Superior Court of New Jersey

Appellate Division

Docket No. A-001121-22

In The Matter of: APPLICATION BY HORIZON HEALTHCARE SERVICES, INC, TO FORM A MUTUAL HOLDING COMPANY PURSUANT TO N.J.S.A. 17:48E-46.1	: : : : : : : : :	CIVIL ACTION ON APPEAL FROM A FINAL AGENCY DECISION OF STATE OF NEW JERSEY DEPARTMENT OF BANKING AND INSURANCE Case No. A22-09

BRIEF ON BEHALF OF APPELLANTS NEW JERSEY CITIZEN ACTION, INC. AND HEALTH PROFESSIONALS AND ALLIED EMPLOYEES, INC.

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1. Appellants are New Jersey Citizen Action ("NJCA") and the Health Professionals and Allied Employees union ("HPAE"), two long-time health insurance policyholders of Horizon Health Services, Inc. ("HHSI" or "Horizon").

2. The Respondent is the Commissioner of the Department of Banking and Insurance's ("DOBI" or "Department").

3. The Order being challenged is the November 1, 2022 approval (Order No. A22-09 or "Order") of Horizon's application to mutualize and reorganize as a mutual holding company ("MHC") (the "Plan").

4. The Commissioner's reasoning is contained in the Post-Hearing Report and Summary and Consultants' Evaluations of Horizon Healthcare Services, Inc.'s Application for Mutualization & Reorganization (October 31, 2022) ("Report" or "Post-Hearing Report").

5. This Post-Hearing Report references a DOBI consultant's Health Impact Study on Horizon's Proposed Reorganization (October 30, 2022) ("Health Impact Study").

PRELIMINARY STATEMENT

The stakes in this appeal are high and, for the reasons shown below, the Order should be overturned as contrary to law, arbitrary, capricious and unreasonable. Under its Plan, Horizon – which insures 3,800,000 policyholders and is the largest and most important health insurer in New Jersey – will immediately transfer nearly 30% of its capital out of its health insurance companies. This is in the form of a special tax triggered by the reorganization: an initial $600 million payable on June 1, 2023, an immediate transfer of $300 million to the new parent MHC. Another $100 million special tax accrues in 2023.

On December 1, 2022, S&P Global Ratings (its primary rating agency) lowered Horizon's rating outlook to "negative based on weakening capital":

> The outlook revision on Horizon reflects a weakened capital position primarily due to the costs associated with Horizon's transition to a not-for-profit mutual holding company and ongoing pressures from constrained profitability. This weakened capital position weighs on our assessment of Horizon's financial risk profile.… With the transition to a mutual holding company structure completed, Horizon agreed to pay the state of New Jersey an assessment of $1.25 billion spread out over nearly 20 years. Its largest payment of $600 million will be accrued in 2022. Combining this with an estimated $50 million net loss and material unrealized investment losses due to market performance results in an expected 20%-25% decline in Horizon's capital base at year-end 2022." (Emphasis added.)

S&P Global Ratings; Research Update: Horizon. Thus, Horizon's Plan will significantly reduce its health insurers' capital while it suffers material investment and operating losses in 2022.

Despite substantially different economic conditions from when Chapter 145 was first adopted, and contrary to the clear language of the statute, the Commissioner reasoned that the preamble to Chapter 145 established a presumption of benefit from any MHC reorganization. This is at odds with the statute, which constrains the preamble's policy statements and reasons for passing the law by requiring that a reorganization be "subject to appropriate standards, oversight, and approval." N.J.S.A. 17:48E-46.1. Based on her erroneous presumption, the Commissioner impermissibly distorted the standard of review which requires her to approve the Plan unless she finds, *inter alia*, that it "does not benefit the interests of the policyholders of [Horizon] or treats them inequitably." N.J.S.A. 17:48E-46.5(b)(3) ("prong 3"). She instead approved the Plan on a weaker standard that the Plan was simply "neither contrary to the interests of the policyholders nor would it treat them inequitably."

The Order is also unsupported by substantial evidence under prong 3. As a consequence of the above capital and financial losses, Horizon will face immediate pressure to increase its capital, which comes from premiums. Yet,

the Commissioner glibly accepts Horizon's claim that it "does not intend to fund the initial $600 million state assessment through premium increases."). This ignores the immediate *additional* $400 million in capital being removed from the insurers, Horizon's losses, and its testimony that higher taxes raise policyholders' premiums. The $1 billion in immediate taxes and transfer due to the Plan are thus predictive of higher premiums. Remarkably, the Commissioner concluded:

> A reasonable assumption is that the premium rates will not be significantly impacted by the changes in the premium taxes and new assessments since they do not significantly impact Horizon's economic position.

But the over 30% depletion of capital establishes the opposite.

The Commissioner also misinterpreted the Legislature's capitalization targets, which protect the health insurers, by reading out of the statute the word "health" as it applies to the "system-wide health RBC" standards in N.J.S.A 17:48E-46.13(c) ("RBC" means Risked-Based Capital) To try and fill the hole, the Order requires the MHC to issue a "parental guarantee" to maintain an RBC of 425% in the insurers. Yet, the Commissioner expressly declined to scrutinize the planned investments of the MHC – the only time she has authority to do so according to her own consultants – rendering the "parental guarantee" of unknown value. As a result, her requisite finding that the Plan not be "detrimental to the safety or soundness" of the reorganized

health insurers, based on that parental guarantee, is also unsupported by substantial evidence. While the Legislature enabled Horizon to seek to reorganize, it required the actual Plan to be found to benefit its policyholder, not treat them inequitably, and not be detrimental to the insurers' safety or soundness. The Order fails to do so, thus rendering the it contrary to law, arbitrary, capricious and unreasonable.

STATEMENT OF FACTS AND PROCEDURAL HISTORY[1]

This infirm Order resulted from a rushed and flawed process. The Commissioner took 5 weeks instead of the statutorily allotted 17 weeks, and failed to provide the required direct notice to "each policyholder" before the public hearings. This latter failing enabled Horizon to selectively notice policyholders in order to manufacture supportive testimony. As a result: all "policyholder and consumer" comments relied on by the Commissioner in her Order were generated by Horizon largely, if not entirely from Horizon's own employees (which it concealed). The Commissioner also failed to include in the public record such crucial documents as the MHC's proposed bylaws even though they literally define who will be a member entitled to benefit from Horizon's statutory charitable and benevolent mission and set forth their voting rights, if any. Similarly, the consultants' reports were made confidential

[1] These sections have been combined due to significant subject overlap.

despite their importance to the proceedings. These failings materially and fatally undermined the regulatory review process as contemplated by the Legislature.

On December 23, 2020 the Legislature adopted Chapter 145 (N.J.S.A. 17:48-46.1 *et seq*.) to provide a mechanism for Horizon to seek to reorganize as an MHC to maintain its benevolent and charitable mission as a not-for-profit holding company while allowing it the flexibility to invest more widely than currently possible to advance that mission. N.J.S.A. 17:48-46.1. Approval by the Commissioner of any particular plan was conditioned on her holding three public hearings and finding based on substantial evidence that that plan met the standards and requirements set forth in Chapter 145 designed to protect the interests of policyholders and the State.

On August 1, 2022, Horizon filed its reorganization Plan twenty months after Chapter 145 was adopted. The Commissioner deemed the application complete on September 22, 2022, held public hearings over a span of twelve days (on October 6, 11, and 17), closed the record on October 18, and on November 1, 2022 issued the Order approving the Plan along with the Report containing her reasoning. She also released the Health Impact Study. The regulatory review process was thus completed in 5 weeks despite having 90 days for hearings and 30 days to render a decision. N.J.S.A. 17:48-46.5(b).

On December 12, 2022, Appellants filed their Notice of Appeal and Case Information Statement ("Notice of Appeal") setting forth in detail the issues they intended to raise in this appeal. (57a) On December 14, 2022, Appellants filed a Request for a Stay ("Stay Request") with DOBI (70a), which Horizon opposed on December 16, 2022, and to which Appellants filed a reply (98a) (with the Certification of Laura Waddell as an exhibit) on December 20, 2022. (114a) On December 23, 2022, the Commissioner issued her Order Denying Request for a Stay. (145a)

While Appellants waited for DOBI to respond to their Stay Request, on December 15, 2022 they submitted an application for a stay on an emergent basis with this Court which was denied that day. On December 23, 2022, Horizon moved to intervene with Appellants' consent; which was subsequently granted. On January 10, 2023, Appellants filed a Motion to Accelerate Proceedings, which was opposed by DOBI and Horizon on January 18, 2023. On January 20, 2023, the Court granted Appellants' motion and issued an accelerated briefing schedule and hearing date the week of May 29, 2023. On January 25, 2023, Appellants requested that the hearing date be held earlier to give the Court time to consider the appeal before June 1, 2023 when the $600 million tax assessment is due the State. On January 27, 2023, the Court granted the request.

