THE STATE OF NEW HAMPSHIRE
SUPREME COURT

No. 2019-0727

Genworth Life Insurance Company

v.

New Hampshire Department of Insurance

APPEAL PURSUANT TO RULE 7 FROM A JUDGMENT OF THE MERRIMACK COUNTY SUPERIOR COURT

BRIEF FOR THE STATE OF NEW HAMPSHIRE DEPARTMENT OF INSURANCE

THE STATE OF NEW HAMPSHIRE
DEPARTMENT OF INSURANCE

By its attorneys,

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(Oral Argument Requested: 15 minutes)

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TEXT OF RELEVANT LAWS & STATUTES

N.H. Const., Pt. I, Art. 23

Retrospective laws are highly injurious, oppressive, and unjust. No such laws, therefore, should be made, either for the decision of civil causes, or the punishment of offenses.

U.S. Const., art. I, § 10, cl. 1

No State shall pass any Law impairing the Obligation of Contracts, nor Grant any Title of Nobility.

N.H. Const., Pt. I, Art. 12

No part of a person's property shall be taken by eminent domain and transferred, directly or indirectly, to another person if the taking is for the purpose of private development or other private use of the property.

U.S. Const. amend. V

No person shall be held to answer for a capital, or otherwise infamous crime, unless on a presentment or indictment of a Grand Jury, except in cases arising in the land or naval forces, or in the Militia, when in actual service in time of War or public danger; nor shall any person be subject for the same offence to be twice put in jeopardy of life or limb; nor shall be compelled in any criminal case to be a witness against himself, nor be deprived of life, liberty, or property, without due process of law; nor shall private property be taken for public use, without just compensation.

United States Constitution, Fourteenth Amendment, Section 1

All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall

abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

RSA 415-D:1

The purpose of this chapter is to promote the public interest, to promote the availability of long-term care insurance policies, to protect applications for long-term care insurance, as defined, from unfair or deceptive sales or enrollment practices, to establish standards for long-term care insurance, to facilitate public understanding and comparison of long-term care insurance policies, and to facilitate flexibility and innovation in the development of long-term care insurance coverage.

RSA 415-D:5

The commissioner may adopt rules, under RSA 541-A, that include standards for:

I. Full and fair disclosure, that set forth the manner, content, and required disclosures for the sale of long-term care insurance policies and certificates, terms of renewability, initial and subsequent conditions of eligibility, non-duplication of coverage provisions, coverage of dependents, preexisting conditions, termination of insurance, continuation or conversion, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, recurrent conditions, and definitions of terms.

II. No long-term care insurance policy may:

(a) Be cancelled, nonrenewed or otherwise terminated on the grounds of the age or deterioration of the mental or physical health of the insured individual or certificate holder.

(b) Contain a provision establishing a new waiting period in the event existing coverage is converted to or replaced by a new or other form within the same company, except with respect

to an increase in benefits voluntarily selected by the insured individual or group policyholder.

(c) Provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care.

(d) Be misleading or unreasonably confusing in connection with either the purchase of long-term care insurance or the settlement of claims.

(e) Be contrary to the health care needs of the public.

(f) Be so limited in scope as to be of no significant economic value to the holders of such policy.

(g) Be issued if not specifically authorized by statute.

(h) In the opinion of the commissioner, be unjust, unfair, and unfairly discriminatory to the policyholder, certificate holder, subscriber or any other person insured under the policy or certificate, or the beneficiary.

III. (a) No long-term care insurance policy or certificate shall use a definition of preexisting condition that is more restrictive than the following: "Preexisting condition" means a condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within 6 months preceding the effective date of coverage of an insured person.

(b) No long-term care insurance policy or certificate may exclude coverage for a loss or confinement that is the result of a preexisting condition unless the loss or confinement begins within 6 months following the effective date of coverage of an insured person.

(c) The commissioner may extend the limitation periods set forth in subparagraphs (a) and (b) as to specific age group categories in specific policy forms upon findings that the extension is in the best interest of the public.

(d) The definition of "preexisting condition" does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant, and, on the basis of the answers on that application, from underwriting in accordance with that insurers established underwriting standards. Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in subparagraph (b) expires. No long-term care insurance policy or certificate may exclude or use waivers or riders of any kind to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in subparagraph (b).

IV. (a) No long-term care insurance policy may be delivered or issued for delivery in this state if such policy:

(1) Conditions eligibility for any benefits on a prior hospitalization requirement;

(2) Conditions eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care; or

(3) Conditions eligibility for any benefits other than waiver of premium, post-confinement, post-acute care, or recuperative benefits on a prior institutionalization requirement.

(b) A long-term care insurance policy containing post-confinement, post-acute care, or recuperative benefits shall clearly label in a separate paragraph of the policy or

certificate entitled “Limitations or Conditions on Eligibility for Benefits” such limitations or conditions, including any required number of days of confinement.

(c) A long-term care insurance policy or rider that conditions eligibility of noninstitutional benefits on the prior receipt of institutional care shall not require a prior institutional stay of more than 30 days.

(d) No long-term care insurance policy or rider that provides benefits only following institutionalization shall condition such benefits upon admission to a facility for the same or related conditions within a period of less than 30 days after discharge from the institution.

(e) The commissioner may adopt rules establishing loss ratio standards for long-term care insurance policies provided that a specific reference to long-term care insurance policies is contained in the rule.

RSA 415-D:6

I. An individual long-term care insurance policy shall not be cancelled, refused renewal, or otherwise terminated by the insurer, except where the required premium has not been paid by or on behalf of the insured; however, this shall not restrict or limit the insurer's right to rescind or revise a policy in the event of fraud or misrepresentation during the contestable period.

II. If a group policy is cancelled, refused renewal or terminated by either the insurer or the policyholder, each certificate holder shall be entitled to have issued to him or her an individual policy or replacement group certificate of insurance providing benefits equivalent to those enjoyed by the certificate holder under the group policy from which conversion is made. Such policy or certificate shall be issued by the insurer without evidence of insurability, provided the certificate holder makes application for the policy and pays the monthly premium within 30 days after receiving written

notice of such cancellation, refusal to renew, or termination. No long-term care insurance policy or certificate shall contain a provision establishing a new waiting period in the event existing coverage is converted to or replaced by a new form or another form within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder.

III. Unless the group policy from which conversion is made replaces previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy from which conversion is made. If the group policy from which conversion is made replaces previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy replaced.

IV. Notwithstanding any other provision of this section, any insured individual whose eligibility for group long-term care coverage is based upon that person's relationship to another person, shall be entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage.

RSA 415-D:12

The commissioner shall issue reasonable rules to promote premium adequacy and to protect the policyholder in the event of substantial rate increases, and to establish minimum standards for marketing practices, agent compensation, agent testing, penalties and reporting practices for long-term care insurance.

RSA 400-A:17

I. The commissioner may hold hearings for any purpose within the scope of this title as he may deem advisable.

II. He shall hold a hearing:

(a) if required by any provision of this title,

(b) or upon written application for a hearing by a person aggrieved by any act or impending act, or by any report, rule, regulation, or order of the commissioner (other than an order for the holding of a hearing, or order on a hearing, or pursuant to such order, of which hearing such person had notice).

III. Any such application must be filed with the commissioner within 30 days after such person knew or reasonably should have known of such act, impending act, failure, report, rule, regulation, or order, unless a different period is provided for by other applicable law, and in which case such other law shall govern. The application shall briefly state the respects in which the applicant is so aggrieved, together with the ground to be relied upon for the relief to be demanded at the hearing. The commissioner may require that the application be signed and sworn to by a person competent to be a witness in civil courts.

IV. If the commissioner finds that the application is timely, made in good faith, and that the applicant would be so aggrieved if his grounds are established he shall hold a hearing within 30 days after the filing of the application, or within 30 days after the application has been sworn to, whichever is the later date, unless in either case the hearing is postponed by mutual consent.

V. Failure to hold the hearing upon application therefor of a person entitled thereto as hereinabove provided shall constitute a denial of the relief sought, and shall be the equivalent of a final order of the commissioner on hearing for the purpose of an appeal under RSA 400-A:24.

VI. Pending the hearing and decision thereon, the commissioner may suspend or postpone the effective date of his previous action.

RSA 400-A:18

I. Except where a longer period is expressly provided in this title, the commissioner shall give written notice of the hearing not less than 10 days in advance. The notice shall state the date, time, and place of the hearing and specify the matters to be considered thereat. If the persons to be given notice are not specified in provision pursuant to which the hearing is held, the commissioner shall give such notice to all persons whose pecuniary interest, to the commissioner's knowledge or belief, are to be directly and immediately affected by the hearing. Notice of the hearing may be waived, and the hearing held at a time mutually fixed by the commissioner and the parties.

II. If any such hearing is to be held for consideration of rules and regulations of the commissioner, or of other matters which, under paragraph I above, would otherwise require separate notices to more than 30 persons, in lieu of other notice, the commissioner may give notice of the hearing by publication thereof in a newspaper of general circulation in this state, at least once each week during the 2 weeks immediately preceding the week in which the hearing is to be held; except, that the commissioner shall mail such notice to all persons who have requested the same in writing in advance and have paid to the commissioner the reasonable amount fixed by him to cover the cost thereof. All such notices, other than published notices, shall be given as provided in RSA 400-A:14.

RSA 400-A:23

I. In the conduct of hearings under this title and making his order thereon, the commissioner shall act in a quasi-judicial capacity.

II. Within 90 days after termination of a hearing, or of any rehearing thereof or reargument thereon, or within such other period as may be specified in this title as to particular proceedings, the commissioner shall make his order on hearing covering matters involved in such hearing, and give a copy of the order to each party to the hearing in the same manner as notice of the hearing was given to such party; except, that as to hearings held with respect to merger, consolidation, bulk reinsurance, conversion, affiliation, or change of control of a licensed insurer as provided in RSA 401-B and RSA 403-A, where notice of the hearing was given to all who are stockholders or policyholders, or both, of an insurer involved, the commissioner is required to give a copy of the order on hearing to the corporation and insurer parties, to intervening parties, to a reasonable number of such stockholders or policyholders as representative of the class, and to other parties only upon written request of such parties.

