New Jersey
Appleseed

December 14, 2022

Via Federal Express and E-mail

Commissioner Marlene Caride
New Jersey Department of Banking and Insurance
20 West State Street
PO Box 325
Trenton, New Jersey 08625-0325
commissioner@dobi.nj.gov

Re: In the Matter of Application by Horizon Healthcare Services to Form a Mutual Holding Company, Pursuant to N.J.S.A. 17:48E-46.1.
Order No. A22-09; Appellate Docket No. A-001121-22
Request for a Stay

Dear Commissioner Caride:

We are writing you at this time to request a stay of your Order No. A22-09, dated November 1, 2022, until the appeal of that decision, filed with the Appellate Division and cited above, can be decided on its merits. This matter is urgent and we urge you to immediately grant this request.

This request for a stay is being filed with you on behalf of the policyholders of Horizon and New Jersey Citizen Action ("NJCA") and the Health Professionals and Allied Employees ("HPAE") union, two long-time health insurance policy holders of Horizon Health Services, Inc. ("HHSI" or "Horizon"), who have filed the afore-captioned appeal seeking to overturn your final decision in this matter. NJCA and HPAE (collectively "Appellants") filed this appeal because they believe, based on the analysis below, that your approval of the proposed mutualization and reorganization application ("Plan") of Horizon, a Blue Cross Blue Shield licensee and the largest health insurance company in New Jersey, was improper and unlawful. Specifically, Appellants contend that your Order No. A22-09 approving the Plan ("Order") is contrary to law, unsupported by substantial evidence, and arbitrary, capricious and unreasonable and should be set aside.

New Jersey Appleseed
Public Interest Law Center of New Jersey
23 James Street
Newark, New Jersey 07102

Phone: 973.735.0523; Cell: 917-771-8060
Email: renee@njappleseed.org
Website: www.njappleseed.org

Appellants are seeking an immediate stay of your Order to prevent the proposed mutualization and reorganization – affecting millions of health insurance policyholders in New Jersey, and billions of dollars – from being effectuated before the record of the proceedings is produced (including all records deemed confidential and/or those which the Appellate Court finds were improperly withheld by the your Department ("DOBI" or "Department") and the Appellate Court has had the opportunity to decide NJCA's and HPAE's appeal on the merits. A stay is particularly merited here because of the enormity of the multi-step corporate changes and transformations involved as shown in Horizon's public exhibits and thus the impossibility of later "unscrambling the eggs."[1] These charts are attached hereto as Exhibit 1.[2]

Your Order states that DOBI has "determined that the reorganization and mutualization of HHSI, as ordered further herein [in the Order], is not contrary to law, would not be detrimental to the safety and soundness of the proposed reorganized insurer and insurance company subsidiaries of the proposed mutual holding company insurer, and is neither contrary to the interests of the policyholders of Horizon nor would it treat them inequitably, consistent with the authority assigned to the Commissioner by 17:48E-46.5." Order at 3. As you know, your approval was granted after a particularly truncated regulatory review process relative to the time provided for in the statute.

## PRIOR PROCEEDINGS

Horizon filed its Plan on August 1, 2022. You deemed the Plan complete on September 22, 2022. Two weeks later, on October 6, the first of three statutorily-required public hearings were held, with the other two held shortly thereafter on October 11 and 17 of 2022. The record was closed on October 18, 2022. The record was sealed in part and made public in part. The Order approving the Plan was issued November 1, 2022. A *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"), setting forth the Commissioner's required reasons in support of her Order was also released, including a *Health Impact Study on Horizon's Proposed Reorganization*, dated October 30, 2022, conducted by DOBI consultant Manatt Health ("Health Impact Study").

## ISSUES APPELLANTS HAVE RAISED IN THEIR APPEAL

In their Case Information Statement filed with their Notice of Appeal, dated December 12, 2022, NJCA and HPAE delineate the following issues they intend to raise on appeal.