On January 26, 2023, Appellants filed a motion to compel the Statement of Record ("Statement") in this matter and the production of those documents to the Appellants. The Statement was due January 11, 2023, but was not filed with the Court until February 3, 2023, three weeks after it was due. On February 6, 2023 DOBI opposed the motion to compel as moot. On February 10, 2023, Appellants sought leave to file a Reply on grounds the motion was not moot because DOBI did not produce the requested documents – i.e., those marked "Confidential" on the Statement. DOBI also refused to state whether it will seek to rely on those "Confidential" documents. On February 10 and 13, 2023, DOBI and Horizon, respectively, opposed Appellants' Motion for leave to file a Reply. The motion is still pending, and accordingly Appellants' arguments rest solely on the public record. On basic due process grounds, DOBI and Horizon should be similarly limited to the public record.

GOVERNING STATUTORY FRAMEWORK

Chapter 145 (N.J.S.A. 17:48E-46.1 et seq.): Legislative Policies

The legislative policies specified in Chapter 145 as recapped in the Commissioner's Order are as follows:

> WHEREAS, the Legislature found in Chapter 145 that it is appropriate, and in the best interest of the State of New Jersey and the subscribers of the health service corporation, to permit HHSI to submit a plan of mutualization and reorganization both to preserve HHSI's "important statutory mission" to "provide

affordable and accessible health insurance and promote the integration of the health care system to meet the needs of its members" as a charitable and benevolent nonprofit, and to allow HHSI "to expand and modernize that mission to encourage further innovation as well as improvement and diversification of services," as a nonprofit mutual holding company system subject to the conditions and limitations set forth in Chapter 145; and

WHEREAS, Chapter 145 requires that any nonprofit mutual holding company formed pursuant to Chapter 145 retain its mission as a charitable and benevolent institution and not convert to a for-profit stock holding company or a domestic stock insurer or otherwise materially change its reorganized corporate form; and

WHEREAS, the Attorney General has confirmed that any nonprofit mutual holding company formed pursuant to Chapter 145 remains subject to the Attorney General's statutory and common law oversight as protector, supervisor, and enforcer of charitable trusts and charitable corporations. (1-2a) (emphasis added).

Chapter 145: Legal Requirements for the Plan

N.J.S.A. 17:48E-46.5(a) permits a health services corporation (Horizon) to submit an application to the Commissioner to form a MHC system. That provision requires certain corporate acts and the submission of specified information therein, including the information required pursuant to N.J.S.A. 17:48E-46(2)(a)(5) requiring direct notice to policyholders to enable their participation in the hearings.

Chapter 145: Legal Requirements for Approval

Chapter 145 states, in relevant part:

The commissioner shall hold three public hearings on the plan to form a mutual holding company within 90 days after the commissioner

> determines that the filing is complete, with notice provided by publication in a manner satisfactory to the commissioner. The public hearings shall also address the plan of reorganization to the mutual holding company system required by P.L.2020, c.145 (C.17:48E-46.1 et seq.). Consistent with subsection a. of section 3 of P.L.1995, c.196 (C.17:48E-47), the commissioner shall approve a plan of mutualization and reorganization unless the commissioner finds the plan:
>
> (1) is contrary to law;
> (2) would be detrimental to the safety or soundness of the proposed reorganized insurer and insurance company subsidiaries of the proposed mutual holding company; or
> (3) does not benefit the interests of the policyholders of the health service corporation or treats them inequitably.

N.J.S.A. 17:48E-46.5(b) (emphasis added). Moreover, "[a]t the expiration of 30 days after the final public hearing, the commissioner shall approve or disapprove the plan of mutualization and reorganization and shall set forth the decision in writing and shall state the reasons therefore." *Id*.

THE FINAL AGENCY DECISION AND POST-HEARING REPORT

On November 1, 2022, the Commissioner issued her Order approving the Plan, along with the Report containing her requisite "reasons therefore." (1a-26a) With regards to notice, the Report stated: "The Department published advanced notice of the public hearings in seven New Jersey newspapers and thereafter held such public hearings …." (11a). In addition, "HHSI will provide notice to each policyholder within 180 days of approval advising them of the reorganization and eligibility for membership interest in HMH." (13-14a) (emphasis added). Although not in the Order, the Commissioner

subsequently explained in her Order Denying Request for a Stay that N.J.S.A. 17:48E-46(2)(a)(5) requires only post-approval notice about the conversion because she says the word "conversion" implies post-reorganization. (152a-153a). As shown below, this is erroneous since "conversion" is defined as a "process" and her interpretation would defy basic due process principles for the nearly 4 million policyholders directly affected by the Plan.

With regards to the application of the three statutory prongs required for approval, the Order approved the Plan on a different legal standard than that required by Chapter 145. The Order states, in material part:

> WHEREAS, the Department has completed its comprehensive review of the application and supporting documentation submitted by HHSI, as well as the public testimony from the three public hearings, written public comments, the entire record in this proceeding, and analyses thereof by the Consultants, and has determined that the reorganization and mutualization of HHSI, as ordered further herein, is not contrary to law, would not be detrimental to the safety or soundness of the proposed reorganized insurer and insurance company subsidiaries of the proposed mutual holding company, and **is neither contrary to the interests of the policyholders of the health service corporation** nor would it treat them inequitably, consistent with the authority assigned to the Commissioner by N.J.S.A. 17:48E-46.5.
> (3a) (emphasis added).

Although the Commissioner also mechanically referred to the 3 prong legal standard, Subsection 46.5(b), in her Report, she made her statutory interpretation of such prong clear in her Order Denying Request for a Stay:

> Plainly, the statute creates a presumption of approval *unless* the Commissioner finds that the plan does not benefit policyholders'

> interests. This [prong 3] does not require the Commissioner to make an affirmative finding that the reorganization would benefit policyholders' interests, only that the commissioner determine that the reorganization would not be contrary to (i.e., "not benefit") policyholders' interests.

(154a). This distortion of the approval standard, which the Legislature clearly distinguished, *inter alia*, from the "contrary to" standard applicable to prong 1, and which is impermissibly reliant on the preamble, is reversible error.

The Commissioner's reasoning for all three prongs in Chapter 145 are set

forth in the Report at pages 16-18 (24a-26a). As for prong 1, the Commissioner determined that the Plan satisfied this standard because it included the "criteria" required by Chapter 145, her team identified no elements of the Plan that were contrary to law, her Order's conditions along with Attorney General enforcement of charitable laws "ensure" its charitable and benevolent mission will be maintained, and Horizon will continue to adhere to legal requirements that it serve the individual market statewide. (24a-25a). However, because the Commissioner, *inter alia*, misinterpreted crucial statutory protections designed to protect the insurers capitalization levels, and therefore the policyholders, the Plan is contrary to law.

As for prong 2, the Commissioner determined that the Plan was not detrimental to the safety or soundness of the reorganized insurers because she required the insurers to maintain a minimum RBC of 425% backed by the

MHC though a parental guarantee. (25a). However, having expressly declined to scrutinize the investments the MHC would make, the Commissioner fatally failed to establish by substantial evidence that the parental guarantee had any value and thus whether the RBC minimum was sustainable and/or enforceable, particularly given Horizon's weakened capital position and operational losses.

And as for prong 3, (set forth above) the Commissioner, *inter alia*, determined that the Plan would not be contrary to the interests of Horizon's policyholders, which is a lesser standard than that specified by the Legislature, and determined that premiums would not be adversely affected although the record evidence contradicts this.

LEGAL ARGUMENT

The Legislature enacted Chapter 145 to enable Horizon to seek to change "its corporate structure, subject to appropriate standards, oversight, and approval, in order to meet the evolving health care needs of its subscribers, while continuing its statutory mission, and maintaining its status as a charitable and benevolent institution." N.J.S.A. 17:48E-46.1(a) (emphasis added). As such, the Legislature required the Commissioner to make factual findings supported by substantial evidence in the record as to any actual plan. The Plan was to be approved unless it is "contrary to law, "detrimental to the safety or soundness of the proposed reorganized insurer[s]," or "does not

benefit the interests of the policyholders of the [HSC] or treats them inequitably." N.J.S.A. 17:48E-46.5(b). Lacking legal basis and substantial evidence as to each legal prong, the Order must be reversed.

I. UNDER THE JUDICIAL STANDARD OF REVIEW, THE COMMISSIONER'S ORDER MUST BE REVERSED AS CONTRARY TO THE LAW AND NOT SUPPORTED BY SUBSTANTIAL EVIDENCE IN THE RECORD. (1a-26a)

An agency's determination on the merits will be sustained unless there is a clear showing that it is arbitrary, capricious, or unreasonable, or that it lacks substantial credible evidence in the record. In re Reorganization of the Medical Inter-Insurance Exchange of New Jersey, 328 N.J. Super. 344 (App. Div.) *certif. denied* 165 N.J. 530 (2000). An action is plainly unreasonable if it violates "express or implied legislative policies." In re Commissioner's Failure to Adopt 861 CPT Codes, 358 N.J. Super. 135 (App. Div. 2003) (citing Campbell v.

Dep't of Civil Serv., 39 N.J. 556, 562 (1963)) (reversing DOBI decision for defective notice).

