife's estate] is entitled to the proceeds from the policies of insurance on [the deceased husband's] life.

(Emphasis in original.) *Lightner v. Centennial Life Ins. Co.,* 242 Kan. 29, 36-37, 744 P.2d 840, 845 (1987).

[5] [6] [7] We thus determine that as used in § 44-370, the phrase "person holding a policy" **816 describes the owner of the policy and that § 44-370 therefore grants the owner of a life insurance policy the right to change the beneficiary unless the appointment of the beneficiary was made irrevocable. It is also clear that the owner need not be the insured, that is, the person whose death obligates the insurer to pay under the policy.

3. OWNERSHIP STATUS OF DECEDENT AND FORMER WIFE

Although the dissolution decree, without distinguishing between tangible and intangible items, awarded the decedent and the former wife the personal property then in the possession of each, neither claimant established which of the dissolution parties had possession of the certificates when the decree was entered. We therefore need not concern ourselves with what the situation might have been had the record done so.

[8] [9] In so saying, we do not overlook that summary judgment is properly granted only when the record discloses that there is no genuine issue concerning any material fact or the ultimate inferences deducible from such fact or facts and that the movant is entitled to judgment as a matter of law. *Ev. Luth. Soc. v. Buffalo Cty. Bd. of Equal.,* 243 Neb. 351, 500 N.W.2d 520 (1993); *First United Bank v. First Am. Title Ins. Co.,* 242 Neb. 640, 496 N.W.2d 474 (1993). However, neither do we overlook that a movant for summary judgment has made a prima facie case by producing enough evidence to demonstrate that the movant is entitled to a judgment if the evidence were *366 uncontroverted at trial. *Ev. Luth. Soc. v. Buffalo Cty. Bd. of Equal., supra; Overmier v. Parks,* 242 Neb. 458, 495 N.W.2d 620 (1993). At that point, the burden of producing evidence shifts to the party opposing the motion. See, *Ev. Luth. Soc. v. Buffalo Cty. Bd. of Equal., supra; Overmier v. Parks, supra.* As there is no other evidence on the matter, the question of who owned the insurance is answered solely by the language of the certificates and the master policy under which they were issued. There thus can exist no genuine issue of either law or material fact in that regard.

[10] [11] [12] In studying the relevant language, we also recall that an insurance policy is to be construed as any other contract to give effect to the parties' intentions at the time the contract was made. When the terms of the contract are clear, they are to be accorded their plain and ordinary meaning. When a clause can be fairly interpreted in more than one way, there is ambiguity. See, *Thorell v. Union Ins. Co.*, 242 Neb. 57, 492 N.W.2d 879 (1992); *Mahoney v. Union Pacific RR. Emp. Hosp. Assn.*, 238 Neb. 531, 471 N.W.2d 438 (1991).

[13] We must also remember that like the interpretation of a statute, the construction of a contract is a matter of law, which we review in like manner. *Northern Bank v. Federal Dep. Ins. Corp.*, 242 Neb. 591, 496 N.W.2d 459 (1993); *Baker v. St. Paul Fire & Marine Ins. Co.*, 240 Neb. 14, 480 N.W.2d 192 (1992); *Spittler v. Nicola*, 239 Neb. 972, 479 N.W.2d 803 (1992).

[14] The first two certificates provide for joint decreasing life insurance, which the master policy defines as insurance on the life of the insured debtor, the original amount of which decreases progressively in accordance with a stated formula. The master policy also provides:

> (3) In no case shall more than one person be insured on account of any one indebtedness except where insurance is provided for Decreasing Life Insurance-Joint Debtor. If more than one name appears on the Certificate of Insurance as "Insured Debtor", the first named insured debtor be [sic] the insured Debtor.
>
> (a) When Decreasing Life Insurance-Joint Debtor is provided, the Debtor and Joint Debtor shall be the "Insured Debtor" jointly.

Level Life Insurance Debtor Only: $1.18

Level Life Insurance Joint Debtor: $1.97

Obviously, providing a premium rate for level life insurance for joint debtors is inconsistent with the earlier mentioned provision of the master policy which permits joint debtors to obtain only decreasing life insurance.

Notwithstanding this inconsistency and resultant ambiguity, the master policy provides for, and the decedent and the former wife were charged, a premium for level life insurance as joint debtors. This resulted in a charge somewhat less than twice as high as the premium for level life insurance on a single debtor.

*367 Consequently, although a wrong or an incomplete form of the verb "to be" is utilized in the above-quoted paragraph (3) of the master policy, the language nevertheless makes clear that as the decedent and the former wife were joint debtors who **817 purchased decreasing life insurance, they were joint insureds.

[15] Moreover, because the bank is named as the irrevocable creditor beneficiary on a joint debt of the decedent and the former wife, and the premium for the coverage was a single one, the decedent and the former wife were not only the joint insureds, they were also joint owners of the insurance provided. Consequently, as to these two certificates, the terms of § 44-370 prevent a change in beneficiary except by the joint act of the two owners.