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[1] *See, e.g.*, Ronson Corp. v. Liquifin Aktiengesellschaft, 483 F.2d 846, 851 (3rd Cir. 1973), *certif. denied*, 419 U.S. 870, 42 L. Ed. 2d 108, S. Ct. 129 (1974)("Once the tender offer becomes consummated it becomes difficult, and sometimes virtually impossible for a court to 'unscramble the eggs.;")(quoting Sonesta International Hotels Corp. V. Wellington Assocs., 483 F. 2d 247 (2d Cir. 1969)).

[2] These Horizon Exhibits at pp. 1 – 22, are also available here: https://nj.gov/hschearings/documentation/HorizonBCBSNJApplicationPublicExhibits220928.pdf

1. Whether the Commissioner's Order No. A22-09, dated November 1, 2022 ("Order") approving the proposed mutualization and reorganization application ("Plan") of Horizon Health Services Inc. ("HHSI" or "Horizon") pursuant to Chapter 145 is contrary to law, unsupported by substantial evidence, and/or arbitrary, capricious and unreasonable. Specifically, but not limited to:

    a. Is the Order contrary to law because the Commissioner failed to order and approve pre-hearing notice to be made directly to Horizon's policyholders per C.17:48E-46.5(a), incorporating C.17:48E-46(a) which requires "the plan shall include… (5) a provision that each policyholder shall be notified of the conversion [in this case the reorganization], which notification process shall be approved by the commissioner"?

    b. Is the Order contrary to law because the Commissioner failed to enforce the Legislative intent that notice be provided uniformly through publication notice (and if the Court agrees, C.17:48E-46.5(a), incorporating C.17:48E-46(a)(5)) thereby improperly enabling Horizon to provide direct notice to select policyholders which not only treated the policyholders inequitably but corrupted the proceedings upon which the Order relied?

    c. Is the Order contrary to law because the Commissioner applied the wrong legal standard in approving the Plan by adopting a "'[not] contrary to' the interests of the policyholders" of Horizon in lieu of the Legislature's "benefit the interests of the policyholders" standard per C.17:48E-46.5(b)(3)?

    d. Is the Order contrary to law, and unsupported by substantial evidence in finding that the Legislature's "benefit" standard per C.17:48E-46.5(b)(3) is satisfied on grounds that per the Plan Horizon would continue to serve the individual insurance market in all counties, when this is already and will continue to be *required by law*, and thus is also arbitrary, capricious and unreasonable?

        i. Under the Commissioner's logic above, since the Order claiming this as a "benefit" applies only to policyholders in the individual market, does the Order violate the standard in C.17:48E-46.5(b)(3) that the Plan not treat policyholders "inequitably"?

    e. Is the Order unsupported by substantial evidence in finding that the Legislature's "benefit" and no "inequitable" treatment standards per C.17:48E-46.5(b)(3) were satisfied on grounds that there were no "provisions [in the Plan] that would lead the Consultants to believe that the Plan would cause premiums to increase", given the significantly higher taxes (plus capital transfers) resulting immediately from the reorganization and the Commissioner's and Horizon's repeated assertions in the record that higher taxes drive higher premiums?

    f. Is the Order unsupported by substantial evidence in finding that the Legislature's "benefit" standard per C.17:48E-46.5(b)(3) was satisfied on grounds that with the

Conditions in the Order impose restrictions on future dividends to the MHC from the reorganized insurers in order to avoid excessive capital drain, and set a regulatory minimum solvency RBC level at 425% RBC, when neither of these "Conditions" benefits the interest of the policyholders" versus the status quo where no such dividends are possible, and it has a statutory minimum 550% RBC?

g. Is the Order unsupported by substantial evidence in finding that the Legislature's "benefit" standard per C.17:48E-46.5(b)(3) was satisfied on grounds that the Conditions in the Order will "ensure" the insurers have sufficient capital "while giving the MHC sufficient capital and flexibility to pursue efforts to better achieve its charitable and benevolent mission", given that the latter claim merely recites the Legislative intent without substantial evidence, and is thus arbitrary, capricious and unreasonable?

h. Is the Order contrary to law, and unsupported by substantial evidence because the Commissioner determined that Chapter 145 does not require Horizon to demonstrate how any proposed investments would differ in kind or quantity from those that can be made by it in its current corporate form, in reaching a determination that the Plan would "benefit the interests of the policyholders" of Horizon?