Specifically, when this standard is applied to a quasi-judicial decision such as that herein it means: "(1) whether the agency's action violates express or implied legislative policies that is, did the agency follow the law; (2) whether the record contains substantial evidence to support the findings on which the agency based its action; and (3) whether in applying the legislative

policies to the facts, the agency clearly erred in reaching a conclusion that could not reasonably have been made on a showing of the relevant factors." In re Attorney General Law Enforcement Directive Nos. 2020-5 and 2020-6, 246 N.J. 462 (2020) (*citing* In re Proposed Quest Acad. Charter Sch. of Montclair Founders Grp., 16 N.J. 370, 385 (2013)

Though when an agency's decision is based on the agency's interpretation of a statute or its determination of a strictly legal issue, the court is not bound by the agency's interpretation. Mondsini v. Local Fin. Bd., 458 N.J.Super. 290, 297 (App. Div. 2019) (although courts afford deference to an agency's interpretation, court is not bound by its interpretation of a statute or a legal issue).

Statutory interpretation involves the examination of legal issues and is, therefore, a question of law subject to *de novo* review. McGovern v. Rutgers, 211 N.J. 94, 107–08, (2012); Russo v. Bd. of Trs., Police & Firemen's Ret. Sys., 206 N.J. 14, 27 (2011); State v. Gandhi, 201 N.J. 161, 176 (2010); Toll Bros., Inc. v. Twp. of West Windsor, 173 N.J. 502, 549 (2002) ("agency's statutory interpretation is reviewed de novo"); *see also* HIP of New Jersey, Inc. v. Dep't of Banking & Ins., 309 N.J. 538 (App. Div. 1998)(citing Mayflower Securities Co., Inc. v. Bureau of Securities, 64 N.J. 85, 92 (1973) ("An appellate tribunal is, however, in no way bound by the

agency's interpretation of a statute or its determination of a strictly legal issue.").

Administrative interpretation of a statute may be helpful, but it must yield to a contrary legislative intent. *See* St. Peter's Univ. Hosp. v. Lacy, 185 N.J. 1, 27 (2005) ("Despite that deference, a rule will be set aside if it is 'inconsistent with the statute it purports to interpret.'" (citations omitted)); Airwork Serv. Div. v. Director, Div. of Taxation, 97 N.J. 290, 296, (1984), *cert. denied*, 471 U.S. 1127, (1985); Matter of November 14, 1989, Non-Group Rate Filing by Blue Cross and Blue Shield of New Jersey, 239 N.J. Super. 434, 452 (App. Div. 1990) ("appellate court is not bound to an agency's interpretation of a statute…"); Friends of the Dinky Woods v. West Windsor, 291 N.J.Super. 325, 332 (Law Div.1996) (administrative usage may be persuasive, but must yield to legislative intent). Based on the above precedent, it is clear that legal interpretations of statutes are properly made by the judiciary, not by the executive branch. AMR Realty Co. v. State Bureau of Securities, 149 N.J. Super. 329, 337, (App.Div.1977).

II. THE COMMISSIONER'S ORDER MUST BE REVERSED BECAUSE IT IS BASED ON A MISINTERPRATION AND MISAPPLICATION OF CHAPTER 145 AND IS CONTRARY TO THE RECORD EVIDENCE. (1a-26a)

Appellants address issues in the following order: the material deficiency and corruption of notice, prong 3 (N.J.S.A. 17:48E-46.5(b)(3)), prong 1 (N.J.S.A. 17:48E-46.5(b)(1)), and lastly prong 2 (N.J.S.A. 17:48E-46.5(b)(2)).

A. Notice of the Proceedings was Contrary to Law and Treated Policyholders Inequitably.

Chapter 145 provides for both direct notice to "each policyholder" and publication notice to the public; both self-evidently prior to public hearings on the Plan. Specifically, N.J.S.A.17:48E-46.5(a) requires the Plan to include specified information, including all the information enumerated in N.J.S.A. 17:48E-46.[2] That provision, at N.J.S.A. 17:48E-46(2)(a), states in material part: "the plan shall include… (5) a provision that each policyholder shall be notified of the conversion, which notification process shall be approved by the commissioner." (Emphasis added.) Chapter 145, N.J.S.A. 17:48E-46.5(b), further requires the Commissioner to hold three public hearings on the plan after the filing is deemed complete "with notice provided by publication in a manner satisfactory to the commissioner."

[2] N.J.S.A.17:48E-46.5(a) ("In addition to including information required pursuant to… (C. 17:48E-46) for the plan of mutualization, with respect to the formation of a mutual holding company system….")

The Commissioner ordered "publication of advanced notice of the public hearings in seven New Jersey newspapers." (11a). She also approved notice to "each policyholder" pursuant to N.J.S.A. 17:48E-46; however, for dissemination "180 days" after approval of the Plan. (13a) ("HHSI will provide notice to each policyholder within 180 days of approval advising them of the reorganization and eligibility for membership interest in HMH."). The Commissioner explained in a later order that the term "conversion" referenced in N.J.S.A. 17:48E-46(2)(a)(5) implies post-reorganization (152a-153a); however, the only statutory definition of "conversion" that does not repeat the term conversion *as part of the definition* appears in N.J.S.A. 17:48E-49 which defines conversion as a "process."[3] Moreover, the Commissioner's interpretation impermissibly redefines the direct "notification" required for "each policyholder" into a mere after-the-fact update of a major reorganization rather than informing them of a proposed transaction in which they have an interest as to the outcome. Critically, current policyholders needed to know whether they will even be eligible for membership in the new MHC and thus entitled to its associated statutory rights of available and affordable insurance,

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[3] Id. ("Conversion" means the process by which a health service corporation converts to a domestic stock insurer in accordance with the provisions of sections 2 through 14 and section 19 of this act.")

as well as the number of votes they will be given, if any. (*See* discussion Section F, *infra*, regarding these rights.) It is current policyholders that have substantial interests at stake in the proceedings not Horizon's future policyholders long after the reorganization is a *fait accompli*.

Moreover, the Commissioner thus enabled Horizon to send direct notice to only some of its policyholders in order to manufacture testimony in support of its Plan.[4] Horizon's ruse succeeded: the submissions were improperly deemed reflective of actual policyholder sentiment and considered favorably by the Commissioner in approving the Plan.

> During and after the completion of three public hearings, approximately 600 people representing several categories of New Jersey stakeholders offered oral and/or written testimony commenting on HHSI's application. The overwhelming majority of comments were enthusiastically supportive of HHSI's Plan and urged the Commissioner to approve the application…." and "[t]he vast majority of comments were offered by policyholders and

[4] *See* Certification of Laura Waddell. (114a). Horizon sent selective notice to only some policyholders resulting in their submission of two form-letters supporting the reorganization. The first set of 339 letters claimed to be from Horizon members and writing for "members like me." These letters were largly, if not all from Horizon employees, which fact was concealed. Id. at ¶5. A second set of 184 letters was submitted by persons claiming to "enthusiastically support" the reorganization and "[f]or consumers like me, this will mean better, more affordable and more convenient health care." The source was again concealed. Id. at para. 6. Id.; *see also* (257-258a) (exemplars of the two form-letters). The remaining few support letters parrot rote language supplied by Horizon as adapted by its grantees and others. All "testimony" on DOBI's website.

> consumers, **all** of whom emphatically supported the approval of HHSI's application.

(15a) (emphasis added); *see also* Order ("testimony" and "written public comments" considered in approval determination). (3a) In reality, the "comments" of every one of these so-called "policyholders and consumers" were generated by Horizon and consisted largely if not mostly of its own employees.

Because the Legislature prescribed the manner of notice, and also prohibited inequitable treatment of the policyholders, the Commissioner's failed interpretation of the notice requirement, combined with Horizon's affirmative improper acts, renders the proceedings improper. The Order, which relied on the product of those inequitable acts and resulting corrupted proceedings, is contrary to law, arbitrary, capricious and unreasonable, and grounds alone for reversal. The Court should rule in the affirmative on the issues raised in Appellants' Notice of Appeal (62a) at ¶¶ 1(a) - (b).

B. The Commissioner applied the wrong legal standard to prong three, N.J.S.A. 17:48E-46.5(b)(3), rendering the Order contrary to law.

The Commissioner failed to apply the correct legal standard under the third prong of the statute. Specifically, the statute states in relevant part that the Plan shall be approved "unless the commissioner finds the plan … 3) does not benefit the interests of the policyholders of the health service corporation

or treats them inequitably." Instead, the Commissioner found that the Plan "is neither contrary to the interests of the policyholders of the health service corporation nor would it treat them inequitably…." (3a) (emphasis added). It is clear that a "[not] contrary to" standard is a different and lesser standard than does not "benefit", and is more akin to a not detrimental standard.[5] However, the Legislature applied the not detrimental standard to the *second prong* of Section 46.5(b) (the commissioner shall approve the plan unless it "(2) would be detrimental to the safety or soundness of the proposed reorganized insurer(s)…"). And the Legislature expressly applied a "[not] contrary to" standard in the *first prong* (not "contrary to law"). Thus, the Legislature distinguished between three different standards: "[not] contrary to" "detrimental" and "benefit." It was contrary to law for the Commissioner to disregard the difference. *See, e.g.*, Sanchez v. Fitness Factory Edgewater, LLC, 242 N.J. 252, 261 (2020) ("A court's first step in interpreting a statute is to look to "the actual words of the statute, giving them their ordinary and

[5] This erroneous interpretation is also akin to "not prejudicial" or "adversely affect" standards. But the Legislature has demonstrated that it knows how to say these. *See, e.g.,* N.J.S.A. 17:48E-47(3)(a) ("The commissioner shall approve the plan unless he finds the plan:… (3) prejudices the interests of the subscribers of the health service corp."); *see also* N.J.S.A. 17:27A-4(a) (holding company system) ("The commissioner… shall consider whether the transactions… may adversely affect the interests of policyholders"). (All emphasis added.)

commonsense meaning." State v. Gelman, 195 N.J. 475 (2008). "If the plain language leads to a clear and unambiguous result, then the interpretive process should end, without resort to extrinsic sources." State v. D.A., 191 N.J. 158, 164 (2007)").