The third certificate was also issued to the decedent and the former wife as the joint insured debtors, but rather than providing joint decreasing life insurance, as do the first two certificates, the third certificate provides level life, joint debtor life insurance. The master policy defines level life insurance as insurance on the life of the insured debtor, at all times to be equal to the amount of insurance selected on the certificate. It specifies the rate at which to compute the single premium required for "Level Life Insurance Joint Debtor" as follows:

> a product of the rate per $100.00 of the initial amount of such Debtors Level Life insurance becoming effective hereunder multiplied by the number of months of the period over which his indebtedness is to be repaid said rates being:

[16] [17] We have oft held:

*368 The resolution of an ambiguity in a policy of insurance turns not on what the insurer intended the language to mean, but what a reasonable person in the position of the insured would have understood it to mean at the time the contract was made.... In the case of ambiguity

in an insurance contract, a construction favorable to the insured prevails so as to afford coverage.

Brown v. Farmers Mut. Ins. Co., 237 Neb. 855, 869, 468 N.W.2d 105, 115 (1991). See, also, *Central Waste Sys. v. Granite State Ins. Co.*, 231 Neb. 640, 437 N.W.2d 496 (1989); *Polenz v. Farm Bureau Ins. Co.*, 227 Neb. 703, 419 N.W.2d 677 (1988).

[18] Under those rules, the payment of a premium based upon joint insurance would foreclose Universal from denying joint coverage to the decedent and the former wife. Since the master policy and the third certificate must be construed to provide joint coverage, we hold that both the decedent and the former wife were insureds and that as joint debtors and joint purchasers of the insurance, they were the coowners of the insurance created by the third certificate.

IV. JUDGMENT

There being no genuine issue concerning any material fact or the ultimate inferences deducible therefrom, and the former wife being entitled to judgment as a matter of law, the judgment of the district court is affirmed.

AFFIRMED.

Parallel Citations

500 N.W.2d 811

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280 Conn. 745
Supreme Court of Connecticut.

Claudia A. FULLERTON
v.
ADMINISTRATOR, UNEMPLOYMENT COMPENSATION ACT.
Carmen Cocchiola
v.
Administrator, Unemployment Compensation Act.

No. 17601. | Argued May 15, 2006. | Decided Dec. 26, 2006.

Synopsis

Background: Applicants appealed from judgments of Employment Security Board of Review affirming denials, by administrator of Unemployment Compensation Act, of their respective applications for unemployment compensation benefits. The Superior Court, Judicial District of Waterbury, Langenbach and Sheldon, JJ., consolidated and sustained the appeals. Administrator appealed, and the appeals were transferred from the Appellate Court.

Holdings: The Supreme Court, Zarella, J., held that:

[1] administrator of Unemployment Compensation Act lacks statutory authority to consider the validity of statutes or regulations governing unemployment compensation claims;

[2] employment security appeals referee, and Employment Security Board of Review, lack statutory authority to consider the validity of statutes or regulations governing unemployment compensation claims;

[3] procedures established to promulgate administrative rules and regulations governing unemployment compensation claims do not provide for challenges, before the Employment Security Board of Review, to validity of regulations adopted to implement the unemployment compensation scheme; and

[4] a trial court lacks authority to hear a claim, on appeal from a decision of Employment Security Board of Review, challenging the validity of regulations governing unemployment compensation claims.

Judgments of trial court reversed; remanded with directions.

West Headnotes (18)

[1] **Courts**
Time of making objection

Courts
Determination of questions of jurisdiction in general

A court may raise and review the issue of subject matter jurisdiction at any time.

Cases that cite this headnote

[2] **Courts**
Jurisdiction of Cause of Action

"Subject matter jurisdiction" involves the authority of the court to adjudicate the type of controversy presented by the action before it.

1 Cases that cite this headnote

[3] **Courts**
Acts and proceedings without jurisdiction

A court lacks discretion to consider the merits of a case over which it is without subject matter jurisdiction.

1 Cases that cite this headnote

[4] **Administrative Law and Procedure**
Statutory basis and limitation

Administrative agencies are tribunals of limited jurisdiction, and their jurisdiction is dependent entirely upon the statutes vesting them with power; they cannot confer jurisdiction upon themselves.

1 Cases that cite this headnote

[5] **Administrative Law and Procedure**
Statutory basis and limitation

An administrative body must act strictly within its statutory authority, within constitutional limitations and in a lawful manner, and it cannot modify, abridge, or otherwise change the statutory provisions under which it acquires authority unless the statutes expressly grant it that power.

3 Cases that cite this headnote

[6] **Appeal and Error**
Review Dependent on Whether Questions Are of Law or of Fact

Statutory construction is a question of law over which the reviewing court exercises plenary review.

1 Cases that cite this headnote

[7] **Statutes**
Intent

When interpreting a statute, the court's fundamental objective is to ascertain and give effect to the apparent intent of the legislature.

3 Cases that cite this headnote

[8] **Unemployment Compensation**
Claims and Applications

Unemployment Compensation
Questions of Fact; Credibility Determinations

Unemployment Compensation
Findings and conclusions

In the processing of unemployment compensation claims, the administrator of the Unemployment Compensation Act, the employment security appeals referee, and the Employment Security Board of Review decide the facts and then apply the appropriate law. C.G.S.A. §§ 31–241(a), 31–244.