i. Is the Order contrary to law because the Commissioner approved the Plan without scrutinizing the investments that Horizon intends to make through the newly formed mutual holding company ("MHC") in determining whether the Plan would "benefit the interests of the policyholders or [does not] treat[] them inequitably"?

j. Is the Order contrary to law, and unsupported by substantial evidence because the Commissioner allowed Horizon to not specify how and when the MHC would deploy the $300 million distribution and yet concluded that the Plan would benefit the interests of the policyholders?

k. Is the Order contrary to law because the Commissioner required a "parental guarantee" from the MHC to backstop the Commissioner's minimum 425% RBC in each insurer, but failed to examine those underlying investments, thus rendering the investments speculative, given that speculative investments are not permitted for insurers under New Jersey law?

l. Is the Order unsupported by substantial evidence in finding that the Legislature's "[not] detrimental to the safety or soundness of the proposed reorganized insurer(s)" standard per C.17:48E-46.5(b)(2) is satisfied, given that its system-wide health RBC will be materially below that set forth in Section 46.13 due to the $300 million transfer of capital to the MHC?

m. Is the Order unsupported by substantial evidence in finding that the Legislature's "[not] detrimental to the safety or soundness of the proposed reorganized insurer(s)" standard per C.17:48E-46.5(b)(2) is satisfied by "Conditions" that the insurers provide a "parental guarantee" to ensure that each reorganized insurer maintains a minimum 425% RBC when at the same time the Commissioner undermined the bona fides of that "parental guarantee" by ruling that no analysis or approval of the MHC's investments was required nor would be performed?

n. Is the Order unsupported by substantial evidence in finding that the Legislature's "[not] detrimental to the safety or soundness of the proposed reorganized insurer(s)" standard per C.17:48E-46.5(b)(2) is satisfied, given her misuse of the RBC as a measure of strength despite the fact that "[t]he purpose of RBC requirements is to identify weakly capitalized companies…" and "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."

o. Is the Order unsupported by substantial evidence in finding that the Legislature's "[not] detrimental to the safety or soundness of the proposed reorganized insurer(s)" standard in C.17:48E-46.5(b)(2) is satisfied by "Conditions" that the insurers maintain a minimum 425% RBC when the flagship company HHSI's RBC will be below 425% at the outset?

p. Is the Order contrary to law because the Commissioner excluded from the public record non-confidential information material to the proceedings, including but not limited to the projected RBC ratios, the MHC's proposed by-laws and the mandated recovery plan, among others?

## STATUTORY FRAMEWORK GOVERNING DOBI DECISION

### 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.

Order at 1-2 (Emphasis added.)

**Chapter 145: Legal Requirements for the Plan**

Chapter 145 (C. 17:48E-46.5(a)) permits a health services corporation (Horizon) to submit an application to the commissioner to form a mutual holding company system. That provision requires certain corporate acts and the submission of specified information therein. This includes information required pursuant to section 2 of P.L. 1995, c. 196 (C.17:48E-46) for a plan of mutualization, and with respect to the formation of a mutual holding company system for purposes of 5(a) eight addition enumerated items.

**Chapter 145: Legal Requirements for Approval**

Chapter 145 (N.J.S.A. 17:48E-46.1 et seq.), 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),[3] 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.

[3] N.J.S.A. 17:48E-17(3)(a) states in relevant part ("The commissioner shall approve the plan unless he finds the plan: (1) is contrary to law; (2) would be detrimental to the safety or soundness of the proposed domestic mutual insurer; or (3) prejudices the interests of the subscribers 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 for the decision in writing and shall state the reasons therefore." *Id*.

## FINAL DECISION APPROVING THE PLAN AND POST-HEARING REPORT [4]

On November 1, 2022, you issued your final Order approving the Plan along with the requisite Report containing your "reasons therefore."

1. Notice: "The Department published advanced notice of the public hearings in seven New Jersey newspapers and thereafter held such public hearings on three different days spread out over two weeks' time…." Report at 3. 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." Id. at 5-6 (emphasis added).