Although not in her Order or Report, the Commissioner later argued that an actual "benefit the interests of the policyholders" finding was not required for approval because the reorganization Plan had a "presumption" of benefit to policyholders. She based her reasoning on the preamble to Chapter 145 (N.J.S.A. 17:48E-46.1). (153-155a). The Commissioner claims that the preamble justifies her reinterpretation of "benefit" as "[not] contrary to the interests of the policyholders." *Id*. But the Commissioner obviously conflates a generalized potential benefit attributable to the new structure with the requisite showing by substantial evidence that a specific Plan will actually benefit the policyholders (as opposed to not harm them). It is black letter law that a preamble does not override clear statutory language;[6] and in this case, the

[6] *See e.g.*, Blackman v. Iles, 4 N.J. 82 (1950) (preamble is "no part of the act" and will not control the enacting part of the statute in cases where the statute is expressed in clear unambiguous term; preamble may be considered to assist in determining the intention of the law makers only where any doubt arises concerning the construction to be placed upon the enacting part); Calabotta v. Phibro Animal Health Corp ., 460 N.J. Super. 38 (App. Div. 2019) (court may turn to a statute's preamble as an aid in determining legislative intent; to the extent that the preamble is at variance with the clear language of the statute, it must give way); In re Adoption of a Minor Child by J.B., 469 N.J. Super. 576

preamble is simply a declaration of legislative intent that does not set forth directives on how to implement the law. Thus, the preamble in this case is distinct from that in Burnett v. County of Bergen, 198 N.J. 408 (2009) where language in the beginning of the Open Public Records Act focused on the law's implementation, and imposed, inter alia, an obligation on public agencies to protect against disclosure of personal information. The language in Burnett did not offer reasons as to why the Open Public Records Act was adopted or simply state the policy of the act, which are typical of a preamble. Here, Chapter 145's preamble does precisely the latter: it offers reasons why the law was adopted and gives the policy of the act, without any implementation directives. Importantly, the preamble to Chapter 145 clearly states that the actual standards set forth in the statute must be satisfied.

Because words are to be given their normal meaning, and agency decisions must be supported by substantial evidence, the Commissioner's admitted failure to find an actual benefit from this speculative and risky reorganization – which was approved when Horizon is experiencing adverse

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(Ch. Div., 2020) (only when faced with uncertainty, the directive to construe statute liberally in favor of the best interests of the child found in the preamble to be heeded); Berkley Condominium Asso. v. Berkley Condominium Residences, Inc., 185 N.J. Super. 313 (Ch. Div. 1982) (*in the absence of standards* with respect to what constitutes evidence sufficient to overcome the presumption of unconscionability, the preamble may be resorted to in order to understand what the legislature intended).

financial results (as discussed in Section E *infra*.) in comparison to December 2020 when Chapter 145 was adopted – means that her Order should be found contrary to law and arbitrary, capricious and unreasonable. Therefore, the Court should rule in the affirmative on the issues raised in the Notice of Appeal at ¶ 1(c). (62a)

C. The Order fails to establish by substantial evidence that the Plan meets the actual "benefit the interests of the policyholders" or does not "treat[] them inequitably" per N.J.S.A. 17:48E-46.5(b)(3).

The Report asserts that the Plan satisfies the third prong of N.J.S.A. 17:48A-46.5(b), but does so impermissibly, including by, among other things, merely parroting the intent of Chapter 145 and describing the structure it permits as if that is a finding in and of itself as to the propriety of Horizon's Plan. As shown below, under this logic any plan would pass statutory muster. The Report first states:

> The Consultants and the Health Impact Study have considered the Plan from a number of perspectives that affect HSC policyholder interests, including, but not limited to, the Plan's impact on: the availability of insurance, the price of insurance, the availability of capital to pay policyholder claims, and the deployment of capital for non-insurance businesses. Based on the entire administrative record, the Consultants concluded that there would not be a basis to determine that the Plan does not benefit the HSC's policyholders or treats them inequitably.

(25a). (Elsewhere, the Report uses the legally incorrect standard of "does not disadvantage or inequitably treat" the policyholders. (22a) Following the block

quote above, the Report then offers three rationales for its conclusion, none of which pass legal muster.

First Rationale: The Report states: "First, the Conditions [in the Plan] reinforce the statutory requirement that HHSI, both in its current form and as the reorganized insurer, is obligated to offer the individual market coverage in every county in the state." (25-26a) But this merely applies the improper "[not] contrary to the interests of the policyholders" standard given that continuing to provide individual coverage is not a change and, in any event, is a function of law, not the Plan.[7]

Second Rationale: The Report states: "[T]he Plan contains no provisions that lead the Consultants to believe the Plan would cause premiums to increase and, in the distant future, lower premium-tax costs could result in premiums being lower than they otherwise would be." (26a)

Not only is this conclusion vague ("contains no provisions that lead…"), but it does not purport to find an affirmative benefit for policyholders; at best, it preserves the status quo. It is the opposite of a clear articulation that satisfies the substantial evidence rule. It only posits a speculation that "in the distant future" there may be premium relief and thus is a nullity, as discussed

[7] Under the Commissioner's reasoning, since this provision applies only to the individual market, it treats the group market policyholders inequitably, contrary to Section 46.5(b)(3).

infra. Most relevant, the Report expressly fails to conclude or establish through substantial evidence that the Plan will result in lower – let alone stable – premiums in the next 1, 3, 5 or even 10 years (versus the status quo) which would actually benefit the interests of the policyholders and be consistent with mission ensuring the provision of "affordable" insurance. Because the Commissioner applied the wrong "[not] contrary to" standard, her Order is contrary to law. The Report is also silent as to whether the Plan treats policyholders inequitably as to premiums and is therefore unsupported by substantial evidence and arbitrary, capricious and unreasonable for that reason as well.

The Report offers, at best, a vague speculative benefit of lower premiums that may perhaps occur sometime "in the distant future [due to] lower premium-tax costs." (26a). In this regard, the Report relies on two important facts that undermine the Order: (1) That there is a direct causal link between higher taxes leading to higher premiums, and the corollary, that lower taxes mean lower premiums. In fact, this is the position taken repeatedly by Horizon's sole testifying officer. *See* (187a) (Horizon is subject to "a special premium tax rate that is higher than any other insurer that increases the cost of premium for our members."); (190a) ("First, the reorganization will reduce the disproportionate tax burden felt by our members by reducing the premium

tax.");[8] and (2) The Report's speculation that a potential for lower premiums exists "in the distant future" acknowledges that following the reorganization there will be no tax-cost savings in the foreseeable future because the reorganized entity will be subject to the initial $600 million tax assessment, first-year special tax of $100 million, and subsequent annual special taxes totaling another $550 million per N.J.S.A. 17:48E-46.13 (due over 17 to 25 years[9]). The insurers must also give up the $300 million they are transferring to the MHC. Given that Horizon paid $68 million in premium taxes in 2021, the $600 million tax assessment alone represents a nearly 9-fold increase in taxes in year one of the reorganization.

Based on the evidence in the record, the Plan instead portends higher premiums for policyholders, at least over the next 10 years.[10] Horizon will suffer a the above-described capital outflow of over $1 billion: over 30% of its

[8] (36a) Health Impact Study at 10 ("Horizon noted in its testimony that… higher taxes currently raise premiums").

[9] Because Horizon's premiums total over $13.5 billion (2021), the tax assessments are capped at the maximum annual levels set forth in N.J.S.A. 17:48E-46.13.

[10] Although Horizon's state annual premium taxes will decline by 7/8^{ths} due to the reorganization (*e.g.*, based on 2021 taxes, declining from $68 million to $8.6 million), those reductions will not offset the special $600 million initial tax assessment, and other annual tax assessments, for over a decade.

capital based on its 2021 financials in the record.[11] This loss of capital is occurring at a time when Horizon had significant net losses in 2022 "estimated at $50 million" by S&P Global, as well as "material unrealized investment losses." (179a) Perhaps even worse, as shown further below, the primary health insurer which issues the medical and hospital insurance policies (*i.e.*, "reorganized HHSI"), incurred a $670 million underwriting loss in 2021 alone, and annual underwriting losses the last six years, totaling $1.32 billion. *See* Section E, Chart 4, *infra*.