7 Cases that cite this headnote

[9] **Unemployment Compensation**
Boards, commissions, and offices, in general

Unemployment Compensation
Officers and employees in general

Unemployment Compensation
Hearing

Unemployment Compensation
Persons entitled to seek review; parties

The Employment Security Appeals Division is separate and apart from the administrator of the Unemployment Compensation Act, and by statute, the administrator is deemed to be a party to any proceeding before an employment security appeals referee, the Employment Security Board of Review, or any reviewing court. C.G.S.A. §§ 31–237a, 31–237b, 31–249c.

6 Cases that cite this headnote

[10] **Unemployment Compensation**
Claims and Applications

The statutory authority of the administrator of the Unemployment Compensation Act to determine the validity of an unemployment compensation "claim" insofar as it is properly filed does not include authority to consider the validity of the statutes or regulations governing unemployment compensation claims. C.G.S.A. §§ 31–235, 31–241(a); Regs. Conn. State Agencies § 31–222–13(a)(3).

1 Cases that cite this headnote

[11] **Unemployment Compensation**
Hearing

Unemployment Compensation
Scope of Review

When processing unemployment compensation claims, the employment security appeals referee, and the Employment Security Board of Review, lack statutory authority to consider the validity of the statutes or regulations governing unemployment compensation claims. C.G.S.A. § 31–222 et seq.

4 Cases that cite this headnote

[12] **Administrative Law and Procedure**
Constitutional questions

Claims regarding the constitutionality of legislative enactments are beyond the jurisdiction of administrative agencies.

Cases that cite this headnote

[13] **Administrative Law and Procedure**
Force of law

Administrative rules and regulations are given the force and effect of law.

Cases that cite this headnote

[14] **Unemployment Compensation**
Rules and Regulations in General

The procedures established to promulgate administrative rules and regulations governing unemployment compensation claims do not provide for challenges, before the Employment Security Board of Review, to the validity of regulations adopted to implement the unemployment compensation scheme. C.G.S.A. § 31–236e.

1 Cases that cite this headnote

[15] **Administrative Law and Procedure**
Judicial Review of Administrative Decisions

There is no absolute right of appeal to the courts from a decision of an administrative agency; appeals to the courts from administrative agencies exist only under statutory authority.

4 Cases that cite this headnote

[16] **Administrative Law and Procedure**
Scope

Administrative Law and Procedure
Wisdom, judgment or opinion

Administrative Law and Procedure
Substantial evidence

Review of an administrative agency decision requires a court to determine whether there is substantial evidence in the administrative record to support the agency's findings of basic fact and whether the conclusions drawn from those facts are reasonable, and neither the Supreme Court nor the trial court may retry the case or substitute its own judgment for that of the administrative agency on the weight of the evidence or questions of fact.

1 Cases that cite this headnote

[17] **Administrative Law and Procedure**
Discretion of Administrative Agency

Administrative Law and Procedure
Arbitrary, unreasonable or capricious action; illegality

The ultimate duty of the court, when reviewing an administrative agency decision, is to determine, in view of all of the evidence, whether the agency, in issuing its order, acted unreasonably, arbitrarily, illegally, or in abuse of its discretion.

1 Cases that cite this headnote

[18] **Unemployment Compensation**
Particular Cases and Issues

There is no authority, under statutes or rules of practice, that permits a trial court to hear a claim, on appeal from a decision of the Employment Security Board of Review, challenging the validity of regulations governing unemployment compensation claims. C.G.S.A. § 31–249b; Practice Book 1998, § 22–9(a).

2 Cases that cite this headnote

Attorneys and Law Firms

****738** Thadd A. Gnocchi, assistant attorney general, with whom was Thomas P. Clifford III, assistant attorney general, and, on the brief, Richard Blumenthal, attorney general, and William J. McCullough, assistant attorney general, for the appellant (defendant).

Susan L. Garten, with whom was Gregory Bass, Hartford, for the appellee (plaintiff Claudia A. Fullerton).

Eric R. Brown, Waterbury, for the appellee (plaintiff Carmen Cocchiola).

Charles Krich and Nancy B. Alisberg filed a brief for the commission on human rights and opportunities et al. as amici curiae.

BORDEN, NORCOTT, PALMER, VERTEFEUILLE and ZARELLA, Js.

Opinion

ZARELLA, J.

*747 The principal issue in this consolidated appeal is whether the requirement in § 31–235–6(a)[1] of the Regulations of Connecticut State Agencies that applicants for unemployment compensation benefits must be available for full-time work is in violation of the requirement in General Statutes § 46a–76(a) that physical or mental **739 disability shall not be considered as a limiting factor in state administered programs involving the distribution of funds to qualify applicants for benefits authorized by law. The defendant, the administrator of the Unemployment Compensation Act,[2] General Statutes § 31–222 et seq., appeals from the judgments of *748 the trial court sustaining the appeals of the plaintiffs, Claudia A. Fullerton and Carmen Cocchiola,[3] from the decisions of the employment security board of review (board), which affirmed the administrator's denial of their respective applications for unemployment compensation benefits. The administrator determined that the plaintiffs were ineligible for benefits because, as a result of their disabilities, they were not "available for full-time work" during the weeks for which they applied for benefits, as required under § 31–235–6(a) of the regulations. The administrator also determined that Fullerton was ineligible for benefits because she failed to make reasonable efforts to secure full-time work during the weeks in question. See General Statutes § 31–235(a) ("[a]n unemployed individual shall be eligible to receive benefits with respect to any week only if it has been found that ... [2] ... he is physically and mentally able to work and is available for work and has been and is making reasonable efforts to obtain work").