2. Commissioner's Application of the Three Statutory Prongs Required for Approval

a. The Order approves the Plan based on a different legal standard. It states, in relevant 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.

Order at 3 (emphasis added).

b. The Post-Hearing Report - standards used and reasoning:

In contrast to the Order, the Report refers to the actual legal standard as to all three prongs of N.J.S.A. 17:48E-46.5(b), including the third prong. The reasoning provided in support of the Order is as follows:

The Consultants considered each of these [three] Grounds for Disapproval:

[4] The terms "Report" or Post-Hearing Report" refer to the Commissioner's *Post-Hearing Report and Summary and Consultants' Evaluations of Horizon Healthcare Services, Inc.'s Application for Mutualization & Reorganization* (October 31, 2022), which contain your reasons as required by 17:48E-46.5(b).

**(1)** ***Contrary to law***

In the course of determining whether the application was complete upon its initial submission, the Consultants and the Department compared Horizon's submissions to the statutory requirements for a complete application under Chapter 145 and concluded those criteria were satisfied. The Consultants and the Department also did not identify any elements of the Plan, including the "step plan" of corporate transactions, capitalization and financing plan, and corporate formation documents, that were contrary to laws within the Department's jurisdiction. As discussed above, some public testimony identified concern regarding whether the mutual holding company system would remain compliant with New Jersey not-for-profit law and the mutual holding company's charitable and benevolent mission, but the Attorney General has submitted a letter indicating his office would continue to be the "protector, supervisor, and enforcer of charitable trusts and charitable corporations, which includes Horizon in its current form and in any new, future corporate form." Chapter 145 "does not diminish the Attorney General's oversight power over charitable trusts and charitable corporations." Thus, the Attorney General remains free to take appropriate action if his office believes there is cause to do so in light of Horizon's status as a not-for-profit with a charitable and benevolent mission. In any case, the comments on Horizon's charitable status focus on future hypothetical actions that could violate the law, not any violations of the law in the Plan itself. The Plan, together with the Conditions and the Attorney General's continuing enforcement of state law with respect to charitable trusts and charitable corporations, ensure that Horizon will remain a not-for-profit entity with a charitable and benevolent mission consistent with Chapter 145. Further, the application and Conditions confirm that HHSI will remain subject to the statutory requirement that it make available insurance coverage in the individual market in every county of the state. Thus, the record, including the public testimony, does not appear to provide any basis to conclude the Plan is contrary to law.

**(2)** ***Detrimental to the safety or soundness of the proposed reorganized insurer and insurance company subsidiaries of the proposed mutual holding company***

The Consultants believe the capital distributions contemplated in the Plan, together with the substantial restrictions on future distributions, do not form a basis to conclude that the Plan would be detrimental to the safety or soundness of the proposed reorganized insurer and insurance company subsidiaries of the proposed MHC. As discussed above, while Chapter 145 specifically exempts the reorganized insurer from the 550% minimum RBC standard currently imposed on HHSI as an HSC, 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%, well in excess of the statutory minimum of 200%, and above any level where there would be serious concerns about the safety or soundness of the insurance company subsidiaries in light of the circumstances. In addition, the Department is imposing a requirement that HMH provide a parental guarantee to its insurance company subsidiaries to ensure they are able to maintain these RBC levels. The Consultants' thorough review of the record in this

proceeding, including Horizon's most recent Own Risk and Solvency Assessment Summary Report filed with the Department, do not reveal other bases to determine that this Ground for Disapproval is triggered.

**(3) *Does not benefit the interests of the policyholders of the HSC or treats them inequitably***

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. First, the Conditions reinforce the statutory requirement that HHSI, both in its current form and as the reorganized insurer, is obligated to offer individual market coverage in every county in the state. Second, the 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. 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 better achieve its charitable and benevolent mission.

## APPELLANTS' GROUNDS FOR REVERSAL OF DECISION

Chapter 145 states clearly what the Legislature's purpose was enacting the reorganization law. Appellants take no issue with the summary contained in the Order, which purpose is "subject to the conditions and limitations set forth in Chapter 145" including importantly that the Plan shall 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."