As a consequence of the above capital and financial losses, Horizon will face immediate pressure to raise significant new capital, the principal source for which is policyholder premiums. (Premiums represented 99.97% of its $13,763,295,809 in revenues in 2021, per Horizon's 2001 Annual Statement. (197a) And, yet, the Commissioner's Order does nothing to assess or prevent this adverse impact on the policyholders. Incredibly, Horizon's counter-factual claims form the basis of her Order ("The Consultants observed that [confidential] financial projections attached to the application indicate that HHSI does not intend to fund the initial $600 million state assessment through premium increases.") (21a). But this ignores the $400 million in capital being removed from the health insurers (*i.e.*, $300 million transfer and $100 million

[11] $1,000,000,000 divided by total adjusted capital of $3,133,240,870 (capital

first-year special tax), but also all other evidence to the contrary, including the company's impaired capital position due to material realized and unrealized losses. And, it ignores Horizon's repeated testimony in the public hearings that higher taxes raise policyholders' premiums. The $1 billion in taxes (including the capital transfer) on its books in a one-year period amounts to a whopping tax increase by any measure.

Despite this, the Commissioner reasoned: "A reasonable assumption is that the premium rates will not be significantly impacted by the changes in the premium taxes and new assessments since they do not significantly impact Horizon's economic position…." (21a-22a). The record evidence clearly undercuts this assumption. Therefore, because the Order is unsupported by – and in fact contradicted by – substantial evidence in the record, it fails to satisfy N.J.S.A. 17:48E-46.5(b)(3) and is thus arbitrary, capricious and unreasonable.[12]

Third Rationale: This rationale has three parts. The Report states that by limiting the upstreaming of dividends from the reorganized insurers to the

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shown in Section E, i*nfra*, at Chart 1 (Row 3, Column G for 2021).

[12] The Commissioner also fails to acknowledge what one of her own consultants admitted: namely, that DOBI "lacks the statutory authority that most other state insurance departments have to regulate rates." (43a). As a consequence, rate regulation that might otherwise temper premium increases is not an available tool.

MHC, and setting a minimum health RBC of 425% in the insurers (above the new statutory minimum RBC of 200%), these conditions ensure that the insurers will have sufficient capital to provide policyholder benefits,[13] "while giving the MHC sufficient capital and flexibility to pursue efforts to **better achieve** its charitable and benevolent mission."[14] (Emphasis added.) But, because this deprives the health insurers of capital needed to provide these policyholder benefits, the claim that the Plan will help Horizon "better achieve" its mission lacks substantial evidence.

Sub-point 1 (limits on upstream dividends to the MHC).[15] This limitation does not benefit policyholder interests over the current structure.

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[13] The term "benefits" in this context means "to pay policyholder claims and honor all other obligations to policyholders," per the Health Impact Study at 22. (48a)

[14] The Report states in full: "Third, by limiting the distributions that may be made from the regulated insurance company subsidiaries to the MHC and by requiring minimum RBCs for the major insurance subsidiaries well in excess of statutory minima, the Conditions ensure sufficient capital will be available to provide benefits to policyholders through the regulated insurance company subsidiaries, while giving the MHC sufficient capital and flexibility to pursue efforts to <u>better achieve</u> its charitable and benevolent mission." (26a) (emphasis added).

[15] *See* (22-23a); Order Conditions 3, 7, 11 (4-6a)) The Order imposes a three-year moratorium on upstreaming dividends (after initial $300 million); requires a minimum RBC of 425% in each insurer (backed by parental guarantee, which only if enforced by the insurers and backed with sufficient capital counter any up-streamed dividend below that level in the future); and Chapter 145 prohibits up-streamed dividends of the system-wide health RBC if

Rather it is a limitation that is necessitated by the reorganization which, for the first time, allows the parent health insurer to upstream its profits away from its insurance operations, and the incumbent risk that too much capital could be removed.

Sub-point 2 (minimum 425% RBC required for each reorganized insurer, purportedly well above new RBC "minima" of 200%). For similar reasons, this condition also does not benefit the interests of the policyholders compared to the status quo. Pre-reorganization Horizon was subject to a much higher statutory minimum RBC of 550% per N.J.S.A. 17:48E-17.3. Similarly, the policyholders currently benefit from an RBC maximum of 725% above which Horizon must return surplus capital to "benefit" its policyholders, including though lower premiums. *Id.* It is not a "benefit" to adopt a Plan that lowers the minimum RBC requirement by 125%, and then claim that the newly established 425% limit is "well in excess of the statutory minima" of the newly applicable 200% RBC. Such claim is clearly misleading given the current higher RBC threshold of 550%. In addition, because the Plan results in the elimination of the maximum 725% RBC with its associated financial benefit to policyholders, it faces an additional bar to establishing that the reorganization

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it is below 550% (calculated assuming payment of the annual tax assessment) per N.J.S.A. 17:48E-46.13(c). The proper statutory interpretation of the 550% limit is in dispute as discussed below. *See* Section D, *infra*.

actually "benefits" those policyholders. This is a detrimental change that goes addressed by the Commissioner.

The Order's rationale also ignores the fact that the Commissioner's regulatory authority to control the reorganized insurers to take direct action is limited, being triggered far below the 425% minimum touted in her order only when the RBC drops to 70% of the action level,[16] or below 100% RBC (if a Court grants takeover authority after a contested proceeding).[17] Moreover, the Order utterly fails to address the fact that Horizon's most recent RBC is 628% (2021) and averaged 660% over the last five years.[18] This is material given that, following the payment and transfer of the initial $900 million in capital, Horizon's combined insurance RBC will drop to 448% based on its 2021

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[16] The RBC ratio is a regulatory tool designed by the National Association of Insurance Commissioners ("NAIC") to identify weakly capitalized companies to help ensure that an insurance company can fulfill its financial obligations to policyholders. *See* NAIC RBC Topics (240a) RBC is the ratio of total adjusted capital ("TAC") to the Authorized Control Level ("ACL"). *Id*. Generally speaking, if the RBC Ratio is above 200% no other steps are required. *Id*. If it falls below 100%, the regulator can seek to take over management and a take-over is required for RBC ratios below 70%. *Id*. *See also* N.J. Admin. Code § 11:2-39A.2 (setting for these RBC levels and related regulatory authorizations).

[17] *See* N.J.A.C. 11:2-39A.6 (Authorized Control Level event and authority to act).

[18] *See* Section E, Chart 1, *infra*. (Row 7, Column G for 2021).

annual statements.[19] The parent insurer will drop to a 405% RBC. *See* Section E, Chart 2, *infra*. These decreases, which result directly from the reorganization, are a significant drop from current capitalization levels and thus detrimental to policyholders' interests. The Order does nothing to counter such negative impacts.

Sub-point 3 ("while giving the MHC sufficient capital and flexibility to pursue efforts to better achieve its charitable and benevolent mission."). This last clause is generic and merely a restatement of the Legislative intent articulated in Chapter 145. It does not establish by substantial evidence that this is or will be true. And, as stated in the Report at 15:

> The Consultants concluded that HHSI's decision to not specify how and when HMH would deploy the $300 million distribution to benefit the interests of policyholders is not a sufficient basis upon which to conclude that approval of HHSI's application does not benefit the interests of policyholders. Given the conditions above [dividend restraints; 425% RBC], the reorganized insurer and other insurance subsidiaries would remain sufficiently capitalized while enabling HMH [the MHC] to determine optimal investments for its charitable and benevolent mission consistent with the legislative intent of Chapter 145. (23a)

Therefore, rather than determine that the Plan actually benefits the interests of the policyholders and will not treat them inequitably, the Report relies on generalized banal statements in the Plan regarding "areas in which the MHC expects to make substantial future investments following approval" and

[19] *See* Section E, Chart 1, *infra*. (Row 22, Column G for 2021).

"initiatives" that the Plan "explains the basis for targeting these areas of investments." (18a) (emphasis added). However, the Order and Report contain no analysis whatsoever as to the specifics of whether or how the $300 million will actually be used in these "areas" or how the general "initiatives" will actually benefit the interests of the policyholders or, importantly, ensure that the policyholders are not treated "inequitably." Nor did the Commissioner conduct the most fundamental analysis required to determine whether these "areas" or "initiatives" are already achievable under its current structure, *ergo*, without the expense and risks engendered by the reorganization. In fact, the Commissioner determined this analysis unnecessary:

> Moreover, Chapter 145 does not require HHSI to commit to specific future investments of any kind, nor does it require HHSI to demonstrate how any proposed investments would differ in kind or quantity from those made by HHSI in its current corporate form. (18a)

But this is obviously contrary to the legislative intent imbedded in Chapter 145. That is, if most or all of the potential (yet undisclosed) investments may currently be available for Horizon to make, without undergoing the proposed reorganization, then the very justification for this reorganization does not exist. Without substantial evidence as to the investments, which the Commissioner has ruled is not relevant to her review under the statute, the policyholders and this Court are left with an unsupported hypothetical claim as

to their impact on policyholders' interests.[20] And, again, there is no specific finding that the policyholders will not be treated inequitably due to the investments to be made.