The administrator maintains on appeal that the trial court improperly sustained the plaintiffs' appeals on the ground that the board improperly considered their respective disabilities as limiting factors, in violation of § 46a–76(a), in determining their eligibility for benefits under the regulations. We conclude, however, that the trial court lacked jurisdiction to consider the plaintiffs' claims alleging a violation of § 46a–76(a). Accordingly, we reverse the judgments of the trial court.

The following facts were found by the employment security appeals referees. Fullerton, who has long been diagnosed with bipolar disorder, worked full-time for fifteen years prior to 1995. In 1995, she suffered a back injury in an automobile accident and discontinued working for three and one-half years. In August, 1996, *749 she began receiving social security benefits. In July, 1999, she returned to work on a part-time basis until October 12, 2000, averaging approximately thirteen to fifteen hours per week.

Subsequently, she filed for five weeks of unemployment compensation benefits, from October 29, 2000, to December 2, 2000. On December 6, 2000, she attended a benefit rights interview. The clinical social worker assigned to Fullerton's case wrote a letter dated December 5, 2000, in support of Fullerton's request for benefits. In that letter, she indicated that Fullerton was unable to work full-time due to her medical condition but that part-time employment would be advantageous.

Fullerton made several unsuccessful attempts to obtain employment after October 29, 2000. In November, 2000, she applied for a part-time job at Showcase Cinema in Enfield, although she did not complete those portions of the application regarding the hours that she would be available to work. In November, 2000, she requested an application for part-time work for the Salvation Army but failed to submit it due to her concerns about the twelve to twenty hour workweek and the physical demands of the job. In December, 2000, she requested an application from Shaw's Supermarkets for part-time work but did not submit the application **740 because of its complexity and her concerns regarding the number of hours she would be required to work. On January 5, 2001, she secured employment with American Legion, working approximately four hours per week.[4]

*750 Meanwhile, the administrator determined on December 7, 2000, that Fullerton was ineligible for unemployment compensation benefits because she was physically unable to work full-time due to her medical problems. On December 28, 2000, Fullerton appealed from the administrator's decision to the employment security appeals referee (referee). On February 6, 2001, the referee affirmed the administrator's decision denying Fullerton benefits, from October 29, 2000, through January 27, 2001. The referee concluded that Fullerton had not made

reasonable efforts to obtain work and was not available for work under Connecticut law because she was not available for full-time work.

On February 23, 2001, Fullerton appealed from the referee's decision to the board, which adopted the referee's findings of fact. On June 27, 2003, the board affirmed the decision of the referee and denied Fullerton benefits, from October 29, 2000, through January 27, 2001. On July 25, 2003, Fullerton appealed from the decision of the board to the trial court.

In the second case, Cocchiola suffered an injury to his right leg in 1994. The injury left him with a permanent impairment to his leg that caused him to have difficulty walking and required him to use a cane for improved mobility. As a result of the injury, Cocchiola's physician diagnosed him with severe vascular disease of the lower right extremity and limited him to a maximum of six hours of work per day, including walking, standing or sitting, for a maximum of five days per week.

Following his injury, Cocchiola's former employer, Whyco Technologies, Inc., provided him with part-time employment as a foreman. On April 27, 2001, the company informed him that it no longer could provide him with part-time work in that capacity. Thereafter, Cocchiola, who possessed a valid driver's license and was able to transport himself to and from potential employment, *751 sought a position as a metal finishing worker. Cocchiola made it known that he preferred to work between the hours of 9 a.m. and 3 p.m., and contacted at least three new potential employers during each week for which he sought unemployment benefits.

Cocchiola attended a benefit rights interview on May 1, 2001, and subsequently filed a claim for unemployment compensation benefits, effective April 29, 2001. On May 18, 2001, the administrator determined that he was ineligible for benefits and denied his claim, reasoning that Cocchiola's injury rendered him unavailable for full-time work as required under § 31–235–6(a) of the regulations. On May 22, 2001, Cocchiola appealed from the administrator's decision to the referee. On October 30, 2001, the referee affirmed the administrator's decision, concluding that, under existing Connecticut law, Cocchiola was ineligible for benefits because of his unavailability for full-time work. Cocchiola appealed to the board, which adopted the referee's findings of fact and affirmed the referee's decision on June 27, 2003. On July 24, 2003, Cocchiola appealed from the board's decision to the trial court. On **741 December 22, 2003, the trial court granted the administrator's motion to consolidate the plaintiffs' appeals.

In their individual appeals to the board, the plaintiffs had challenged the validity of the requirement under § 31–235–6(a) of the regulations that claimants must be available for full-time work, arguing that the requirement was in violation of the Connecticut constitution as well as various state and federal statutes, including General Statutes § 46a–71(a), which provides in relevant part that "[a]ll services of every state agency shall be performed without discrimination based upon ... mental disability ... or physical disability," General Statutes § 46a–76(a), which provides in relevant part that "mental disability ... or physical disability ... shall not be considered as limiting factors in state-administered *752 programs involving the distribution of funds to qualify applicants for benefits authorized by law," and Title II of the Americans with Disabilities Act of 1990(ADA), 42 U.S.C. § 12101 et seq.,[5] which prohibits public entities from discriminating against persons with disabilities. In both cases, however, the board concluded that it did not have jurisdiction to rule on the constitutionality of a duly enacted regulation or on the plaintiffs' contentions that the regulation violated state and federal statutes other than the Unemployment Compensation Act, stating that it would leave those issues for the courts to decide.