Horizon's Plan fails to meet these three requisite prongs and, therefore, is contrary to the statute and Legislative policies therein. As shown below, the Order lacks substantial evidence as to each legal prong, and is arbitrary, capricious and unreasonable. *See, e.g.*, In re Atty. Gen. Law Enforcement Directive Nos. 2022-5 and 2020-6, 246 N.J. 462 (2021).

Below, Appellants address issues in the following order: the material deficiency and corruption of notice, the third prong (N.J.S.A. 17:48E-46.5(b)(3)), and finally the second prong (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, N.J.S.A.17:48E-46.5(a), states in relevant part:

> In addition to including information required pursuant to section 2 of P.L. 1995, c. 196 (C. 17:48E-46 for the plan…, the plan shall include… "
>
> The cross-referenced 17:48E-46(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."

Chapter 145, N.J.S.A. 17:48E-46.5 (b), states further 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 al.). [omitting recitation of the three legal prongs required for approval]

N.J.S.A. 17:48E-46.5(b) (underline added). The Legislative policy in prescribing notice is clear: 1) to provide prior notice to policyholders (and the general public) through publication, and 2) direct notice to the policyholders who are those most impacted, 3) about the regulatory proceedings that directly affect the policyholders' interests, 4) to allow informed participation at the hearings 5) to inform the Commissioner's deliberations pursuant to Chapter 145 and any subsequent court review.

To comply with the "publication notice" requirement, the Commissioner ordered "publication of advanced notice of the public hearings in seven New Jersey newspapers. Report at 3. She also approved direct notice to the policyholders; however, contrary to law failed to require said notice prior to the public hearings as self-evidently required per 17:48E-46, given that the current policyholders have the interest in notice.[5] Moreover, the Commissioner failed to constrain Horizon from sending selective direct notice to only some of its policyholder members. (Said selective notice was not that approved pursuant to 17:48E-46. See Report at 5 at bottom.) In its select pre-hearing notice, Horizon requested that these select members submit one of two form-letters as testimony supporting the reorganization. The first set of letters numbering 339 claim to be from Horizon members also writing on behalf of "members like me." These letters were actually submitted by Horizon employees although this is not disclosed in the letters.[6] In

[5] The Commissioner treated the direct "notice" as a pro-forma post-facto update of a major corporate transaction to Horizon's future policyholders and long after the reorganization would be a *fait accompli*. Report at 5 ("HHSI will provide notice to each policyholder within 180 days of approval advising them of the reorganization and eligibility for membership interest in HMH.").

[6] This was determined by Appellants by cross-checking the names using LinkedIn. The letter testimony can be found at https://nj.gov/hschearings/documentation/HSCReorganizationPublicComments.pdf

fact, Horizon expressly concealed this material fact from the Commissioner and the public in order to corrupt the deliberative process. A second set of form letters, of which 184 were submitted, claim to "enthusiastically support" the reorganization "[f]or consumers like me, this will mean better, more affordable and more convenient health care." Again, the source for this manufactured testimony is concealed.[7]

As such, the Legislative policy in achieving an honest public hearing process based on equal notice, including directed notice to all policyholders, was subverted. Substantial evidence shows that the proceedings were materially corrupted: the submissions were improperly deemed reflective of actual policyholder sentiment and considered favorably by the Commissioner:

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

Report at 7 (emphasis added); see also Order at 3 ("testimony" and "written public comments" considered in approval determination). In reality, all of the comments from "policyholders and consumers" were generated by Horizon following its illegitimate selective direct notice to select policyholders, most of whom are Horizon employees.

Because the Legislature prescribed the manner of notice, and also prohibited inequitable treatment of the policyholders, the Commissioner's failed notice program, combined with Horizon's affirmative acts, renders the Order relying on the product of those inequitable acts and resulting corrupted proceedings contrary to law. The Commissioner's failure to order the requisite notice, and failure to preclude notice other than that prescribed by Chapter 145 further renders the Order contrary to law, and arbitrary, capricious and unreasonable and grounds alone for reversal.