In short, the Order merely parrots the intent of Chapter 145 and the structure it affords as if that were sufficient to justify approval of the Plan. *See* Wenzel v. Board of Review Dept. of Labor, 2014 WL 8104824, *4 (NJ Sup. App. 2014) ("It is not enough to provide factual conclusions that merely reiterate governing law and do not disclose their basis in the record.") (262a) Unsupported by facts in contrast to empty shibboleths about potential investments, the Order is arbitrary, capricious and unreasonable.

Moreover, even assuming the MHC were to reveal its actual investments and could establish that these were unavailable to it in its non-MHC corporate form, the MHC is designed to invest in riskier investments than currently permitted by law. If these investments result in losses, then the MHC may not be able to honor the "parental guarantee" to the reorganized insurers, even if it

[20] In a parallel context, the Report admits that the transfer of funds from the insurers (in that case unlimited future dividends) "without sufficient controls and oversight by the Department could result in the reallocation of insurer resources for undefined purposes when such funds, if left in the insurer, would be used to pay claims and provide benefits to policyholders." (22a) The approved $300 million upstream of capital is being done "without sufficient controls and oversight" and is precisely such a "reallocation from insurer resources for undefined purposes" that would otherwise be used to pay policyholder benefits.

wanted to. Therefore, without having evaluated the investments intended to be made upon reorganization, the parental guarantee upon which the Order relies to bolster the minimum 425% RBC is of unknown, speculative value.[21]

Furthermore, the Commissioner will lack future authority over the MHC's investments, as admitted by DOBI's consultant, Manatt Health, making her failure to scrutinize the investments particularly glaring:

> It will take ongoing and enhanced monitoring by the Department to ensure that Horizon continues to honor its statutory mission. [Once reorganized] [t]he Department does not have authority to order or prohibit specific investments…

(47a) (emphasis added). While Manatt also conjectured that other pressures could be brought to bear to influence those investments, such as denying dividends to the MHC – which "extralegal" tactics are highly contestable – the fact remains that now, pre-reorganization, is the time the initial investments can and must be scrutinized to determine whether the Plan actually benefits the interests of policyholders or treats them inequitably. The Order utterly fails to do so.

Lastly, with regards to assets held by the MHC, in the event of its bankruptcy, the policyholders lose their priority (over other creditors) as to

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[21] The Order also relies on the parental guarantee to support the determination that the Plan would not be detrimental to the safety or soundness of the insurers, thus rendering that finding infirm, as discussed in Section E, *infra.*

those assets for payment of insurance claims. Such a priority only applies to insurance companies, which the MHC is not. *See* N.J.S.A. 17:48E-46.3(d). For a discussion of this MHC bankruptcy issue *see* The Feeling's Not Mutual, NY State Assembly Insurance Committee, (Section "Regulatory and Legal Issues.") (251a). Nothing in the Order addresses or ameliorates this harm. Therefore, the Court should rule in the affirmative on the issues raised in the Notice of Appeal at ¶¶ 1(d) - (k). (62-63a) Each and every one of these material failings is an independent basis for overturning the Order.

D. The Order fails to establish by substantial evidence that the Plan is not "contrary to law" per N.J.S.A. 17:48E-46.5(b)(1).

An additional issue for adjudication in this appeal concerns whether or not the Commissioner impermissibly applied the RBC level set forth in Chapter 145 to the MHC. Chapter 145, N.J.S.A. 17:48E-46.13(c), sets a "system-wide **health** RBC" (bold added) target of 550%. If this "system-wide health RBC" falls below 550%, then two financial protections are triggered under Subsection 46.13(c). First, the special annual tax assessments, which are based on the health insurance companies' earned premiums for the prior year, are deferred until the capitalization level of 550% is reestablished. Second, no upstream dividends or distributions may be made to the MHC from

these same health insurers so long as the tax assessments are deferred due to the under-capitalization.[22]

Based on the statutory focus on the health insurers, Appellants contend that the "system-wide health RBC" capitalization level must apply to the combined reorganized **health** insurance companies to ensure that they are adequately capitalized for their policyholders, prior to the payment of the special tax to the State or dividends to the MHC.[23] As for the MHC,

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[22] N.J.S.A. 17:48E-46.13(c) ("The mutual holding company shall not pay any portion of the annual assessment for a given calendar year if the mutual holding company's system-wide **health** risk-based capital authorized control level would fall below 550 percent based on the standards for risk based capital for health organizations as adopted by the National Association of Insurance Commissioners following the payment as applied against the prior calendar year's risk based capital, or if in the opinion of any nationally recognized statistical rating organization, the group credit rating of the mutual holding company would not be considered investment grade. The commissioner shall determine that the mutual holding company's system-wide health risk-based capital authorized control level would fall below 550 percent before payments shall be deferred pursuant to this subsection and paragraph (1) of subsection d. of this section. Neither the insurance company subsidiaries nor the reorganized insurer shall make dividends or distributions to the mutual holding company or any subsidiaries thereof until such time as the annual assessment deferred pursuant to paragraph (1) of subsection d. of this section is satisfied.") (Emphasis added); *see also* N.J.S.A. 17:48E-46.13(d) (1) (annual assessments not paid pursuant to subsection c. shall be deferred to the next calendar year, no two annual assessments will be due in the same year, and deferred assessment not due until deferral date).

[23] In construing any statute, the court must give words "their ordinary meaning and significance," recognizing that generally the statutory language is "the best indicator of [the Legislature's] intent." DiProspero v. Penn, 183 *N.J.* 477, 492, (2005); Sanchez v. Fitness Factory Edgewater, LLC, 242 N.J. 252, 261 (2020)

Subsection 46.13(c) protects it by precluding payment of the tax assessments unless a nationally recognized statistical rating organization deems the MHC's "group credit rating" to be at investment grade as to its holdings. Thus, while the first combination of provisions protect the health insurers' capitalization (their *investments* are already strictly regulated), the second ensures that the MHC itself has an investment grade rating (important because, as a non-insurer, the MHC is expressly excluded from the investment standards applicable to insurers per N.J.S.A. 17:48E-46.3(d).

Conversely, and curiously, the Commissioner contends that the "system-wide **health** RBC" of 550% applies to the MHC and all of its assets (including non-health or non-insurance operations), thereby impermissibly reading the word "health" out of the statute.[24] *See, e.g.*, Sanchez v. Fitness Factory

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("ordinary and commonsense meaning"); *see also N.J.S.A.* 1:1-1 (stating that customarily "words and phrases shall be read and construed with their context, and shall ... be given their generally accepted meaning"). Each statutory provision must be viewed "in relation to other constituent parts [not in isolation] so that a sensible meaning may be given to the whole of the legislative scheme." Wilson ex rel. Manzano v. City of Jersey City, 209 N.J. 558 (2012)(citing Kimmelman v. Henkels & McCoy, Inc., 108 N.J.123, 129 (1987)). Courts will not presume that the Legislature intended a result different from what is indicated by the plain language or add a qualification to a statute that the Legislature chose to omit. Tumpson v. Farina, *supra*, at 467- 468.

[24] The "health" designation is deliberate. *See, e.g.*, NAIC RBC Topics (241a) ("There are now separate RBC formulas for each of the primary insurance lines of business: 1) life and fraternal; 2) P/C; and 3) health. Differences in RBC across lines of business reflect differences in the economic environments

Edgewater, LLC, 242 N.J. 252, 261 (2020). This reading would also eliminate the statutory prohibition on upstreaming dividends if the health insurance companies themselves have a lower capitalization level. That is, under the Commissioner's interpretation of Chapter 145, dividends would not be barred from being extracted from lower-capitalized health insurers (the statutory minimum is 200% for health insurers in New Jersey), whilst the MHC maintains a high RBC (even assuming against reality that it can be calculated). This is illogical because it would prioritize the financial strength of the MHC over that of the health insurers even though the MHC's assets are not available to subsidize premiums nor, as DOBI's consultant acknowledged, available to pay claims.[25]

The Commissioner's disassociation of the 550% RBC from the health insurers thus turns Subsection 46.13(c) on its head. It also violates the express prohibition against subjecting the MHC to capital or surplus requirements. N.J.S.A. 17:48E-46.4(c) states:

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facing these companies. Although the components in the RBC calculation differ across lines of business, the formulation is roughly the same."); *see also* N.J. Admin. Code § 11:2-39.2 (RBC regulations for non-health insurers); *with* N.J. Admin. Code § 11:2-39A.2 (RBC regulations for health insurers).

[25] *See* Health Impact Study at 22 (48a) ("requiring that there is sufficient capital in the regulated insurers to pay policyholder claims and honor all other obligations to policyholders.") (Emphasis added.)

> The mutual holding company and each of its non-insurance subsidiaries, other than the reorganized insurer and any insurance company subsidiaries, shall not be: (1) an insurer and therefore shall not be subject to… **any capital or surplus requirements**." (Emphasis added.)

This prohibition is reinforced by N.J.S.A. 17:48E-46.3(d) which states in part:

> … for the avoidance of doubt, the [MHC] shall be expressly excluded from insurance operations and reporting, investment limits, and risk-bearing provisions of P.L.1985, c. 236 (C. 17:48E-1 et seq.), including the following provisions because a mutual holding company is not a risk bearer: … (3) … (C. 17:48E-17.3).