(a) The order shall contain:

(1) A concise statement of facts found by the commissioner upon the evidence adduced at the hearing;

(2) A concise statement of the commissioner's conclusions from the facts so found;

(3) His order, and the effective date thereof; and

(4) Citation of the provisions of this title upon which the order is based; but failure to so designate a particular provision shall not deprive the commissioner of the right thereafter to rely thereupon.

(b) The order may affirm, modify, or rescind action theretofore taken or may constitute taking of new action within the scope of the notice of hearing.

RSA 400-A:24

I. An appeal from the commissioner shall be taken only from an order on hearing, or as to a matter on which the commissioner has refused or failed to hold a hearing after application therefor under RSA 400-A:17, or as to a matter as to which the commissioner has failed to make his order on hearing as required by RSA 400-A:23.

II. Any appeal shall be in accordance with RSA 541

RSA 541-A:22, II

. . .

II. Rules shall be valid and binding on persons they affect, and shall have the force of law unless they have expired or have been amended or revised or unless a court of competent jurisdiction determines otherwise. Except as provided by RSA 541-A:13, VI, rules shall be prima facie evidence of the proper interpretation of the matter that they refer to.

. . .

N.H. Admin. R. **Ins 3601.16**

The commissioner may upon written request and after an administrative hearing, issue an order to modify or suspend a specific provision or provisions of this rule with respect to a specific long-term care insurance policy or certificate upon a written finding that:

(a) The modification or suspension would be in the best interest of the insureds;

(b) The purposes to be achieved could not be effectively or efficiently achieved without the modification or suspension; and

(c) (1) The modification or suspension is necessary to

the development of an innovative and reasonable approach for insuring long-term care; or

(2) The policy or certificate is to be issued to residents of a life care or continuing care retirement community or some other residential community for the elderly and the modification or suspension is reasonably related to the special needs or nature of such a community; or

(3) The modification or suspension is necessary to permit long-term care insurance to be sold as part of, or in conjunction with, another insurance product.

N.H. Admin. R. **Ins 3601.18**

(a) This section shall apply to all long-term care insurance policies or certificates except those covered under Ins 3601.09 and Ins 3601.19.

(b) Benefits under long-term care insurance policies shall be deemed reasonable in relation to premiums provided the expected loss ratio is at least 60 percent calculated in a manner which provides for adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio, due consideration shall be given to all relevant factors, including:

(1) Statistical credibility of incurred claims experience and earned premiums;

(2) The period for which rates are computed to provide coverage;

(3) Experienced and projected trends;

(4) Concentration of experience within early policy duration;

(5) Expected claim fluctuation;

(6) Experience refunds, adjustments or dividends;

(7) Renewability features;

(8) All appropriate expense factors;

(9) Interest;

(10) Experimental nature of the coverage;

(11) Policy reserves;

(12) Mix of business by risk classification; and

(13) Product features such as long elimination periods, high deductibles and high maximum limits.

(c) Subsection (b) above shall not apply to life insurance policies that accelerate benefits for long-term care. A life insurance policy that funds long-term care benefits entirely by accelerating the death benefit is considered to provide reasonable benefits in relation to premiums paid, if the policy complies with all of the following provisions:

(1) The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;

(2) The portion of the policy that provides life insurance benefits meets the nonforfeiture requirements of RSA 409;

(3) The policy meets the disclosure requirements of RSA 415-D:8 VI., VII. and VIII.;

(4) Any policy illustration that meets the applicable requirements of Ins 309; and

(5) An actuarial memorandum is filed with the insurance department that includes:

a. A description of the basis on which the long-term care rates were determined;

b. A description of the basis for the reserves;

c. A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

d. A description and a table of each actuarial assumption used. For expenses, an insurer shall include percent of premium dollars per policy and dollars per unit of benefits, if any;

e. A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

f. The estimated average annual premium per policy and the average issue age;

g. A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

h. A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying life insurance policy, both for active lives and those in long-term care claim status.

N.H. Admin. R. **Ins 3601.19**

(a) This section shall apply to all requests for premium rate schedule increases.

(b) An insurer shall provide notice of a pending premium rate schedule increase, including an exceptional increase, to the commissioner at least 30 days prior to the notice to the policyholders and shall include:

(1) Information required by Ins 3601.08;

(2) Certification by a qualified actuary that:

a. If the requested premium rate schedule increase is implemented and the underlying assumptions are realized, then no further premium rate schedule increases are anticipated;

b. The premium rate filing is in compliance with the provisions of this section;

(3) An actuarial memorandum justifying the rate schedule change request that includes:

a. Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase; and the method and assumptions used in determining the projected values, including reflection of any assumptions that deviate from those used for pricing other forms currently available for sale;

1. Annual values for the 5 years preceding the 3 years following the valuation date shall be provided separately;

2. The projections shall include the development of the lifetime loss ratio;

3. The projections shall demonstrate compliance with subsection (c); and

4. For exceptional increases:

(i) The projected experience should be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase; and

(ii) In the event the commissioner determines as provided in Ins 3601.03 (a)(4) that offsets may exist, the insurer shall use appropriate net projected experience;

b. Disclosure of how reserves have been incorporated in this rate increase whenever the rate increase will trigger contingent benefit upon lapse;

b. Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and what other actions taken by the company have been relied on by the actuary;

d. A statement that policy design, underwriting and claims adjudication practices have been taken into consideration; and

e. In the event that it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase, the insurer will need to file composite rates reflecting projections of new certificates;

(4) A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for

differences attributable to benefits, unless sufficient justification is provided to the commissioner;

(5) Sufficient information for review and approval of the premium rate schedule increase by the commissioner; and

(6) In assessing the reasonableness of the assumptions proposed, the commissioner may use the services of an independent actuary and may charge the insurer for the cost of these services. The commissioner may also accept a review done by or for another state or states for the same or substantially the same policy form where any differences in benefits and premiums are not material and such review was completed within 18 months of the date of the premium rate schedule filing and substantially complies with these standards.

(c) All premium rate schedule increases shall be determined in accordance with the following requirements:

(1) Exceptional increases shall provide that 70 percent of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits;

(2) Premium rate schedule increases shall be calculated such that the sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, will not be less than the sum of the following:

a. For policies issued on or after May 1, 2004:

1. The accumulated value of the initial earned premium times the difference between 2 percent and the greater of the original anticipated loss ratio when the product was originally filed and 60 percent.;

2. Eighty-five percent of the accumulated value of prior premium rate schedule increases on an earned basis;

3. The present value of future projected initial earned premiums times the difference between 2 percent and the greater of the original anticipated loss ratio when the product was originally filed and 60 percent; and

5. Eighty-five percent of the present value of future projected premiums not in subparagraph 3. on an earned basis;

b. For policies issued prior to May 1, 2004:

1. The accumulated value of earned premium, using rates that had been approved and implemented prior to January 1, 2016, times the difference between 2 percent and the greater of the original anticipated loss ratio when the product was originally filed and 62 percent;

2. Eighty percent for individual policies and 75 percent for group policies of the accumulated value of premium rate increases approved and proposed for implementation on or after January 1, 2016;

3. The present value of future projected earned premium using rates that had been approved and implemented prior to January 1, 2016, times the difference between 2 percent and the greater of the original anticipated loss ratio when the product was originally filed and 62 percent; and

4. Eighty percent for individual policies and 75 percent for group policies of the present value of future projected premiums not in subparagraph 3. on an earned basis;

(3) In the event that a policy form has both exceptional and other increases, the values in paragraph (2) b. and d. will also include 70 percent for exceptional rate increase amounts;

(4) All present and accumulated values used to determine rate increases shall use the maximum valuation interest rate for contract reserves. The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages;

(5) All calculated accumulated values shall use the actual experience of the product, except for the interest rate as specified in (4), in as close a manner to that used in the original development of rates as possible. This shall not preclude the inclusion of multiple policy forms into one rate increase determination if such pooling enhances the credibility of the combined accumulated experience; and

(6) All calculated present values shall use reasonable estimates of future premium payments and claim payments. Such estimates shall be based on reasonable assumptions, which may include a margin for moderately adverse experience, as characterized herein.

(d) For any single increase approved, at the requested amount and based on the actuarial assumptions pursuant to (b) above, the insurer shall not be permitted to implement any further increases on the subject policy for a period of 3 years following the date the approved increase was implemented and no increase shall be implemented for a period of 3 years following the issue date.

(e) For any increase that is greater than 20%, the insurer shall be required to implement a series of scheduled increases to ensure that no policyholder will realize an annual rate increase of more than

20%. The entire scheduled series, or methodology for establishing a series, shall be approved as part of the rate filing justifying the premium rate schedule increase. For the purposes of Ins 3601.08(e), any schedule series implemented pursuant to this paragraph shall be considered one premium rate schedule increase. The insurer shall not be permitted to implement any further increases on the subject policy during the period of such scheduled increases. The insurer shall not be permitted to implement any further increases within a period of 3 years following the date the first approved scheduled increase was implemented.

(f) The commissioner shall not approve any increase if the resultant increase results in a percentage increase for any policyholder that exceeds an amount as set forth below based on the policyholder's attained age:

Table 3601.1
Maximum Permitted

Attained Age	Increase
Under 50	50%
50	50%
51	50%
52	50%
53	50%
54	50%
55	50%
56	50%
57	50%
58	50%
59	50%
60	50%
61	50%
62	50%
63	50%
64	50%

65	50%
66	50%
67	50%
68	50%
69	50%
70	50%
71	48%
72	46%
73	44%
74	42%
75	40%
76	38%
77	36%
78	34%
79	32%
80	30%
81	28%
82	26%
83	24%
84	22%
85	20%
86	18%
87	16%
88	14%
89	12%
90	10%
Over 90	10%

(g) For each rate increase that is implemented, the insurer shall file for review by the commissioner updated projections, as defined in (b) (3) a., annually for the next 3 years and include a comparison of actual results to projected values. The commissioner may extend the period to greater than 3 years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in subsection (n), the projections

required by this subsection shall be provided to the policyholder in lieu of filing with the commissioner.