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

The Order should be set aside as contrary to law because you have failed to apply the correct legal standard under the third prong. 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 under this *third prong* that the Plan "is neither contrary to the interests of the policyholders of the health service corporation nor would it treat them

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[7] Some cross-checking via LinkedIn and Google suggest senders do business with Horizon. (The remaining few pro-reorganization letters also contain rote language supplied by Horizon as adapted by its grantees and others in their letters of support.)

inequitably…." Order at 3 (emphasis added). But a "[not] contrary to" standard is a different and lesser standard than "benefit", and is more akin to not detrimental.[8] 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)…"). 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 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)").

Moreover, the Commissioner's reasoning as applied to the prong three standard establishes beyond any doubt that she actually applied the improper "[not] contrary to" standard instead of the requisite "benefit the interests of the policyholders." The Report (at 17-18) cites three bases for approving the Plan under this prong as will be discussed further below.

### 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" standards in N.J.S.A. 17:48E-46.5(b)(3).

The Report reasons that the Plan satisfies the third prong of N.J.S.A. 17:48A-46.5(b), but does so impermissibly by using circular reasoning. Specifically, the Report merely parrots the intent of Chapter 145 and describes the structure it permits as if that is a finding in and of itself as to the propriety of the Plan. As shown in the discussion below, under this logic, any plan would pass statutory muster.

The Report 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

[8] This erroneous interpretation is also akin to "not prejudicial" or "not adversely affect" standards. But the Legislature has demonstrated that it knows how to say these. *See, e.g.*, N.J.S.A. 17:48E-17(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"); N.J.S.A. 17:27A-2(d)(1) ("The commissioner shall approve any merger or other acquisition of control… unless… he finds that: … (v) The plans or proposals… are unfair and unreasonable to policyholders of the insurer…; (vi) The competence, experience and integrity of those persons who would control… the insurer are such that it would not be in the interest of policyholders of the insurer….") (All emphasis added.)

> 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.

Report at 17 (emphasis added). (Elsewhere, the Report uses the legally incorrect standard of "does not disadvantage or inequitably treat" the policyholders. Id. at 14.) Following the block quote above, the Report then offers three rationales for its conclusion, none of which passes muster.

**1. The first rationale**

The Report relies on the reorganized insurer continuing to provide the statutorily-mandated individual market coverage in every county in the state. This applies the improper "[not] contrary to" rather than "benefit the interests of" the policyholders standard: Horizon is currently subject to this obligation, and the enabling law also requires them to adhere to such obligation after the reorganization. Continuing to do so is thus a function of the law, and not the Plan and thus it cannot be used to support the conclusion that it benefits the policyholders.[9]

**2. The second rationale**

The Report states that "the Plan contains no provisions that lead the Consultants to believe the Plan would cause premiums to increase and, in the distant future, lower tax-premium costs could result in premiums being lower than they otherwise would be." Report at 18.

a. The second rationale is contrary to law.

Not only is this conclusion vague ("contains no provisions that lead…") and contains no factual predicates to support the conclusion; it is the opposite of a clear articulation that satisfies the substantial evidence rule. It also fails to state how the Plan will actually benefit the interest of the policyholders by its own terms by merely suggesting that premiums may not increase thus merely averting a negative. (The vague speculation that "in the distant future" there may be premium relief is a nullity addressed below.) What the Report expressly fails to conclude or establish through substantial evidence is that the Plan will result in lower or even stable premiums in the next 1, 3, 5 or 10 years (versus the status quo) which would have actually qualified to benefit the interests of the policyholders. Because the Commissioner applied the wrong "[not] contrary to" standard, her Order violates the law.

b. The second rationale is unsupported by substantial evidence, and arbitrary, capricious and unreasonable.

[9] Under the Commissioner's reasoning, since this provision applies only to policyholders in the individual market, it could be argued that the provision treats policyholders in the group market inequitably contrary to Section 46.5(b)(3). Obviously, adherence to the statute cannot serve as grounds for approval as a benefit of the Plan.

First, the Report is silent as to whether the Plan treats policyholders equitably or inequitably as to premiums and is therefore unsupported by substantial evidence and arbitrary, capricious and unreasonable.