Id. (Emphasis added.) The excluded provision cited above, N.J.S.A. 17:48E-17.3, is that which sets Horizon's current statutory RBC levels (at between a minimum of 550% and maximum of 725%) and makes Horizon subject to annual scrutiny and enforcement by the Commissioner based on its reported RBCs, **all of which the MHC is expressly exempted from per N.J.S.A. 17:48E-46.3(d).**

It is therefore contrary to logic and basic principles of statutory interpretation to interpret the "system-wide **health** RBC" of 550% per Subsection 46.13(c) as nonetheless applicable to the MHC itself plus its non-health operations. *See* Matter of DiGuglielmo, __N.J.__, 2022 WL 17246816 (2022) (N.J. Courts strive "for an interpretation that gives effect to all of the statutory provisions and does not render any language inoperative, superfluous, void[,] or insignificant;" and "Statutes must 'be read in their

entirety; each part or section should be construed in connection with every other part or section to provide a harmonious whole.'") (citations omitted).[26]

Tellingly, the Order specifies that the "system-wide health RBC shall be calculated using the NAIC Risk-Based Capital for Health Organizations methods and instructions" (Order, Condition 5, 4a), attempting to be consistent with Subsection 46.13(c) ("the mutual holding company's system-wide **health** risk-based capital authorized control level… based on the standards for risk-based capital for health organizations as adopted by the National Association of Insurance Commissioners"). But these NAIC methods and instructions apply only to insurers and thus are not applicable to the Commissioner's group-wide MHC RBC interpretation of the statute.[27] The New Jersey RBC regulations are similarly inapplicable because the MHC is not a "health organization."[28] Thus, consistent with Appellants' view, the NAIC manual and

[26] *See also* Matter of Commitment of W.W., 245 N.J. 438 (2021) (same); Hubbard v. Reed, 168 N.J. 387, 392-93 (2001) (same).

[27] The RBC calculations defined by the NAIC "determine the minimum amount of capital required for an insurer to support its operations and write coverage" and apply only to insurers. *See* NAIC RBC Topics (240a); *Compare* N.J.S.A. 17:48E-46.3(d) ("[MHC] shall be expressly excluded from insurance operations").

[28] Per N.J.A.C. 11:2-39A.2 health RBC calculations apply only to "health organizations" which are defined as health maintenance organizations, hospital service corporations, medical service corporations, dental service corporations, dental plan organizations, health service corporations, prepaid prescription

instructions apply to the health insurers as reflected in all statutory language, including Subsection 46.13(c).[29]

For all these reasons, the Order is directly contrary to the enabling statute and thus arbitrary, capricious and unreasonable. *See, e.g.,* McClain v. Bd. of Review, Dep't of Labor, supra, 237 N.J. at 445 (court not bound by legislative interpretation of agency especially when unreasonable or mistaken); McGovern v. Rutgers, *supra*, 211 N.J. at 107-8 (statutory interpretation involves the examination of legal issues and is, therefore, a question of law subject to *de novo* review).

E. The Order fails to establish by substantial evidence that the Plan "would [not] be detrimental to the safety or soundness of the proposed reorganized insurer(s)" per N.J.S.A 17:48E-46.5(b)(2).

While the Order at least applies the correct legal standard to the second prong of the statutory standard, it too falls far short of being supported by substantial evidence in the record. The Report provides a single basis to

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services organizations, and licensed organized delivery systems. The MHC is not a "health organization" per Chapter 145, so the regulations are inapplicable.

[29] The NAIC manual and instructions consist of the NAIC Risk-Based Capital 2019 Health Forecasting & Instructions. These apply only to health insurers. *See, e.g.* Manual at p. ii (247a) ("The NAIC Health RBC Report has been developed for companies who file the NAIC Health annual statement"). The 2022 version of the NAIC's Risk-Based Capital Instructions are protected behind a pay-wall, but contain the same relevant language as in 2019. (Available on NAIC website.)

conclude that the Plan would not be detrimental to the safety or soundness of the reorganized insurers: that each insurer will be required to maintain a minimum RBC of 425%, backed by a parental guarantee from the MHC to maintain that level.[30] As shown below, the Order lacks substantial evidence to justify its "not detrimental" finding.

As a preliminary matter, the Order ignores the elephant in the room: the clear detriment to Horizon's financial soundness resulting from the reorganization, which is occurring at the same time the company is suffering material operational and market losses. The resulting "weakening capital" and "expected 20%-25% decline in Horizon's capital base at year-end 2022" (according to S&P Global's December 1, 2022 report) are material by any measure. (179a) The special tax payments of $700 million accruing in 2022 and 2023 alone, on capital of only $3.1 billion, plus $300 million transfer to the MHC, happening at the same time as Horizon's "ongoing pressures from constrained profitability," *id*., are self-evidently detrimental to the safety and soundness of the reorganized health insurers. Presumably, this is no surprise to

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[30] (25a) ("… the Conditions ensure that the reorganized insurer and the two other major insurance company subsidiaries of the MHC will maintain RBC levels at least at 425%.... "In addition, the Department is imposing a requirement that HMH [the MHC] provide a parental guarantee to its insurance company subsidiaries to ensure they are able to maintain these RBC levels.")

the Commissioner, who must have had access to the same (if not more) financial data as S&P Global, which issued its outlook 30 days after the Order. *Id.* Her RBC minimum and parental guarantee fail to materially alter this detriment, including as demonstrated by the S&P Global negative outlook. The Order as to prong 2 also lacks substantial evidence for the following additional reasons:

First, the Commissioner admitted that she did not scrutinize, assess or otherwise value the MHC's intended investments or the incumbent risks associated with those investments. Therefore, she failed to determine if those investments would be available, sufficient or liquid enough to maintain a 425% RBC in the insurers now or in the future. These failings are fundamental because they render the assets purportedly backing the parental guarantee of only unsubstantiated, nebulous value. For the guarantee to actually "ensure [the insurance subsidiaries] are able to maintain these RBC levels," as the Report contends, the investments had to have been scrutinized.[31]

[31] Moreover, not only was the parental guarantee not required to be executed until 90 days after the approval (6a), there is not even a draft of the guarantee in the record. *See* Statement of Record (Items). In this way, the Order is also defective. In addition, the guarantee is not directly enforceable by the Commissioner based on the Order's language which merely provides for "a parental guarantee… from HMH [the MHC] to the regulated entities" to maintain a minimum RBC of 425% each (excepting HHD which is 200%). Condition 11 (6a) Omission of enforcement authority by DOBI further impairs the parental guarantee.

Second, the Commissioner misuses the RBC as a measure of financial strength in her Order contrary to law. The RBC is not a magic bullet. The creation and determination of RBC ratios is done according to rules set the National Association of Insurance Commissioners ("NAIC"). Per the NAIC:

> The RBC requirement is a statutory minimum level of capital that is based on two factors: 1) an insurance company's size; and 2) the inherent riskiness of its financial assets and operations. That is, the company must hold capital in proportion to its risk. RBC is intended to be a regulatory standard and not necessarily the full amount of capital that an insurer would need to hold to meet its objectives.
>
> The purpose of RBC requirements is to identify weakly capitalized companies, which facilitates regulatory actions to ensure policyholders will receive the benefits promised without relying on a guaranty association or taxpayer funds. In essence, the RBC formula calculations are critical thresholds that enable timely regulatory intervention. RBC requirements are not designed to be used as a stand-alone tool in determining financial solvency. Rather, RBC is one of the tools that gives regulators legal authority to take control of an insurance company.

NAIC RBC Topics (240a) (emphasis added). The NAIC RBC calculation formula is codified in the NAIC's Risk-Based Capital (RBC) For Insurers Model Act, and codified in N.J. by regulation N.J.A.C. 11:2-39A *et seq.* The regulation provides in pertinent part:

> The comparison of a health organization's total adjusted capital to any of its RBC levels is a regulatory tool that may indicate the need for corrective action with respect to the health organization, and is not intended as a means to rank health organizations generally.

N.J.A.C. 11:2-39A.10(e) (emphasis added). Thus, the Order's finding under prong 2 is predicated on the 425% RBC ratio which does not establish that Horizon will have "the full amount of capital that an insurer would need to hold to meet its objectives." *See* NAIC RBC Topics (240a) (emphasis added). The RBC is merely one tool to indicate whether an insurer is weakly capitalized, and not a metric to rank the overall health of the organization. N.J.A.C. 11:2-39A.10(e). Yet, the Report relies explicitly on the Order's 425% RBC requirement to conclude that the insurers will be "amply capitalized" and "sufficiently capitalized." (23a).

This misuse is indicative of why RBC ratios are not generally suited to establish that a plan would not be detrimental to the safety or soundness of the insurers. However, in the context of the Legislative intent that Horizon pay $1.25 billion in special tax assessments over 17 years – the statute explicitly requires a system-wide health RBC of 550%. But the Order does nothing to secure a system-wide **health** RBC of 550% which, if RBCs were to be considered a measure of soundness, is the level that the Legislature deemed made the insurers safe and sound. In this way, the Order is not only contrary to Chapter 145, but fails to provide a sufficient rationale under the prong 2 statutory approval standard. Given the express limitations of the RBC ratio,

which are fatal to the Commissioner's reasoning the Order is unsupported by substantial evidence.