(h) If any premium rate in the revised premium rate schedule is greater than 200 percent of the comparable rate in the initial premium schedule, lifetime projections, as defined in subsection (b)(3)a., shall be filed for review by the commissioner every 5 years following the end of the required period in subsection (g). For group insurance policies that meet the conditions in subsection (n), the projections required by this subsection shall be provided to the policyholder in lieu of filing with the commissioner.

(i) (1) If the commissioner has determined that the actual experience following a rate increase does not adequately match the projected experience and that the current projections demonstrate that incurred claims will not exceed proportions of premiums specified in subsection (c), the commissioner may require the insurer to implement any of the following:

a. Premium rate schedule adjustments; or

b. Other measures to reduce the difference between the projected and actual experience.

(2) In determining whether the actual experience adequately matches the projected experience, consideration should be given to subsection (b)(3)e., if applicable.

(j) If the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer shall file:

(1) A plan, subject to commissioner approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect; otherwise

the commissioner may impose the condition in subsection (k) of this section; and

(2) The original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to subsection (c) had the greater of the original anticipated lifetime loss ratio or 58 percent been used in the calculations described in subsection (c)(2)a. and c.

(k) (1) For a rate increase filing that meets the following criteria, the commissioner shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the 12 months following each increase to determine if significant adverse lapsation has occurred or is anticipated:

a. The rate increase is not the first rate increase requested for the specific policy form or forms;

b. The rate increase is not an exceptional increase; and

c. The majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse.

(2) In the event significant adverse lapsation has occurred, is anticipated in the filing or is evidenced in the actual results as presented in the updated projections provided by the insurer following the requested rate increase, the commissioner may determine that a rate spiral exists. Following the determination that a rate spiral exists, the commissioner may require the insurer to offer, without underwriting, to all in force insureds subject to the rate increase the option to replace existing coverage with one or more reasonably comparable products being offered by the insurer or its affiliates.

a. The offer shall:

1. Be subject to the approval of the commissioner;

2. Be based on actuarially sound principles, but not be based on attained age; and

3. Provide that maximum benefits under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy.

b. The insurer shall maintain the experience of all the replacement insureds separate from the experience of insureds originally issued the policy forms. In the event of a request for a rate increase on the policy form, the rate increase shall be limited to the lesser of:

1. The maximum rate increase determined based on the combined experience; and

2. The maximum rate increase determined based only on the experience of the insureds originally issued the form plus 10 percent.

(l) If the commissioner determines that the insurer has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, the commissioner may, in addition to the provisions of subsection (k) of this section, prohibit the insurer from either of the following:

(1) Filing and marketing comparable coverage for a period of up to 5 years; or

(2) Offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases.

(m) Subsections (a) through (l) shall not apply to policies for which the long-term care benefits provided by the policy are incidental, as

defined in Ins 3601.03 (b), if the policy complies with all of the following provisions:

(1) The interest credited internally to determine cash value accumulations, including long-term care, if any, rate guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;

(2) The portion of the policy that provides insurance benefits other than long-term care coverage meets the nonforfeiture requirements as applicable in any of the following:
a. RSA 409; and

b. RSA 409-A;

(3) The policy meets the disclosure requirements of RSA 415-D:8 VI., VII., and VIII.;

(4) The portion of the policy that provides insurance benefits other than long-term care coverage meets the requirements as applicable in policy illustrations as required by Ins 309;

(5) An actuarial memorandum is filed with the insurance department that includes:

a. A description of the basis on which the long-term care rates were determined;

b. A description of the basis for the reserves;

c. A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

d. A description and a table of each actuarial assumption used. For expenses, an insurer shall include percent of

premium dollars per policy and dollars per unit of benefits, if any;

e. A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

f. The estimated average annual premium policy and the average issue age;

g. A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

h. A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying insurance policy, both for active lives and those in long-term care status.

(n) Subsections (h) and (k) shall not apply to group insurance policies as defined in RSA 415-D:3 IV. (a) where:

(1) The policies insure 250 or more persons and the policyholder has 5,000 or more eligible employees of a single employer; or

(2) The policyholder, and not the certificateholders, pays a material portion of the premium, which shall not be less than 20 percent of the total premium for the group in the calendar year prior to the year a rate increase is filed.

ISSUES PRESENTED

I. Whether the trial court correctly dismissed the plaintiff's contract clause claims when the plaintiff failed to allege that the challenged regulations substantially impair existing contractual relationships and when those regulations are reasonable and necessary to serve a significant and legitimate public purpose.

II. Whether the trial court correctly entered summary judgment for the defendant on the plaintiff's *ultra vires* claim when RSA chapter 415-D expressly authorizes rulemaking and the challenged regulations were promulgated under that chapter, fall within its scope, and are consistent with its text.

III. Whether the trial court correctly entered summary judgment for the defendant on the plaintiff's confiscatory-rate taking claim when the plaintiff challenged the methodology of the ratemaking formula, and not a specific rate, and when legal mechanisms exist for an insurer to seek relief from a confiscatory rate.

STATEMENT OF THE FACTS AND OF THE CASE

A. The statutory and regulatory landscape.

Since 1990, the Long-Term Care Insurance ("LTCI") Act has governed LTCI policies issued in New Hampshire. *See* 1989 N.H. Laws ch. 166, *repealed and reenacted by* 2003 N.H. Laws ch. 180. Codified at RSA chapter 415-D, the LTCI Act's purposes are to "promote the public interest," "to promote the availability of [LTCI] policies," "to protect applications for long-term care insurance, as defined, from unfair or deceptive sales or enrollment practices," and to "facilitate flexibility and innovation in the development of [LTCI] coverage." RSA 415-D:1.

Under the LTCI Act, an LTCI policy may not be: "cancelled, nonrenewed or otherwise terminated on the grounds of the age or deterioration of the mental or physical health of the insured individual or certificate holder," "so limited in scope as to be of no significant economic value to the holders of such policy," or "unjust, unfair, and unfairly discriminatory to the policyholder, certificate holder, subscriber or any other person insured under the policy or certificate, or the beneficiary." RSA 415-D:5, II(a, f, h). The New Hampshire Insurance Commissioner (the "Commissioner") is empowered to promulgate rules in furtherance of these statutory limits. RSA 415-D:5, I. The LTCI Act also provides that an insurer may not "cancel[], refuse renewal, or otherwise terminate[]" an LTCI policy unless "the required premium has not been paid by or on behalf of the insured . . . ." RSA 415-D:6, I. The Act further requires the Commissioner to "issue reasonable rules to promote premium adequacy and to protect the policyholder in the event of substantial rate increases, and

to establish minimum standards for marketing practices, agent compensation, agent testing, penalties and reporting practices for long-term care insurance." RSA 415-D:12.

Exercising his statutory authority, the Commissioner has promulgated regulations to implement the LTCI Act, *see N.H. Admin R.* ch. Ins 3600, including rules governing premium rate increases on LTCI policies, *see N.H. Admin R.* Ins 3601.19. Since 2004, these rules have required "review and approval of [any] premium rate schedule increase by the commissioner." *N.H. Admin R.* Ins 3601.19(b)(5). Once the Commissioner approves a request for a premium rate increase under this rule, no further increases are permitted for three years. *N.H. Admin R.* Ins 3601.19(d).

Effective February 13, 2015, the Commissioner amended these regulations to specify limits on maximum premium rate increases based on the age of the policyholder (the "amended regulations"). *See N.H. Admin R.* Ins 3601.19(f). Under these amendments, the maximum premium rate increase is 50% for insureds with an attained age of 70 or younger. *See id.* This percentage decreases by 2% per year for each year of attained age over the age of 70. *See id.* For insureds with an attained age of 90 or older, the maximum premium rate increase is 10%. *See id.* These amendments were approved by the Joint Legislative Committee on Administrative Rules ("JLCAR"). *See* RSA 541-A:2; RSA 541-A:13.

Statutory and regulatory mechanisms exist for insurers aggrieved by the amended regulations to seek relief. RSA 400-A:17-24 provide long-term care insurers a mechanism for comprehensive relief, including an evidentiary hearing with the Commissioner and an avenue to seek an appeal

under RSA chapter 541. The Insurance Rules permit long-term care insurers to seek an exemption from the amended regulations when innovation is used to deliver long-term care insurance. *See N.H. Admin. R.* Ins 3601.16. Also, under *N.H. Admin. R.* Ins pt. 205, a long-term care insurer can seek a declaration from the Department that a particular regulation is confiscatory as applied to the insurer.

B. Relevant background

Genworth Life Insurance Company ("Genworth"), a long-term care insurer, brought this action against the New Hampshire Insurance Department (the "Department"), challenging the validity of the amended regulations. PAI 5-50.[1] Genworth alleges that it has issued LTCI policies to approximately 6,000 New Hampshire residents. PAII 98 ¶ 4. Genworth alleges that these policies contain the following provision:

> **We have a limited right to change premiums**. Premiums will not change due to a change in [y]our age or health. We can change premiums based on premium class; but only if [w]e change them for all similar policies issued in the same state and on the same form as this [p]olicy. We will give you at least 45 days written notice before [w]e change premiums.

PAII 104 ¶ 25 (emphasis in original). Genworth contends that the application of the amended regulations to these policies violates the State

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[1] "PB __" refers to Genworth's brief and page number.
"PAI __" refers to volume I of the appendix to Genworth's brief and page number.
"PAII __" refers to volume II of the appendix to Genworth's brief and page number.
"PAO __" refers to the addendum to Genworth's brief containing the trial court's orders and page number.
"DAO __" refers to the order appended to this brief and page number.

and Federal Contract Clauses and that the amended regulations are *ultra vires* and effect a taking in violation of the State and Federal Constitutions. *See* PAII 98 ¶ 3.

On the Department's motion, PAII 5-34, the trial court dismissed Genworth's contract clause claims for failure to state a claim, PAO 41-42. The trial court concluded that Genworth had not "alleged facts establishing that the [a]mended [r]egulations are a change that substantially impairs its contractual relationships." PAO 42. The trial court maintained this conclusion after Genworth amended its complaint, finding that "the amended complaint doesn't establish that the regulations impinge on contract terms bearing on Genworth's ability to charge a certain premium." PAO 42.