In their appeals to the trial court, the plaintiffs continued to argue that the regulation violated state and federal statutory and constitutional provisions prohibiting discrimination on the basis of physical or mental disability. The plaintiffs specifically argued that the regulation, as applied to them, violated: (1) Title II of the ADA; (2) § 46a–71(a); (3) § 46a–76(a); (4) the equal protection clause of the constitution of Connecticut, article first, § 20, as amended by article twenty-one of the amendments; and (5) the equal protection clause of the fourteenth amendment to the United States constitution.

The trial court initially determined that it could consider the plaintiffs' statutory and constitutional claims pursuant to *753 *Rayhall v. Akim Co.*, 263 Conn. 328, 819 A.2d 803 (2003). In *Rayhall,* we concluded that General Statutes § 31–301b provided a jurisdictional basis for the trial court to consider a constitutional challenge to the Workers' Compensation Act, even though the workers' compensation review board did not have jurisdiction to hear the claim, because § 31–301b provides that "[a]ny party aggrieved by the decision of the Compensation Review Board upon *any question or questions of law arising in the proceedings* may

appeal the decision of the Compensation Review Board to the Appellate Court." (Emphasis added.) General Statutes § 31–301b; see *Rayhall v. Akim Co.,* supra, at 339–40, 819 A.2d 803.

On April 12, 2005, the trial court rendered judgments sustaining the appeals **742 insofar as they were based on the unavailability of the plaintiffs to work full-time by reason of their respective physical or mental disabilities. The court concluded that § 31–235–6(a) of the regulations "violate[d] the clear command of ... § 46a–76 (a) not to consider 'physical disability ... as [a] limiting [factor] in state-administered programs involving the distribution of funds to qualify applicants for benefits authorized under law.' " To the extent that Fullerton also challenged the board's decision that she had failed to make reasonable efforts to seek full-time work during the period for which she sought benefits, the trial court remanded the case to the board to ascertain the precise basis on which the board had found that her efforts were unreasonable, including whether the basis for the finding was her failure to seek full-time employment that was not suitable because of her physical or mental disability. The court also determined that the record lacked sufficient evidence to consider the plaintiffs' claims under Title II of the ADA. In light of these rulings, the court did not reach the plaintiffs' constitutional claims and did not consider their claims alleging a violation of § 46a–71.

*754 On appeal,[6] the administrator contends that § 31–235–6(a) of the regulations does not violate the state or federal constitutions or the state and federal antidiscrimination laws cited by the plaintiffs. Following oral argument, this court, sua sponte, requested supplemental briefing on the issue of whether the board or the trial court, on appeal from the board, had jurisdiction to hear the plaintiffs' claims that the regulation violated Title II of the ADA. In their supplemental briefs to the court, the parties agreed that the board could not hear those claims because there was no statutory authority to do so. Both parties also agreed that the trial court *did* have jurisdiction to hear those claims on appeal from the board. We conclude that neither the board nor the trial court had subject matter jurisdiction to consider the plaintiffs' claims that § 31–235–6(a) of the regulations violates Title II of the ADA. We additionally conclude that neither the board nor the trial court had subject matter jurisdiction to consider *any* of the plaintiffs' state or federal statutory or constitutional claims challenging the validity of the regulation.

[1] [2] [3] "[I]t is a fundamental rule that a court may raise and review the issue of subject matter jurisdiction at any time.... Subject matter jurisdiction involves the authority of the court to adjudicate the type of controversy presented by the action before it.... [A] court lacks discretion to consider the merits of a case over which it is without jurisdiction...." (Internal quotation marks omitted.) *Fedus v. Planning & Zoning Commission,* 278 Conn. 751, 755, 900 A.2d 1 (2006).

I

[4] [5] We begin by examining the jurisdiction of the board to consider the plaintiffs' constitutional and statutory *755 claims challenging the validity of the regulation. "Administrative agencies ... are tribunals of limited jurisdiction and their jurisdiction is dependent entirely upon ... the statutes vesting them with power and they cannot confer jurisdiction upon themselves.... We have recognized that [i]t is clear that an administrative body must act strictly within its statutory authority, within constitutional limitations and in a lawful manner.... It cannot modify, abridge or otherwise **743 change the statutory provisions ... under which it acquires authority unless the statutes expressly grant it that power." (Internal quotation marks omitted.) *Tele Tech of Connecticut Corp. v. Dept. of Public Utility Control,* 270 Conn. 778, 789, 855 A.2d 174 (2004). Accordingly, whether the board had jurisdiction to hear the plaintiffs' claims requires an examination of the relevant statutes.