Third, the Order fails to reconcile Horizon's low RBCs following the removal of so much capital under the Plan. Based on its most recent five-year financials, Horizon could not have transferred $900 million in surplus in any of those years without its system-wide health RBC (applied to combined health insurers) dropping materially below 550% as shown in Chart 1 (Row 22) contained in Appellants' Appendix. (266a)

Per Chart 1, the bottom line is that the transfer of $300 million to the MHC, on top of paying the initial taxes, is too much since it would render Horizon's system-wide health RBC well below even 500% in four of the last five years, including 2021. Id. (Row 22). Thus, Horizon would instantly be below the Legislature's deemed level of safety and soundness. Even if just the $600 million tax was paid, irrespective of how the system-wide health RBC was calculated, it would still have been below 550% for 2021 and all other years except 2020. Id. (Row 15). If history is prologue, then 2022 will be no different. (Appellants do not have access to Horizon's quarterly financial data, which is not publicly available[32] and the 2022 annual statements are not reported until March 1, 2023.) In any event, only its 2021 annual statements

[32] *See* N.J.S.A. 17B:21-1.

are in the record (which includes some prior year data). Thus, the record evidence establishes that Horizon's financial condition cannot support a $600 million loss in capital, let alone $900 million at this time. Approval of the Plan under these financial conditions is therefore contrary to Legislative intent and lacks substantial evidence that it would not be detrimental to the safety or soundness of the insurers.

Fourth, the Order fails to reconcile reorganized HHSI's low RBCs following the removal of its subsidiaries with its finding under prong 2. Under the Plan, based on Horizon's financial statements, HHSI (the flagship parent health insurer) as a stand-alone insurer can be expected to fall immediately below a 425% RBC. (Appellants, NJCA and HPAE, and the vast majority of employer-sponsored health plans are policyholders of parent insurer HHSI, as are those in the individual market.) This assessment is based on HHSI's most recent 628% RBC ratio (200a), the calculation of which includes the capital held by its insurance subsidiaries. Under the Plan, all of the insurers will instead be separated and report directly to an intermediate holding company of the MHC.[33] As a result, $1.27 billion of surplus will be removed from HHSI upon reorganization, thereby reducing its RBC to 405% calculated even before

[33] *Compare* current versus proposed organizational charts. (236-239a)

the payment of any tax assessments as shown in Chart 2, based on its 2021 annual statements. (266a)

At a 405% RBC, HHSI will be below the 425% threshold established in the Order at the outset. The loss of $1.27 billion in capital would also reduce HHSI's future investment income on assets.

To increase its RBC, it is uncontroversial that HHSI (stand-alone) could offset some of its risk by adjusting to more conservative investments or by reducing writing future business. But the former is counter to what the Plan is all about, and the latter would undermine Horizon's mission to make insurance more available. Alternatively, Horizon could raise premiums to re-build surplus, but this would undermine its affordability mission (and cannot be factored in by DOBI on this point because the Order concluded (wrongly) that premiums would not be increased as a result of the Plan.

Fifth, the Order also fails to reconcile Horizon's significant underwriting losses with the safety and soundness requirement under prong 2. The above facts leave HHSI in a difficult position. In four of the last five years, Horizon (including its insurance subsidiaries) suffered underwriting losses, meaning that its medical/hospital, claims adjustment and administrative expenses exceeded its premium income. As shown in Chart 3, Horizon overall suffered

$430 million in such underwriting losses in 2021 alone, and $654 million in such losses in total the last five years. (267a)

The underwriting losses were even worse for HHSI as a stand-alone insurer (without its insurance subsidiaries). In 2021, these losses were $670 million, and totaled $1.32 billion over the last six years as shown in Chart 4. (267a)

These underwriting losses do not include other losses or other income such as investment income. However, the loss of so much capital will reduce that investment income in the future. *See, e.g.*, Chart 1 (Rows 25 and 31 for historic view of investment income loss). (266a) Given that investment income is expected to increase in the coming years as interest rates rise, and can represent a significant source of revenues, the loss of this income further undermines the Commissioner's safety or soundness determination.

Based on Horizon's financial data in the record as applied to the Plan, the Order is unsupported by substantial evidence in finding that the reorganization would not be detrimental to the safety or soundness of the reorganized insurers. This is particularly true for HHSI as a stand-alone insurer given that its capital will be substantially reduced beyond what its financial condition can support and what Chapter 145 (and even the Order) demand in terms of RBC levels – which is especially problematic because HHSI already

operates with significant underwriting losses. Therefore, the Court should rule in the affirmative on the issues raised in the Notice of Appeal at ¶¶ 1(L) - (o). (63a)

F. The Commissioner Abused her Discretion in Excluding Essential Documents from Public Record, including Bylaws that define who will be a Member Protected by Statutory Mission and Voting Rights.

The Commissioner abused her authority in withholding vital information from the public record concerning the Plan during the public hearing process. Indicative of this overreach, the Commissioner withheld the MHC's proposed bylaws despite their containing foundational information as to who Horizon's mission will actually serve. N.J.S.A. 17:48E-46.3 provides: "The mission of the mutual holding company shall be to: (1) provide affordable and accessible health insurance to its **members**…." According to N.J.S.A. 17:48E-46.2: "'Member' means the holder of a membership interest in a [MHC], pursuant to the articles of incorporation or bylaws of that mutual holding company.") (Emphasis added.)

In turn, the proposed MHC's articles of incorporation, which are in the public record, state that the definition of "members" is per the MHC's **bylaws**.[34]

[34] *See* (172a) ("Articles of Incorporation of Horizon Mutual Holdings, Inc." which state in relevant part: "ARTICLE V MEMBERS Membership in the

Yet the bylaws remain undisclosed. The policyholders had a substantial interest in knowing if they would be members or not under the Plan because N.J.S.A. 17:48E-46.9 gives discretion to Horizon to define eligibility for membership based on the number of in-force policies, amount of premiums, or other "reasonable factors" and may even define members to include "entities holding administrative services agreements with the [MHC]." Id. (emphasis added).[35]

Clearly, Appellants and all current policyholders were entitled to know from the outset who among them – and/or which other entitles, if any – would be become "members" of the MHC entitled to the benefits of its statutorily defined mission by virtue of the bylaws and their voting rights. *See, e.g.*, Delmarmo Associates v. New Jersey Engineering & Supply Co., 177 N.J. Super 15, 17 (1980) (corporate bylaws are a contract between corporation and its stockholders and stockholders are entitled to access the bylaws) (citing Leeds v. Harrison, 7. N.J.Super. 558 (Ch. Div. 1950)). The Commissioner's failure to produce them thus prejudiced the policyholders and delegitimized

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Corporation shall be determined in accordance with the Corporation's Bylaws…" (Emphasis added.)

[35] *See also* N.J.S.A. 17:48E-46.9(b)("Members of a [MHC] shall be entitled to vote for the election of directors of the mutual holding company in accordance with the [MHC's] **bylaws**.") (emphasis added); *see also* N.J.S.A. 17:48E-46.15 (c).

the proceedings. Remarkably, she persists in denying Appellants access to the bylaws, as does Horizon to date.

Withholding the bylaws is indicative of overreach as to public records, which removes any presumption that the Commissioner properly exercised her discretion thereto. Indeed, the public record was meager and insufficient because the Commissioner deemed essential components of the reorganization confidential (*e.g.*, reports and written opinions of the outside legal, actuarial and financial advisors). Even the parental guarantee is missing. Such excessive secrecy burdened Appellants' effort to be heard, and deprived the record of pertinent testimony, thus delegitimizing the hearing process and biasing the Order and findings. The Commissioner must now be limited on appeal to that public record to preclude Appellants from being further prejudiced.

G. Enforcement of the Statutory Approval Standards is Vital to Securing Legislative Intent in Protecting Policyholders, and Preserving Horizon Against Future (Hostile) Acquisitions.

In the Health Impact Study, the consultants concede that while the reorganization "would give Horizon the flexibility to be competitive… perhaps most important, <u>there is one unfavorable scenario – acquisition of Horizon by a for-profit insurer</u>…" (54a) (emphasis added). The consultants then list three provisions that make this scenario "less likely" including "the authority of the

Commissioner to review and disapprove changes in ownership that would be detrimental to policyholders." *Id*. No citation was provided.

It follows that to deter the consultant's feared for-profit-acquisition scenario, and preserve Horizon as a New Jersey charitable institution into the future, the standards for approval set forth by the Legislature must be strictly enforced.

CONCLUSION

Appellants have established that the Commissioner's Order is contrary to law and arbitrary, capricious and unreasonable and should be overturned. It was the product of a truncated and inadequate public process and evident rush to get it done without satisfying the Legislature's clear intent to protect the policyholders, Horizon and the public. This Court must avert the adverse impact from this thinly presented, poorly conceived, and badly timed reorganization Plan that depletes the health insurers of much needed capital and threatens premium hikes that will reduce affordability and availability of health insurance in New Jersey – contrary to Horizon's very mission.

Respectfully Submitted,

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