Genworth thereafter represented that its *ultra vires* and confiscatory-rate taking claims were facial challenges to the validity of the amended regulations. PAII 264-276 (repeatedly making this representation). The trial court accepted this representation and indicated that "considerations are limited to the terms of the regulations and enabling statutes, and won't venture into issues of appropriate rates." PAO 51. The parties structured the case without discovery, DAO 75-77, and filed cross-motions for summary judgment, *see generally* PAII 290-422. The trial court granted the Department's motion, concluding that the Commissioner possessed the authority to promulgate the amended regulations under RSA chapter 415-D and that those regulations did not, on their face, effect a taking. PAO 55-65. Genworth sought reconsideration, PAII 424-443, which the trial court denied, PAO 67.

This appeal followed.

SUMMARY OF THE ARGUMENT

The trial court correctly dismissed Genworth's contract clause claims. Genworth failed to allege that any provision in its LTCI policies guaranteed it the ability to increase premiums to whatever amount it desired. Instead, Genworth's policies exist in a highly regulated field where, since 2004, all premium rate increases have been subject to review and approval by the Commissioner. The amended regulations did not change the law in this area and Genworth has not identified any existing contract right that those regulations impaired at all, much less substantially. Accordingly, the trial court correctly held that Genworth failed to allege a substantial impairment of its contractual relationships in New Hampshire. Additionally, the amended regulations are reasonable and necessary to advance a significant and legitimate public purpose, *i.e.*, protecting policyholders who have invested decades of premiums into LTCI policies from losing those policies before they realize their value because insurers increase premiums beyond what a policyholder can afford to pay. This stands as an independent basis to affirm the trial court's dismissal of the contract clause claims.

The trial court also correctly entered summary judgment in favor of the Department on Genworth's facial *ultra vires* claim. RSA 415-D:12 vests the Commissioner with broad discretion to make rules "to protect the policyholder in the event of substantial rate increases." On their face, the amended regulations fall within that broad grant of authority, helping to protect policyholders (particularly those of advanced age on fixed incomes) in the event of substantial rate increases by requiring insurers to stage rate

increases over time and in a predictable and affordable manner. Accordingly, the amended regulations are not facially *ultra vires*.

The trial court further correctly entered summary judgment in favor of the Department on Genworth's facial confiscatory-rate taking claim. In its brief, Genworth contends that the amended regulations are facially confiscatory because: (1) the Department purportedly admitted during testimony to JLCAR that the amended regulations would cause all insurers in the LTCI industry to operate, on average, at a loss, and (2) the amended regulations do not contain a "safety valve" granting the Commissioner discretion to avoid a confiscatory rate. Both arguments are incorrect.

The first argument is incorrect as a matter of law and fact. The JLCAR testimony Genworth references does not establish the proposition Genworth cites it for, as the trial court correctly observed, and does not meet Genworth's burden to show that the amended regulations result in a confiscatory taking in every set of circumstances (*i.e.*, across all long-term care insurers and all LTCI products). The second argument also fails because neither this Court nor the United States Supreme Court has recognized a facial taking challenge to a ratemaking methodology like the amended regulations. Rather, existing precedent requires only that a regulated entity receive a "just and reasonable" rate and emphasizes that the methodology used to get to that rate is constitutionally irrelevant. This forecloses Genworth's facial challenge to the ratemaking methodology, as the trial court observed.

But Genworth's claims also fail even if the State and Federal Constitutions permitted such a challenge and mandated the existence of a "safety valve" mechanism. RSA 400-A:17-24, *N.H. Admin. R.* ch. Ins

3600, and *N.H. Admin. R.* Ins pt. 205 provide legal mechanisms through which the Commissioner could provide an insurer with relief from a confiscatory rate. These mechanisms are more than sufficient to defeat Genworth's taking claim even under the foreign decisions cited in its brief.

Accordingly, the trial court's orders in this case were correct and should be affirmed.

ARGUMENT

I. THE TRIAL COURT CORRECTLY DISMISSED GENWORTH'S CONTRACT CLAUSE CLAIMS

A. The standard of review and applicable law.

This Court will "uphold the trial court's grant of a motion to dismiss if the facts pleaded do not constitute a basis for legal relief." *Clark v. N.H. Dep't of Emp't Sec.*, 171 N.H. 639, 645 (2019). The Court thus determines whether "the allegations in the plaintiff's pleadings are reasonably susceptible of a construction that would permit recovery." *Id.* While the Court must assume the truth of well-pleaded facts and draw all inferences in the plaintiff's favor, it should not "assume the truth of statements . . . that are merely conclusions of law." *Id.*

The State and Federal Contracts Clauses offer equivalent protections. *See Deere & Co. v. State*, 168 N.H. 460, 471 (2015). When, as here, a regulation applies to a contract in effect when the regulation was promulgated, then the analysis consists of two steps. First, "a court must determine whether a change in state law has resulted in the substantial impairment of a contractual relationship." *Id.* at 472 (same omissions). If so, then a court must decide whether the regulation has "a significant and legitimate purpose." *Id.* (same omissions). In this case, Genworth's contract clause claims fail at each step.

B. The amended regulations do not substantially impair Genworth's policies.

A substantial impairment exists if: (1) "there is a contractual relationship"; (2) "a change in law impairs that contractual relationship"; and (3) "the impairment is substantial." *Id.* (same omissions). Genworth alleges existing contractual relationships with insureds in New Hampshire. PAII 98 ¶ 4. The amended complaint does not, however, contain well-pleaded factual allegations establishing an impairment of those contracts, much less one that is substantial. Genworth therefore failed to state a viable contract clause claim.

Genworth alleges a right to increase premium rates in its LTCI policies "to the degree necessary to achieve the applicable expected loss ratio." *See* PB 17. No such right exists in Genworth's LTCI policies. Under those policies, Genworth possesses only a "limited right to change premiums." PAII 104 ¶ 25. Nothing in this language gives Genworth the right to receive premiums sufficient to maintain any particular loss ratio, and the amended regulations do not prevent Genworth from exercising this "limited" contract right. Genworth remains free, with the Commissioner's approval, to implement rate increases, as has been the case since 2004. Genworth has not identified any other contractual provision giving it the right to increase premiums in order to achieve a particular loss ratio. The trial court therefore properly concluded that "the amended complaint doesn't establish the regulations impinge on contract terms bearing on Genworth's ability to charge a certain premium." PAO 47.

Genworth resists this conclusion on two related grounds. First, Genworth contends that the prior regulatory framework required the

Commissioner to approve any actuarially justified premium increase necessary to achieve "premium adequacy." Second, Genworth contends that its LTCI policies incorporated this regulatory requirement as an enforceable *contractual* right. Both arguments are unavailing.

Genworth has never identified *any* statutory or regulatory provision requiring the Commissioner to approve every actuarially justified rate increase sufficient to achieve "premium adequacy." This is unsurprising because no such requirement has ever existed. No provision in the LTCI Act guarantees long-term care insurers any level of "premium adequacy." Similarly, nothing in the LTCI Act guarantees that an insurer will receive a premium rate increase if it shows the increase is needed to achieve premium adequacy. Rather, the LTCI Act permits the creation of rules designed to "promote premium adequacy" and also "to protect policyholders in the event of substantial rate increases." RSA 415-D:12. Since 2004, the applicable rules have given the Commissioner the authority to approve premium rate increases without imposing any *requirement* that he do so. *See N.H. Admin R.* Ins 3601.19(b)(5). There is, in other words, no legal support for Genworth's contention that it was ever guaranteed a particular rate increase before the amended regulations.[2]

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[2] The contrary "allegations" in Genworth's amended complaint are incorrect legal conclusions not entitled to an assumption of truth. *See Clark*, 171 N.H. at 645. Genworth's assertion that the Department allegedly "acknowledged it had no basis to disapprove actuarially justified requests for rate increases under the regulations [previously] in effect," PAII 117 (formatting altered), does not change this. RSA chapter 415-D, not any isolated statement allegedly made by the Department, sets the scope of the Commissioner's authority. Neither that chapter nor any rule promulgated thereunder has ever *required* the Commissioner to approve actuarially justified rate increases.

Yet, even if the prior regulations did require the Commissioner to approve actuarially required increases, this still does not mean that Genworth had a *contractual* right to such increases triggering the protections of the State and Federal Contracts Clauses. A plaintiff can only succeed on a contract clause claim if it shows both a change in the law and the substantial impairment of a contractual relationship. *See Deere & Co.*, 168 N.H. at 471-72. Genworth has shown neither. The Department has always had the authority to enact regulations to "protect policyholders in the event of substantial rate increases." RSA 415-D:12. Genworth issued LTCI policies in New Hampshire knowing this. Thus, the amended regulations did not change existing law, but rather reflect one possible way that the law may be implemented. Moreover, Genworth has not identified *any* prior regulation that its LTCI policies incorporated.

Genworth's reliance on *Tuttle v. New Hampshire Medical Malpractice Joint Underwriting Association* is unavailing. In *Tuttle*, the regulations at issue were expressly "incorporated into the policies by reference" and established a policyholder's right to participate in the excess earnings of the JUA. 159 N.H. 627, 644 (2010). On this basis, the Court held that "the language of the policies and regulations" together conferred "a vested contractual right" on the policyholders. *Id.* Here, in contrast, Genworth points to no policy language incorporating by reference the regulations in effect at the time its LTCI policies issued, much less any regulation in effect during that time giving it a right to implement any premium rate it desires so long as it is actuarially justified. *Tuttle* therefore does not support Genworth's position.