[6] [7] Statutory construction is a question of law over which we exercise plenary review. E.g., *State v. Hardy,* 278 Conn. 113, 119, 896 A.2d 755 (2006). "When interpreting a statute, [o]ur fundamental objective is to ascertain and give effect to the apparent intent of the legislature." (Internal quotation marks omitted.) *D'Angelo Development & Construction Co. v. Cordovano,* 278 Conn. 237, 243, 897 A.2d 81(2006). "The meaning of a statute shall, in the first instance, be ascertained from the text of the statute itself and its relationship to other statutes. If, after examining such text and considering such relationship, the meaning of such text is plain and unambiguous and does not yield absurd or unworkable results, extra-textual evidence of the meaning of the statute shall not be considered." General Statutes § 1–2z.

[8] [9] "In the processing of unemployment compensation claims, [the governing statutes[7] provide that] the

administrator, *756 the referee and the employment security board of review decide the facts and then apply the appropriate law." *Petyan v. Ellis,* 200 Conn. 243, 248, 510 A.2d 1337 (1986). As we explained in *Finkenstein v. Administrator, Unemployment Compensation Act,* 192 Conn. 104, 470 A.2d 1196 (1984), "[t]he administrator is the labor commissioner. General Statutes § 31–222(c). [The administrator] is charged with the initial responsibility of determining whether claimants are entitled to unemployment benefits. [See generally] General Statutes § 31–241. Upon the filing of a claim, the administrator or a representative (examiner) designated by him must examine the claim and on the basis of the facts found by him, determine whether the claim is valid. [General Statutes § 31–241(a)]. Such determinations are made after an evaluation of evidence presented in person or in writing at a hearing called for such purpose. [General Statutes § 31–241(a)]. This initial determination becomes final unless the claimant or the employer files an appeal within twenty-one days after notification of the determination is mailed. [General Statutes § 31–241(a)]. Appeals are taken to the employment security appeals division which consists of a referee section and the board of review. [See] General Statutes §§ 31–237a, 31–237b. The appeals division is separate and apart from the administrator; *Robinson v. Unemployment Security Board of Review,* 181 Conn. 1, 2, 434 A.2d 293 (1980); and **744 by statute the administrator is deemed to be a party to any proceeding *757 ... before a referee, the board or any reviewing court. General Statutes § 31–249c." (Internal quotation marks omitted.) *Finkenstein v. Administrator, Unemployment Compensation Act,* supra, at 108, 470 A.2d 1196.

"The first stage of claims review lies with a referee who hears the claim de novo. The referee's function in conducting this hearing is to make inquiry in such manner, through oral testimony or written and printed records, as is best calculated to ascertain the substantial rights of the parties and carry out justly the provisions ... of the law. General Statutes § 31–244. This decision is appealable to the board of review. General Statutes § 31–249. Such appeals are heard on the record of the hearing before the referee although the board may take additional evidence or testimony if justice so requires. [General Statutes § 31–249]. Any party, including the administrator, may thereafter continue the appellate process by appealing to the Superior Court and, ultimately, to [the Appellate and Supreme Courts]. [See] General Statutes [Rev. to 1983] § 31–249b [as amended by Public Acts, Spec. Sess., June, 1983, No. 83–29, § 14]." (Internal quotation marks omitted.) *Finkenstein v. Administrator, Unemployment Compensation Act,* supra, 192 Conn. at 108–109, 470 A.2d 1196.General Statutes § 31–249b also provides that the Superior Court "may order final disposition" of the appeal if it does not remand the case for further proceedings.

To assist in interpreting the statutory scheme, General Statutes § 31–236e(b) grants the administrator authority to "adopt regulations, in accordance with the provisions of [the Unemployment Compensation Act], which establish all necessary criteria for the determination of a claimant's eligibility for unemployment compensation benefits." Subsection (a) of the statute specifically provides that "the determination of a claimant's eligibility for unemployment compensation benefits shall be based solely on the provisions of [the *758 Unemployment Compensation Act] and any regulations adopted pursuant thereto." General Statutes § 31–236e(a).

[10] **[11]** With respect to the "validity" of a claim, § 31–222–13(a)(3) of the Regulations of Connecticut State Agencies defines a "valid initiating claim" as "a claim filed by an unemployed or partially unemployed individual who meets the requirements of subdivisions (1) and (3) of subsection (a) of section 31–235 of the Connecticut General Statutes[8] ...." The **745 designated subdivisions of § 31–235(a) refer to the procedural requirements for making a claim and to whether the employer is subject to the provisions of the Unemployment Compensation Act. None of the governing statutes grants the reviewing body authority to consider issues beyond those relating to the requirements for making a claim, as expressed in § 31–235(a), to the eligibility of the claimant and to the amount and duration of the benefits to which the *759 claimant is entitled. In other words, although § 31–241(a) permits the administrator to determine the validity of an unemployment compensation "claim," insofar as it is properly filed, there is no provision in this or any other portion of the statutory scheme that permits the referee or the board to consider the validity of the governing statutes or regulations.

[12] **[13]** Furthermore, as the board notes, it is well established that claims regarding the constitutionality of legislative enactments are beyond the jurisdiction of administrative agencies; *Rayhall v. Akim Co.,* supra, 263 Conn. at 337, 819 A.2d 803; and that "[administrative rules and regulations are given the force and effect of law." (Internal quotation marks omitted.) *Teresa T. v. Ragaglia,* 272 Conn. 734, 751, 865 A.2d 428 (2005).

Consequently, the board lacked authority to address the constitutional issues that the plaintiff had raised on appeal from the decision of the referee.