Genworth fares no better under the United States Supreme Court decisions cited in its brief. While *Home Building & Loan Association v. Blaisdell* contains broad language suggesting that the laws in effect at the time a contract is executed are incorporated into its terms, *see* 290 U.S. 398, 429-30 (1934), this statement was based on a distinction between obligations and remedies, *see id.* at 430, which the Supreme Court has since declared obsolete. Indeed, the Supreme Court observed in *United States Trust Company of New York v. New Jersey*—which *Genworth* also cites in its brief, *see* PB 18—that "[m]ore recent decisions have not relied on the remedy/obligation distinction, primarily because it is now recognized that *obligations as well as remedies* may be modified without necessarily violating the Contract clause." 431 U.S. 1, 19 n.17 (1977) (emphasis added). To that end, the Supreme Court noted that contracting parties "are *unlikely to expect that state law will remain entirely static*." *Id.* (emphasis added). Thus, the broad language in *Home Building & Loan Association*, whatever its rhetorical appeal, does not support the proposition that an insurance policy implicitly incorporates any regulation in effect at the time it issued such that an amendment to that regulation animates a contract clause claim.

But Genworth's contract clause claim would also fail even if it had alleged a cognizable impairment of an existing contractual relationship. Not every impairment of a contractual relationship is substantial. Rather, "[i]n order to weigh the substantiality of a contractual impairment, courts look long and hard at the reasonable expectations of the parties." *Houlton Citizens' Coal. v. Town of Houlton*, 175 F.3d 178, 190 (1st Cir. 1999). "In this inquiry, it is especially important whether the parties operated in a

regulated industry." *Id.* (citing, *inter alia*, *Energy Reserves Grp., Inc. v. Kansas Power and Light Co.*, 459 U.S. 400, 411 (1983)).

The LTCI Act has extensively regulated the LTCI industry since 1990. Since 2004, insurers have been powerless to raise their premiums on LTCI policies without the Commissioner's approval. *See N.H. Admin R.* Ins 3601.19(b)(5). Genworth therefore could not have reasonably expected, even before the amended regulations were enacted, that it would be able to freely raise its long-term care rates by any particular amount, much less an amount exceeding the percentages set forth in the amended regulations. Any impairment to Genworth's rights under its existing LTCI policies is accordingly insubstantial.

The United States Supreme Court's decision in *Energy Reserves Group* confirms this. In that case, the Court ruled that a Kansas law prohibiting enforcement of price escalator clauses in existing natural gas supply agreements did not substantially impair the supplier's rights under those agreements. *See* 459 U.S. at 407-16. Like Genworth, the supplier had a limited contractual right to increase its rate through escalator clauses providing that the price would rise to the level set by the federal government or other authority. *Id.* at 403-04. But Kansas set price controls on natural gas that prohibited suppliers from using these escalator clauses to increase rates under their existing agreements. *Id.* at 407. In rejecting the supplier's contract clause challenge, the Supreme Court observed that the "indefinite escalator clauses at issue . . . are to be viewed" in the context of the "extensive and intrusive" regulation of the natural gas industry. *Id.* at 414. The Court explained:

> Price regulation existed and was foreseeable as the type of law that would alter contract obligations. Reading the Contract Clause as [the supplier] does would mean that indefinite price escalator clauses could exempt [it] from any regulatory limitation of prices whatsoever. Such a result cannot be permitted. In short, [the supplier's] reasonable expectations have not been impaired by the Kansas Act.

Id. (citations omitted).

This reasoning controls here. Due to the broad language in RSA 415-D:12, and the Commissioner's longstanding authority to approve or disapprove premium increases for LTCI policies, "[p]rice regulation existed and was foreseeable as the type of law that would alter contract obligations" since at least 2004. *See id.* And, unlike the supplier in *Energy Reserves Group*, which had a contract right to particular price increases that the Kansas law vitiated, Genworth's policies merely give it a "limited right to change premiums," which it still possesses under the amended regulations. Thus, even if Genworth were able to identify some contractual right that the amended regulations impair, any such impairment is insubstantial as a matter of law.

C. The amended regulations are reasonable and necessary to serve a significant and legitimate public purpose.

Assuming *arguendo* that the amended regulations substantially impair Genworth's rights under its existing LTCI policies, those regulations serve a significant and legitimate public purpose. *See Deere & Co.*, 168 N.H. at 472-73. "'The requirement of a legitimate public purpose guarantees that the State is exercising its police power, rather than providing a benefit to special interests.'" *Id.* at 472 (same quotation).

When such a purpose is identified, "the next inquiry 'is whether the adjustment of the rights and responsibilities of contracting parties is based upon reasonable conditions and is of a character appropriate to the public purpose justifying the legislation's adoption.'" *Id.* (quoting *Energy Reserves Grp, Inc.*, 459 U.S. at 412) (formatting altered). "'Unless the State itself is a contracting party . . . courts properly defer to the legislative judgment as to the necessity and reasonableness of a particular measure.'" *Id.* (quoting *Energy Reserves Group, Inc.*, 459 U.S. at 412-13).

It is clear that "a state can enact laws for the protection and welfare of its citizens under its police powers," including laws regulating the terms and conditions of insurance policies issued to its residents. *Metro. Life Ins. Co. v. Whaland*, 119 N.H. 894, 904 (1979). Genworth does not suggest that the amended regulations are not designed to promote "the protection and welfare" of New Hampshire LTCI policyholders. And the LTCI Act has the express purpose of protecting the public. *See* RSA 415-D:1; RSA 415-D:5, II(a, f, h); RSA 415-D:6, I. This is a significant and legitimate public purpose.

"'Upon finding a legitimate public purpose, the next step involves ascertaining the reasonableness and necessity of the adjustment of contract obligations effected by the regulation to determine finally whether the regulation offends the Contract Clause.'" *Deere & Co.*, 168 N.H. at 477 (quoting *Houlton Citizens' Coalition*, 175 F.3d at 191) (ellipsis omitted). "However, 'when the contracts at issue are private and no appreciable danger exists that the governmental entity is using its regulatory power to profiteer or otherwise serve its own pecuniary interests, a court properly

may defer to the legislature's judgment.'" *Id.* at 477-78 (same citation) (ellipsis omitted).

As discussed below in Section II.C, the amended regulations reflect a valid exercise of the Commissioner's authority under RSA 415-D:12 to, among other things, "protect the policyholder in the event of substantial rate increases." When, as here, "there is no danger that the State is using its regulatory power to serve its own pecuniary interests," this Court has "'refuse[d] to second-guess'" the determination that a particular law or regulation "was a reasonable and necessary way to address [a] concern." *Id.* at 478-79 (quoting *Keystone Bituminous Coal Ass'n v. DeBenedictis*, 480 U.S. 470, 506 (1987)).

Genworth's contract clause claims invite this Court to second-guess the Commissioner's exercise of his statutory rulemaking and JLCAR's approval of the amended regulations, based on Genworth's competing views of the wisdom of the regulations themselves. Those claims are therefore not susceptible of a construction that would permit recovery under established precedent. This stands as an alternative basis to affirm the dismissal of those claims.

II. THE TRIAL COURT CORRECTLY ENTERED SUMMARY JUDGMENT FOR THE DEPARTMENT ON GENWORTH'S FACIAL *ULTRA VIRES* AND CONFISCATORY-RATE TAKING CLAIMS.

A. The standard of review and Genworth's burden.

The remaining claims were resolved in the Department's favor on the parties' cross-motions for summary judgment. "In reviewing the trial court's rulings on cross-motions for summary judgment," this Court "consider[s] the evidence in the light most favorable to each party in its capacity as the nonmoving party and, if no genuine issue of material fact exists, . . . determine[s] whether the moving party is entitled to judgment as a matter of law." *JMJ Properties, LLC v. Town of Auburn*, 168 N.H. 127, 129 (2015). If the Court's review "discloses no genuine issue of material fact and if the moving party is entitled to judgment as a matter of law, then [the Court] will affirm the grant of summary judgment." *Id.* at 129-30 (citation and quotation marks omitted).

Genworth faced an extraordinarily heavy burden on its facial *ultra vires* and confiscatory-rate taking claims. The amended regulations are presumed valid and constitutional. *See, e.g.*, *Appeal of Nolan*, 134 N.H. 723, 727 (1991) (explaining that regulations promulgated in accordance with RSA 541-A are "presumptively valid"). The regulations also constitute "*prima facie* evidence of the proper interpretation of the matter that they refer to." RSA 541-A:22, II. Moreover, these claims present facial challenges to the validity of the amended regulations, which is "the most difficult challenge to mount successfully, since the challenger must establish that no set of circumstances exists under which the [statute or

regulation] would be valid." *State v. Ploof*, 162 N.H. 609, 614 (2011) (citation and quotation marks omitted). The trial court correctly concluded that Genworth did not meet this extraordinarily heavy burden in this case.

B. Genworth could not meet its burden by referencing "statements" made to JLCAR.

In the proceedings below, Genworth premised its summary judgment arguments on the incorrect notion that it could prove its facial claims by pointing to "statements" the Department purportedly made to JLCAR when the amended regulations were being considered for approval. This notion also features prominently in Genworth's opening brief. For instance, in the context of its *ultra vires* claim, Genworth contends that "the Department acknowledged to JLCAR that it 'lacked a clear basis to disapprove' rate increases necessary to achieve the expected loss ratios under the regulations then in effect." PB 21 (quoting PAI 413). And with respect to both claims, Genworth relies heavily on an "analysis" that the Department "proffered" to JLCAR purportedly demonstrating that, if adopted, the amended regulations would result in average loss ratio levels of 112% following "allowable rate increases." *See* PB 27 (citing PAI 360-361, 372-373); *see also* PB 22 (citing PAI 338).

These purported "statements" were not material to the summary judgment analysis. "An issue of fact is 'material' for the purposes of summary judgment if it affects the outcome of the litigation under *the applicable substantive law.*" *VanDeMark v. McDonald's Corp.*, 153 N.H. 753, 756 (2006) (emphasis). Under the standard for facial challenges, however, extrinsic matters are irrelevant. *See United States v. Marcavage*,

609 F.3d 264, 273 (3d Cir. 2010) ("A facial attack tests a law's constitutionality based on its text alone and does not consider the facts or circumstances of a particular case."); *Ezell v. City of Chicag*o, 651 F.3d 684, 697 (7th Cir. 2011) ("In a facial constitutional challenge, individual application facts do not matter."); *McGuire v. Reilly*, 386 F.3d 45, 57 (1st Cir. 2004) (stating that a facial challenge "turns not on the historical facts of how the statute has been applied, but on the words of the statute"). This is particularly true in the context of the claims at issue here, as a facial *ultra vires* claim requires only a comparison of the text of the regulation to the text of the enabling statute and the relevant taking analysis focuses only on the result of a ratemaking decision (*i.e.*, the rate), and not the underlying methodology. *See infra*, Sections II.C. and II.D.

But Genworth's reliance on the Department's purported "statements" would remain misplaced even if the trial court could have considered extrinsic matters. "The party offering evidence generally bears the burden of demonstrating its admissibility." *State v. Rice*, 169 N.H. 783, 800 (2017) (citation and quotation marks omitted). While Genworth suggests in its brief that the Department's "statements" to JLCAR are "matter[s] of public record," *see* PB 21, 27, it does not explain how this renders them admissible. This Court "will not expend judicial resources on undeveloped argument." *State v. Fortier*, 146 N.H. 784, 792 (2001).

In the proceedings below, Genworth argued that the Department's "statements" were entitled to judicial notice. This was incorrect as a matter of law. "A judicially noticed fact must be one *not subject to reasonable dispute* in that it is either (1) generally known with the territorial jurisdiction of the trial court or (2) capable of accurate and ready

determination by resort to sources whose accuracy cannot reasonably be questioned." *N.H. R. Ev*. 201(a) (emphasis added). A court is only required to take judicial notice "if requested by a party and *supplied with the necessary information*." *N.H. R. Ev*. 201(d) (emphasis added).

In this case, Genworth has never identified any specific facts that it believes are entitled to judicial notice, let alone supplied the information necessary for a court to actually notice them. *Accord* Charles Alan Wright & Arthur R. Miller, 21B Federal Practice and Procedure: Evidence 2d § 5107.01 (2005) (noting what a request for judicial notice should indicate when made under Federal Rule of Civil Procedure 201, the federal counterpart to the state rule). Moreover, the Department expressly disputed Genworth's interpretation and characterization of the "statements" it purportedly made to JLCAR. *See* DAII 204 ¶ 57, 208 ¶ 83, 215 ¶ 175. Thus, Genworth failed to demonstrate that any of these "statements" were judicially noticeable. Any argument to the contrary lacks merit.[3]

[3] Judicial notice of the JLCAR proceedings would, at most, be appropriate only to establish the existence of a public document in the JLCAR record. A court cannot take judicial notice of the *truth* of any factual "statements" reflected in a public document, particularly where the meaning of those "statements" is unclear from the documents themselves and the interpretation of those "statements" is disputed. *See, e.g.*, *Unigestion Holding, SA. v. UPMTech., Inc.*, 2016 U.S. Dist. LEXIS 97083, at *17 (D. Or. July 26, 2016) ("It is improper for a court to take judicial notice of the veracity and validity of a public document's contents when the parties dispute the meaning and truth of the contents."); *Loveman v. Lauder*, 484 F. Supp. 2d 259, 267 n.48 (S.D.N.Y. 2007) ("[T]he Court may take judicial notice of matters of public record . . . . It would be entirely inappropriate, however, to take judicial notice of the . . . dubious conclusions that plaintiff would dram from those facts."); *United States v. S. Cal. Edison Co.*, 300 F. Supp. 2d 964, 974 (E.D. Cal. 2004) ("While the authenticity and existence of a particular [public record] is judicially noticeable, veracity and validity of its contents (the underlying arguments made by the parties, disputed facts, and conclusions of applicable facts or law) are not.").

Genworth alternatively contends that "the Superior Court was obligated to consider the Department's representations to JLCAR, and the inferences properly drawn therefrom, in the light most favorable to Genworth." PB 28. But the only support Genworth provides for this assertion is a passing reference to this Court's decision in *Carter v. Concord General Mutual Insurance Company*, in which the Court reiterated the well-worn proposition that a court may consider "the affidavits and other evidence, and all inferences properly drawn from them" when ruling on a motion for summary judgment. *See* PB 28 (citing 155 N.H. 515, 517 (2007)). It hardly bears noting that "affidavits and other evidence" do not encompass any extrinsic hearsay statements a party might reference in or attach to a summary judgment filing. Rather, RSA 491:8-a puts express limits on what a court may consider when ruling on a motion for summary judgment and how a party must present it. And a movant cannot use unsubstantiated personal opinions to meet its summary judgment burden. *See Granite State Mgmt. & Res. v. City of Concord*, 165 N.H. 277, 290 (2013). In this case, Genworth did not demonstrate, through affidavits or otherwise, that the purported "statements" on which it rests its facial claims were admissible at all. The trial court therefore properly declined to rely on them in the context of its summary judgment analysis.

Genworth also mischaracterizes and misinterprets the Department's purported "statements." Contrary to Genworth's contention, the Department's statement that it "lacked a clear basis to disapprove" certain premium rate increases is not a concession that no such basis exists. Nor could it be when neither RSA chapter 415-D nor the Insurance Code has

ever required the Department to approve any particular rate increase an insurer might request.

Similarly, David Sky's October 16, 2014 JLCAR testimony—which Genworth characterizes as an "analysis" of the effect the amended regulations would have on average loss ratios—does not come close to establishing all long-term care insurers doing business in New Hampshire would experience an average 112% loss ratio under the amended regulations. Mr. Sky's testimony related to certain objections lodged by insurers during the rulemaking process. PAI 360.[4] To give JLCAR "a sense" of those objections, Mr. Sky provided "statistics on 25 long-term care rate filings." PAI 360. Mr. Sky explained that the average premium rate increase requested in those filings was 62%, on top of previous rate increases averaging 30%. PAI 360. Mr. Sky explained that, when those specific policies were originally issued, the anticipated lifetime loss ratio averaged 63% and that, without the 62% premium rate increase, the average loss ratio on the 25 specific rate filings sampled would be 118%. PAI 360-361. In other words, Mr. Sky's testimony demonstrates that the original business assumptions underlying the LTCI products in question were highly problematic.

Mr. Sky also explained that, even if the specific rate increases sought were permitted, the insurers who made them would still receive an average loss ratio of 100% on the policies to which they applied, meaning that these insurers understood the failing nature of the policies at issue and were

[4] Mr. Sky noted that comment letters received from ten long-term care insurers and six members of the public were supportive of the amended regulations, and that the only objections received came from long-term care insurers. PAI 360.

willing to tolerate losing money on them. PAI 361. Mr. Sky stated that, under the amended regulations, the insurers whose filings were sampled would realize an average loss ratio of 112% on those particular, problematic policies. PAI 361. This average loss ratio would be more than 100%, but less than 118%. PAI 361. Thus, Mr. Sky's testimony also demonstrates that insurers were willing to take losses on the LTCI products reflected in the sample. This testimony does not establish an industry-wide average loss ratio of 112% across all long-term care insurers and every LTCI product those insurers sell.

Finally, the trial court also properly disregarded the Department's alleged "statements" to JLCAR because Genworth limited its claims to facial legal challenges in order to defeat the Department's third motion to dismiss. In doing so, Genworth "b[ore] the risk of failing to prove [its] claims." *Schaffer ex rel. Schaffer v. Weast*, 546 U.S. 49, 56 (2005). And having made this choice, Genworth could not properly inject disputed factual material into the summary judgment record. Thus, whatever theoretical evidentiary value the "statements" to JLCAR may have, they were not properly before the trial court in this case.

C. The trial court correctly concluded that the amended regulations are not facially *ultra vires*.

A facial *ultra vires* claim tests the text of a regulation against the plain language of the statute it implements to determine whether the regulation falls within the scope of the enabling authority and is otherwise consistent with the statutory text. *See, e.g.*, *Bach v. N.H. Dep't of Safety*, 169 N.H. 87, 92 (2016) (conducting this type of analysis); *K.L.N. Constr.*

Co. v. Town of Pelham, 167 N.H. 180, 184 (2014) (same); *Appeal of Mays*, 161 N.H. 470, 475 (2011) (same). "[T]he legislature may delegate to administrative agencies the power to promulgate rules necessary for the proper execution of the laws." *Bach*, 169 N.H. at 92 (citation and quotation marks omitted). "[T]he authority to promulgate rules is designed only to permit the [agency] to fill in the details to effectuate the purpose of the [enabling statute]." *Id.* (same omissions). "Thus, administrative rules may not add to, detract from, or modify the statute which they are intended to implement." *Id.* (same omissions).

Under this framework, the amended regulations are not facially *ultra vires*. The Department's authority to adopt the amended regulations emanates from RSA 415-D:12. *See N.H. Admin. R*. ch. Ins. 3600 ("Statutory Authority: RSA 400-A:15; RSA 415-D:12."). RSA 415-D:12 empowers the Department to issue reasonable rules to accomplish three different goals: (1) promote premium adequacy; (2) protect the policyholder in the event of substantial rate increases; or (3) establish minimum standards for marketing practices, agent compensation, agent testing, penalties and reporting practices for long-term care insurance.[5] *See Permian Basin Area Rate Cases*, 390 U.S. 747, 776 (1968) (recognizing that "the width of administrative authority must be measured in part by the purposes for which it was conferred" and that broad administrative

[5]RSA 400-A:15 grants the Commissioner similarly broad authority "to make, promulgate, amend and rescind reasonable rules and regulations for, or as an aid to, the administration or effectuation of any provision or provisions of [Title XXXVI of the New Hampshire Statutes]."

responsibilities "demand a generous construction of [the agency's] statutory authority").