[14] The procedures established to promulgate administrative rules and regulations likewise do not provide for challenges to the validity of regulations adopted to implement the unemployment compensation scheme. In its decisions dismissing the plaintiffs' appeals, the board explained: "Where the legislature authorizes an administrative agency to issue a rule, the agency utilizes a notice and comment procedure and the rule has the same binding effect as a statute, [and] that 'legislative rule' or regulation is binding on the agency itself. [1 R. Pierce, Administrative Law Treatise (4th Ed.2002) § 6.6, pp. 353–54, citing *United States v. Nixon,* 418 U.S. 683, 694–96, 94 S.Ct. 3090, 41 L.Ed.2d 1039] (1974). The administrator duly enacted [§] 31–235–6(a) of the [regulations] pursuant to the authority conferred by ... §§ 31–236e and 31–250. The regulation review committee and the office of the attorney general reviewed the regulation for legal sufficiency. The administrator could repeal the regulation by duly enacting another regulation; *760 see 1 R. Pierce, [supra] § 6.4, at p. 342; but is not currently seeking to do so. Although the board may expand or interpret a regulation duly enacted by the administrator ... we have no authority to determine whether the administrator's regulation violates other state or federal laws, including [Title II of the ADA]." (Citations omitted.) Accordingly, we conclude that the board lacked jurisdiction to decide the plaintiffs' state and federal statutory and constitutional claims concerning the validity of the regulation.

II

[15] We next consider whether the trial court had jurisdiction to consider the plaintiffs' claims, on appeal from the decision of the board, challenging the validity of § 31–235–6(a) of the regulations. We have declared that "[t]here is no absolute right of appeal to the courts from a decision of an administrative agency.... Appeals **746 to the courts from administrative [agencies] exist only under statutory authority.... Appellate jurisdiction is derived from the ... statutory provisions by which it is created ... and can be acquired and exercised only in the manner prescribed.... In the absence of statutory authority, therefore, there is no right of appeal from [an agency's] decision...." (Internal quotation marks omitted.) *Fedus v. Planning & Zoning Commission,* supra, 278 Conn. at 756, 900 A.2d 1.

[16] [17] This court previously has considered the jurisdiction of courts to review decisions of administrative agencies and has concluded that it is limited in scope. "[R]eview of an administrative agency decision requires a court to determine whether there is substantial evidence in the administrative record to support the agency's findings of basic fact and whether the conclusions drawn from those facts are reasonable.... Neither this court nor the trial court may retry the case or substitute its own judgment for that of the administrative agency on *761 the weight of the evidence or questions of fact.... Our ultimate duty is to determine, in view of all of the evidence, whether the agency, in issuing its order, acted unreasonably, arbitrarily, illegally or in abuse of its discretion." (Internal quotation marks omitted.) *JSF Promotions, Inc. v. Administrator, Unemployment Compensation Act,* 265 Conn. 413, 417, 828 A.2d 609 (2003).

[18] Similarly, chapter 22 of the rules of practice, which describes the function of the trial court in unemployment compensation appeals, specifies that the court is not to "retry the facts or hear evidence. [The trial court] considers no evidence other than that certified to it by the board, and then for the limited purpose of determining whether the finding should be corrected, or whether there was any evidence to support in law the conclusions reached." Practice Book § 22–9(a). Consequently, there is no authority under the statutes or rules of practice that would permit the trial court to hear a claim, on appeal from the decision of the board, challenging the validity of the regulations.

In arguing that the trial court has jurisdiction to consider their claims, the plaintiffs rely on our decision in *Rayhall v. Akim Co.,* supra, 263 Conn. at 328, 819 A.2d 803, as well as language in General Statutes § 31–249b providing that the Superior Court "may order final disposition" of the issues on appeal. As we previously noted, the trial court also relied on *Rayhall* in concluding that it had jurisdiction, on appeal from the decision of the board, to hear *all* of the plaintiffs' state and federal statutory and constitutional claims not specifically implicating the unemployment compensation statutes. An examination of *Rayhall,* however, leads us to conclude not only that the trial court lacked jurisdiction to hear the ADA claim pursuant to that case or to § 31–249b, which, although broadly worded, does not address the jurisdictional question, but that the court also lacked jurisdiction to *762 hear *any* of

the plaintiffs' claims not directly related to the unemployment compensation statutes or regulations.

In *Rayhall,* the issue was whether this court had jurisdiction in an administrative appeal from the workers' compensation review board to consider a constitutional challenge to the validity of a statute that was not part of the workers' compensation scheme when the compensation review board itself lacked jurisdiction to hear the claim. See *Rayhall v. Akim Co.,* supra, 263 Conn. at 338, 819 A.2d 803. We concluded that § 31–301b provided a jurisdictional basis to consider the challenge because that statute provides that "[a]ny party aggrieved by the decision of the Compensation Review Board upon *any* **747 *question or questions of law arising in the proceedings* may appeal the decision of the Compensation Review Board to the Appellate Court." (Emphasis added.) General Statutes § 31–301b; see *Rayhall v. Akim Co.,* supra, at 339–40, 819 A.2d 803. The statutory language regarding workers' compensation thus expressly permits the court to consider those issues actually decided by the compensation review board *and* those issues that present themselves in the proceedings or become operative as a result of the compensation review board's decision. See *Rayhall v. Akim Co.,* supra, at 340, 819 A.2d 803.