The amended regulations control the amount of premium rate increases a long-term care insurer may request every three years, based on the age of the policyholder. In this way, the amended regulations protect LTCI policyholders in the event of substantial premium rate increases, while ensuring that long-term care insurers still receive premium rate increases. This type of policyholder protection is critical to the operation of the LTCI Act. One of the primary aims of the LTCI Act is to protect policyholders from losing their policies due to advanced age or deteriorating health or from otherwise buying into worthless policies. The LTCI Act accomplishes this goal in at least three ways. First, it prohibits cancellation, nonrenewal, or termination of a policy on the grounds of age or deterioration of mental or physical health of the policyholder. RSA 415-D:5, II(a). Second, it mandates that LTCI policies not be so limited in scope that they are of no significant economic value to the policyholder. RSA 415-D:5, II(f). Third, it empowers the Commissioner to issue rules to protect policyholders in the event of substantial rate increases. RSA 415-D:12; *see* RSA 415-D:5, II(h) (stating that no LTCI policy may "[i]n the opinion of the commissioner, be unjust, unfair, and unfairly discriminatory to the policyholder, certificate holder, subscriber or any other person insured under the policy or certificate, or the beneficiary").

The power to issue rules to protect policyholders in the event of substantial rate increases enables the Commissioner to prevent long-term care insurers from doing indirectly what they cannot do directly: canceling a policy on the grounds of advanced age or deteriorating health or rendering

the policy worthless by raising the premium price to a level beyond the policyholder's means and forcing the policy to lapse. *See* RSA 400-A:3 ("The commissioner shall have all powers specifically granted to him or her or reasonably implied in order to enable him or her to perform the duties imposed by this title."); RSA 415-D:6, I (permitting a long-term care insurer to cancel a policy "where the required premium has not been paid by or on behalf of the insured"). Consequently, the amended regulations are, on their face, within the enabling authority contained in RSA 415-D:12. They do not add to, detract from, or otherwise modify any provision of RSA chapter 415-D. Rather, they complement and promote the important purposes of the LTCI Act by protecting policyholders such as the elderly or the disabled from losing their policies due to unchecked premium rate increases, thereby assuring the continued economic value of the policies. They are therefore not facially *ultra vires* as a matter of law.

In its brief, Genworth assails this conclusion on two related grounds: that the amended regulations "do not promote premium adequacy" and that they "prevent substantial rate increases rather than protect policyholders in the event of a substantial increase." PB 20. The Court should reject these arguments for several reasons. First, each of these assertions is factual in nature, and would likely call for expert evidence. Such factual inquiries do not bear on whether the amended regulations are facially *ultra vires* for the reasons stated in the previous section. And, in any event, Genworth did not submit any affidavits or other evidence to support either of these factual assertions. *See, e.g.*, *Stewart v. Bader*, 154 N.H. 75, 85 (2006) ("RSA 491:8-a, II provides, in pertinent part, that the party moving for summary judgment must accompany its motion with an 'affidavit based upon

personal knowledge of admissible facts as to which it appears affirmatively that the affiants will be competent to testify.'"). For this reason alone, the arguments fail.

Second, the LTCI Act does not require that every section of every rule the Department adopts *both* protect policyholders in the event of substantial rate increases *and* promote premium adequacy. Rather, RSA 415-D:12 merely requires that whatever regulatory framework the Commissioner adopts further these objectives, while also establishing minimum standards for marketing practices, agent compensation, agent testing, penalties, and reporting practices. The LTCI Act does not specify how the Commissioner must act if these goals are in tension with one another. Moreover, the LTCI Act more generally provides the Commissioner with the flexibility to adopt a regulatory framework that promotes the Act's myriad, and at times conflicting, goals. *See* RSA 415-D:5. The Commissioner's choices in this regard are entitled to substantial deference. *See, e.g.*, *Appeal of Town of Seabrook*, 163 N.H. 635, 644 (2012) ("[I]t is well established in our case law that an interpretation of a statute by the agency charged with its administration is entitled to deference."); *Appeal of Salem Regional Med. Ctr.*, 134 N.H. 207, 219 (1991) ("[T]he construction of a statute by those charged with its administration is entitled to substantial deference." (quotation omitted)); *NH Retirement System v. Sununu*, 126 N.H. 104, 108 (1985) ("[T]he construction of a statute by those charged with its administration is entitled to substantial deference.").

Third, the phrase "in the event of a substantial increase" does not limit the Commissioner's regulatory authority to after-the-fact damage

control. RSA 415-D:12 permits the Commissioner to promulgate "reasonable rules . . . *to protect* the policyholder in the event of substantial rate increases." (emphasis added). The word "protect" means "to cover or shield from exposure, injury, damage, or destruction: guard," to "defend," "to maintain the status or integrity of especially through financial or legal guarantees." Merriam-Webster, Inc., https://www.merriamwebster.com/dictionary/protect (last visited: July 19, 2020). The phrase "in the event of" is an expression of condition synonymous with the word "if." *See, e.g.*, *In re Estate of Magoon*, 109 N.H. 211, 212 (1968) ("The words 'in the event of her death' describe an uncertain event. . . . We hold that it was the intention of the testator to devise to his wife a fee simple *if she survived him*.") (emphasis added); *Venture Stores v. Pacific Beach Co.*, 980 S.W.2d 176, 181 (Mo. Ct. App. 1998) ("'In the event of does not equate to 'upon' or 'at the time of.' Instead, 'in the event of is read as an expression of condition, as 'if.' 'If' is defined as 'in the event that' in both The American Heritage College Dictionary 675 (3d ed. 1993) and Merriam-Webster's Collegiate Dictionary 576 (10th ed. 1993).").

Read together, and in the context of the LTCI Act generally, RSA 415-D:12 permits the Commissioner to shield long-term care policyholders if substantial rate increases are requested and before the damage is inflicted. The amended regulations accomplish this goal. In the event an insurer requests a substantial rate increase, that request is tested against the relevant regulations. If the insurer's proposed rate increase is beyond what the regulations permit, then the proposed increase is rejected or otherwise

reduced through the established regulatory process.[6] The policyholder is thereby protected in the event of a substantial rate increase made by the insurer.[7] This interpretation is wholly consistent with the enabling authority.

D. The trial court correctly concluded that the amended regulations do not constitute a facial confiscatory-rate taking as a matter of law.

Under the United States Constitution, there is no such thing as a facial confiscatory-rate taking challenge to a ratemaking methodology like the one Genworth has brought in this case. Indeed, the Court "has never considered a taking challenge on a rate setting methodology without being presented with specific rate orders alleged to be confiscatory." *Verizon Communs., Inc. v. FCC*, 535 U.S. 467, 524-25 (2002) (*Souter*, J.). "[A]n otherwise reasonable rate is not subject to constitutional attack by questioning the theoretical consistency of the method that produced it." *Duquesne Light Co. v. Barasch*, 488 U.S. 299, 314 (1989). Thus, "it is the result reached not the method employed which is controlling." *Federal Power Com. v. Hope Natural Gas Co.*, 320 U.S. 591, 602 (1944).

This Court adopted the same "end results" approach in *In re Public Serv. Co.*, 130 N.H. 265 (1988) (*Souter*, J.). Specifically, this Court

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[6] An insurer whose proposed rate increase is rejected in whole or in part may challenge that decision through the RSA 400-A:17 hearing process and ultimately seek judicial review of the resulting decision in this Court under RSA 541.

[7] The fact that the Commissioner has *also* promulgated rules to protect policyholders after the fact does not mean this is the *only* way he could protect policyholders in the event of substantial rate increases. RSA chapter 415-D imposes no such limitation on the Commissioner's rulemaking authority.

analyzed the United States Supreme Court's decision in *Hope Natural Gas Co.*, regarding it as "the culmination of decades of judicial inquiry into the proper constitutional restraints on the process of public utility rate regulation and the focus of substantive judicial review of ratemaking." *Id.* at 274. This Court observed that "[t]he opinion in *Hope* establishes a limited and simplified constitutional yardstick," *id.*, explaining that:

> [t]he import of *Hope* is that the constitution is only concerned with the end result of a rate order; *i.e.*, that it be just and reasonable. Under *Hope*, the particular ratemaking methodology employed by the regulatory agency is, for the most part, constitutionally irrelevant. The only limitation on the methodology is that it produce neither confiscatory nor exploitative rates.

In re Public Serv. Co., 130 N.H. at 275 (internal citation omitted). This Court has adhered to this approach in numerous subsequent decisions. *See, e.g.*, *Appeal of Campaign for Ratepayers Rights*, 145 N.H. 671, 676 (2001) (rejecting an argument that one aspect of a rate resulted in an unconstitutional taking and emphasizing that "a constitutional argument, in this context, cannot be sustained unless the claim is that the entire rate is either unjust or unreasonable"); *Appeal of Richards*, 134 N.H. 148, 164-65 (1991) (holding that the Public Utilities Commission was not required to apply a traditional ratemaking formula to determine a "just and reasonable" rate, but could use any method so long as the end result was a just and reasonable rate).

It is therefore clear that only the "end product" of a *particular* ratemaking decision, and not the ratemaking methodology in general, is subject to constitutional scrutiny. In this case, however, Genworth

challenges the amended regulations—which are merely part of the methodology for determining LTCI premium rates—as facially confiscatory because those regulations do not contain a mechanism for an insurer to seek relief from a confiscatory rate. Such a challenge is an attack on the ratemaking methodology itself, which is not cognizable under controlling precedent. Rather, a confiscatory-rate taking claim is only concerned with whether a *particular plaintiff's* premium rates are substantively "just and reasonable." [8] Accordingly, the trial court properly entered summary judgment in the Department's favor on the confiscatory-rate taking claim.

In its brief, Genworth raises two arguments for why the trial court nevertheless erred by entering summary judgment in the Department's favor. First, Genworth contends that the amended regulations are facially unconstitutional because they do not provide the Commissioner with discretion to avoid confiscatory rates. Second, Genworth contends that the amended regulations effect a confiscatory-rate taking because the

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[8] That is why such a review requires courts to have an actual rate order from the relevant agency to evaluate. *See, e.g.*, *Verizon Communs., Inc.*, 535 U.S. at 524-25; *Fitchburg Gas & Elec. Light Co. v. Dep't of Pub. Utils*., 7 N.E.3d 1045, 1057 (Mass. 2014) ("The confiscation analysis clearly requires a challenge to a specific rate decision in order to assess whether the ultimate rate set is confiscatory. . . . Because the petitioners do not bring the [confiscation] claim within the context of a specific rate decision, we do not engage in this analysis."); *Anthem Health Plans of Me., Inc. v. Superintendent of Ins.*, 40 A.3d 380, 390 (Me. 2012) (explaining that "a confiscatory rate occurs in the insurance rating field where the approved rate denies a regulated entity the opportunity to realize a reasonable return on [its] investment and where the inadequate return results directly from the rate approval process and not from other causes") (internal quotations omitted); *Mich. Consol. Gas Co. v. Mich. PSC*, 691 N.W.2d 29, 31-32 (Mich. App. Ct. 2004) ("[N]o claim of an unconstitutionally confiscatory rate is ripe for consideration before a reconciliation proceeding at which MichCon's actual return or loss on regulated gas sales would be known or determined.").

Department admitted that they would cause long-term care insurers to operate, on average, at a loss. Because both of these arguments (and the case law Genworth cites for support) contemplate a methodology-based approach unknown to this Court's and the Supreme Court's ratemaking jurisprudence, they fail for the reasons stated above.

Even assuming, however, that this Court were to recognize the type of facial confiscatory-rate taking claim Genworth advocates, Genworth's arguments still fail as a matter of law. Genworth's argument that the Commissioner lacks discretion to avoid confiscatory rates is simply incorrect. Genworth premises this argument on foreign case law, primarily from California and New Jersey, requiring that ratemaking regulations include a "safety valve" in order to avoid confiscatory rates. *See* PB 23-25 (citing cases). As suggested above, the New Hampshire Insurance Code and the Department's regulations provide several efficient mechanisms that any long-term care insurer can use in the event the amended regulations threaten to create a confiscatory rate.

First, and most notably, a long-term care insurer could request a hearing pursuant to RSA 400-A:17, alleging that, as applied to it, the challenged regulations result, or imminently threaten to result, in a confiscatory rate. The action must be heard within 30 days. RSA 400-A:17, IV. The Commissioner may notice the hearing to more than a single party (*e.g.*, to all long-term care insurers). RSA 400-A:18. The issues raised in the action can be adjudicated and, following adjudication, the Commissioner may modify the challenged regulations or otherwise provide specific insurers with targeted relief to cure confiscatory rates. RSA 400-A:23, II(b). And if an insurer is dissatisfied with the Commissioner's

decision, it has an avenue for rehearing and appeal under RSA chapter 541. RSA 400-A:24.

Second, long-term care insurers could propose new, innovative ways to insure long-term care and obtain a variance from the challenged regulations. *N.H. Admin. R.* Ins 3601.16. One of the primary purposes of the LTCI Act is to promote this type of innovation. RSA 415-D:1. Thus, if the challenged regulations hinder an innovative and reasonable approach to insuring long-term care, the insurer can seek modification or suspension of those regulations.

Third, a long-term care insurer could file a petition for declaratory ruling with the Department asking it to declare the challenged regulations confiscatory as applied to it. *N.H. Admin. R.* Ins pt. 205. Within the context of that process, the Department could decide whether or to what extent the challenged regulations could be applied to the insurer. The Department could also determine what further process might be required to ensure a non-confiscatory rate.

Genworth ignores the existence of these legal mechanisms because they doom its taking claim. Indeed, the California Supreme Court upheld a law against a facial confiscatory-rate taking claim based on a procedure that appears to be similar to RSA 400-A:17-24. *See Calfarm Ins. Co. v. Deukmejian*, 48 Cal. 3d 805, 824 (Cal. 1989). The New Jersey Supreme Court upheld a law against a similar challenge based on a procedure that appears to be more complex and less certain in application than RSA 400-A:17-24. *See State Farm Mut. Ins. Co. v. Ins. Dep't*, 590 A.2d 191, 207 (N.J. 1991). Accordingly, the expedient hearing procedure provided by RSA 400-A:17-24, as well as the regulatory procedures available in *N.H.*

Admin. R. Ins. 3601.16 and *N.H. Admin. R*. Ins Pt. 205, are more than sufficient to render the challenged regulations facially constitutional even under the foreign cases Genworth cites. Genworth's "safety valve" argument accordingly lacks merit.

The same is true of Genworth's contention that the Department "admitted" that the amended regulations would cause long-term care insurers to operate, on average, at a loss. This argument is premised entirely on Mr. Sky's October 16, 2014 JCLAR testimony. As discussed above, the trial court could not consider that testimony and, in any event, it does not say what Genworth wishes it did. *See supra* Section II.B. Genworth's reliance on that testimony is accordingly misplaced.

But even if that testimony were admissible and Genworth had accurately characterized it, this would at most demonstrate that the amended regulations resulted in rates that were confiscatory "on average" across some unknown subset of long-term care insurers and LCTI products. Such testimony does not demonstrate that the amended regulations would result in confiscatory rates when applied to *every* long-term care insurer in New Hampshire or across *all* LTCI products. Accordingly, even as mischaracterized and misinterpreted by Genworth, Mr. Sky's testimony does not demonstrate that there is "no set of circumstances" under which the amended regulations "would be valid." *See Ploof*, 162 N.H. at 614. It therefore cannot sustain Genworth's facial challenge. *See id.*

Finally, Genworth's reliance on Mr. Sky's testimony, and indeed its entire case, is premised on the incorrect notion that an insurer is entitled to a certain level of "premium adequacy." There is nothing in the LTCI Act that guarantees insurers the ability to make money or earn a profit,

particularly on insurance products that insurers themselves improperly modeled from the outset. Similarly, the State and Federal Constitutions do not guarantee regulated entities a profit, and a regulation does not result in a taking simply because the regulated entity may be losing money or is failing financially. *See In re Public Serv. Co.*, 130 N.H. at 277 (holding that the New Hampshire and United States Constitutions do not guarantee "financial integrity"; neither is concerned with "restoring the financial integrity" of an entity whose "'zenith of opportunity' has been eclipsed by the operation of economic forces" (citing *Market Street R. Co. v. R.R. Comm'n of Cal.*, 324 U.S. 548, 554 (1945)). In arguing otherwise, Genworth conflates the loss ratios referenced in *N.H. Admin. R.* Ins 3601.18 and *N.H. Admin. R.* Ins 3601.19(c) with "premium adequacy," without any evidentiary basis to do so. Those loss ratios are *minimum* loss ratios below which the plan is presumed to not supply sufficient value to the policyholder. They therefore do not serve as "target" loss ratios for the purposes of achieving premium adequacy, from which a court can infer the confiscatory effect of a regulation merely by way of comparison. And, to be sure, Genworth has offered no evidence establishing that *N.H. Admin R.* Ins 36-1.18 and *N.H. Admin. R.* Ins 3601.19(c) have any connection to premium adequacy. For this reason, too, Genworth's facial taking claim fails.

CONCLUSION

For the foregoing reasons, the Department respectfully requests that this Honorable Court affirm the judgment below.

The Department requests a 15-minute oral argument.

Respectfully Submitted,

THE NEW HAMPSHIRE
DEPARTMENT OF INSURANCE

By its attorneys,

GORDON J. MACDONALD
ATTORNEY GENERAL

July 22, 2020

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CERTIFICATE OF COMPLIANCE

I, Samuel R.V. Garland, hereby certify that pursuant to Rule 16(11) of the New Hampshire Supreme Court Rules, this brief contains approximately 9,464 words, which is fewer than the words permitted by this Court's rules. Counsel relied upon the word count of the computer program used to prepare this brief.

July 22, 2020 *<u>/s/ Samuel R.V. Garland</u>*
Samuel R.V. Garland

CERTIFICATE OF SERVICE

I, Samuel R.V. Garland, hereby certify that a copy of the State's brief shall be served on Arnold Rosenblatt, Kathleen Mahan, Paul M. Hummer, and Sean T. O'Neill, counsel for the Appellant through the New Hampshire Supreme Court's electronic filing system.

July 22, 2020 *<u>/s/ Samuel R.V. Garland</u>*
Samuel R.V. Garland

APPENDIX TABLE OF CONTENTS

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NOTICE OF DECISION

File Copy

Case Name: **Genworth Life Insurance Company v The State of New Hampshire Department of Insurance**
Case Number: **217-2016-CV-00381**

Enclosed please find a copy of the court's order of March 28, 2018 relative to:

Joint Proposed Scheduling Order
"Agreement Approved. So Ordered."

March 29, 2018

Tracy A. Uhrin
Clerk of Court

(485)

C: Kathleen M Mahan, ESQ; J. Christopher Marshall, ESQ; Anthony J. Galdieri, ESQ; Laura Beardsley Lombardi, ESQ

029176

STATE OF NEW HAMPSHIRE

MERRIMACK COUNTY

SUPERIOR COURT
SUPERIOR COURT

Docket No. 217-2016-CV-00381

GENWORTH LIFE INSURANCE COMPANY 2018 MAR 27 PM 1 44

v.

THE STATE OF NEW HAMPSHIRE DEPARTMENT OF INSURANCE

JOINT PROPOSED SCHEDULING ORDER

In accordance with this Court's February 28, 2018 order, the parties are in agreement that this case should be resolved on motions for summary judgment without discovery. The parties, by their undersigned counsel, therefore move this Court to approve this joint proposed scheduling order as follows:

1. Each party will file its motion for summary judgment no later than May 14, 2018;
2. Each party will file its opposition to the other party's summary judgment motion no later than June 14, 2018; and
3. Reply briefs in support of each party's motion for summary judgment will be due no later than June 28, 2018.
4. In accordance with New Hampshire Superior Court Civil Rule 32, good cause exists to exempt the parties from ADR in this case. This case concerns the validity and constitutionality of a state agency regulation. These issues are incapable of resolution through ADR.

WHEREFORE, the parties request that the Court:

A. Grant this joint proposed scheduling order; and

B. Grant such other and further relief as may be just and proper.

Agreement Approved, So Ordered

3/28/18

Brian T. Tucker
Presiding Justice

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Respectfully submitted,

Genworth Life Insurance Company,

By its attorneys,

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I hereby certify that a copy of the foregoing was sent this 22nd day of November 2017 by mail, postage prepaid, to counsel of record for the plaintiffs:

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