There is no analogous provision in the unemployment compensation scheme. An appeal to the Superior Court from a decision of the board is permitted pursuant to General Statutes § 31–249b, which simply provides that "[a]t any time before the board's decision has become final, any party, including the administrator, may appeal to the superior court...." There is no language in this or any other unemployment compensation statute suggesting that the court may hear claims on appeal from the board over which the board lacks jurisdiction. Accordingly, *Rayhall* does not support the plaintiffs' view that the trial court had subject matter jurisdiction *763 to consider their constitutional and statutory claims regarding the validity of the challenged regulation.

Although we conclude that the trial court did not have jurisdiction to consider the plaintiffs' claims of discrimination on appeal from the board, they were not without an alternative forum. They could have brought an independent action in Superior Court pursuant to General Statutes § 46a–99, which provides that "[a]ny person claiming to be aggrieved by a violation of any provision of sections 46a–70 to 46a–78, inclusive, or sections 46a–81h to 46a–81*o*, inclusive, may petition the Superior Court for appropriate relief and said court shall have the power to grant such relief, by injunction or otherwise, as it deems just and suitable." Alternatively, the plaintiffs could have filed a complaint with the commission on human rights and opportunities pursuant to General Statutes § 46a–82(a), which provides in relevant part that "[a]ny person claiming to be aggrieved by an alleged discriminatory practice, except for an alleged violation of section 46a–68, may, by himself or his attorney, make, sign and file with the commission a complaint in writing under oath, which shall state the name and address of the person alleged to have committed the discriminatory practice, and which shall set forth the particulars thereof and contain such other information as may be required by the commission...." The plaintiffs failed to bring their discrimination claims in either of these alternate forums.

The judgments are reversed and the cases are remanded with direction to dismiss the plaintiffs' appeals.

In this opinion the other justices concurred.

Parallel Citations

911 A.2d 736

Footnotes

1 Section 31–235–6(a) of the Regulations of Connecticut State Agencies provides in relevant part: "In order to find an individual eligible for benefits for any week, the Administrator must find the individual available for full-time work during that week...."

2 We hereinafter refer to the defendant as the administrator.

3 We hereinafter refer to Fullerton and Cocchiola collectively as the plaintiffs.

4 On December 16, 2000, Fullerton sustained injuries resulting from a fall. On or about January 12, 2001, she went to a chiropractor, who provided her with a note indicating that she was subject to limitations with respect to lifting, bending and twisting. Fullerton scheduled surgery for January 29, 2001, but did not know how long she would be disabled as a result of the surgical procedure.

5 Title 42 of the United States Code, § 12132, provides in relevant part: "[N] o qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." 42 U.S.C. § 12132 (2000).

> The ADA defines "qualified individual with a disability" as "an individual with a disability who, with or without reasonable modifications to rules, policies, or practices, the removal of architectural, communication, or transportation barriers, or the provision of auxiliary aids and services, meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity." 42 U.S.C. § 12131(2) (2000).

6 The administrator appealed from the judgments of the trial court to the Appellate Court, and we transferred the administrator's consolidated appeal to this court pursuant to General Statutes § 51–199(c) and Practice Book § 65–1.

7 Unemployment compensation appeals are exempt from the Uniform Administrative Procedure Act pursuant to General Statutes § 4–186, which provides in relevant part: "(a) Appeals from the decisions of the administrator of the Unemployment Compensation Act, *appeals* from decisions of the employment security *appeals* referees to the board of review, and *appeals* from decisions of the Employment Security Board of Review to the courts, as is provided in [the Unemployment Compensation Act] ... are excepted from the provisions of this chapter.

> "(b) In the case of conflict between the provisions of this chapter and the provisions of chapter 567 and provisions of the general statutes relating to limitations of periods of time, procedures for filing appeals, or jurisdiction or venue of any court or tribunal governing unemployment compensation, employment security or manpower appeals, the provisions of the law governing unemployment compensation, employment security and manpower appeals shall prevail...."

8 General Statutes § 31–235(a) provides in relevant part: "An unemployed individual shall be eligible to receive benefits with respect to any week only if it has been found that (1) he has made claim for benefits in accordance with the provisions of section 31–240 and has registered for work at the public employment bureau or other agency designated by the administrator within such time limits, with such frequency and in such manner as the administrator may prescribe, provided failure to comply with this condition may be excused by the administrator upon a showing of good cause therefor; (2) except as provided in subsection (b) of this section, he is physically and mentally able to work and is available for work and has been and is making reasonable efforts to obtain work ... (3) he has been paid wages by an employer who was subject to the provisions of [the Unemployment Compensation Act] during the base period of his current benefit year in an amount at least equal to forty times his benefit rate for total unemployment: Provided an unemployed individual who is sixty-two years of age or older and is involuntarily retired under a compulsory retirement policy or contract provision shall be eligible for benefits with respect to any week, notwithstanding subdivisions (1) and (2) of this section, if it is found by the administrator that he has made claim for benefits in accordance with the provisions of section 31–240, has registered for work at the public employment bureau, is physically and mentally able to work, is available for work, meets the requirements of this subdivision and has not refused suitable work to which he has been referred by the administrator...."