Second, at best, the Report offers a vague speculative benefit of lower premiums that may occur perhaps sometime "in the distant future [due to] lower tax-premium costs." *Id*. at 18. In this regard, the Report relies on two important underlying facts:

(1) That there is a direct causal link here between higher tax costs (rates) and higher premium levels, and the corollary, that lower tax costs means lower premiums. This is consistent with the position taken repeatedly by Horizon. *See* Oral (written) Remarks of Jennifer Velez (October 6, 2022) testifying for Horizon, at 2 (Horizon is now subject to "a special premium tax rate that is higher than any other insurer that increases the cost of premium for our members."); *id* at 5 ("It is also worth noting that a change in Horizon's corporate structure yields more direct benefits to our members in terms of affordability. First, the reorganization will reduce the disproportionate tax burden felt by our members by reducing the premium tax.");[10] and

(2) A potential exists for lower premiums "in the distant future," which acknowledges that under Chapter 145 there will be no tax-cost savings in the foreseeable future because the reorganized entity will be subject to $1.25 billion in special tax assessments: that is, an upfront $600 million assessment, and subsequent annual tax assessments totaling $650 million over the next 17 years per N.J.S.A. 17:48E-46.13. Given that Horizon paid approximately $68 million in premium taxes in 2021, the $600 million tax assessment represents a nearly 9-fold increase in taxes in year one of the reorganization.

Based on the Commissioner's own factual determinations, the Plan portends higher premiums for policyholders at least over the next at least 10 years because (1) Horizon's taxes will increase significantly as a direct result of the reorganization during that time period,[11] and (2) the Plan approved by the Commissioner authorizes the immediate transfer of an additional $300 million from the health insurers to the MHC (a non-insurer), for a total immediate transfer of $900 million. (Another $100 million tax assessment is due the following year under the Plan per Section 46.13). Astonishingly, the Commissioner asserts that:

> 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….

[10] https://nj.gov/hschearings/documentation/Horizonoralremarks221006.pdf; see also Health Impact Study at 10 ("Horizon noted in its testimony that it will be relieved of higher tax burdens on premiums than other insurers and that those higher taxes currently raise premiums.").

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

Report at 13-14. This "assumption" is belied by the fact that Horizon is giving up approximately 30% of its capital (which was $3.2 billion in 2021) when making the above $900 million payments, which is significant under any objective analysis.

Therefore, the Commissioner's strangely worded Order and evasive reasoning regarding the Plan's impact on health insurance premiums is contradicted by the facts in the record and Horizon's own claims that higher tax rates drive higher premiums. In this way, the Order is unsupported by – and in fact contradicted by – substantial evidence, in addition to failing to show the Legislature's requisite benefit to policyholders that the Plan must generate, thus rendering it arbitrary, capricious and unreasonable.[12]

### 3. The third rational

The third rationale that the Plan will "benefit the interests of the policyholders" has three parts. The Report states that by limiting the upstreaming of dividends from the reorganized insurers to the MHC, and setting a minimum health RBC of 425% in the insurers (above the new statutory minimum RBC of 200%), these conditions will ensure the insurers 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." But, because Horizon currently has sufficient capital currently to provide these policyholder benefits, that leaves open the showing as to how it will "better achieve" its mission.

(a) Sub-point 1 (limits on upstream dividends)[14]

This is not a benefit to policyholder interests over the current structure. Rather it is only necessitated by the reorganization, which allows such dividends out of the insurers for the first time, and a concern that too much capital could be removed from the health insurers. At best, this is a "[not] contrary to" standard and thus your determination is contrary to the enabling statute.

(b) Sub-point 2 (minimum 425% RBC required for each reorganized insurer, well above new RBC "minima" of 200%)

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[12] The Commissioner also fails to acknowledge that which one of her own consultants did: namely, that her Department "lacks the statutory authority that most other state insurance departments have to regulate rates." *See* Health Impact Study at 17. As a consequence, rate regulation that might otherwise temper premium increases is not an available tool.

[13] The term "benefits" referred to here mean "to pay policyholder claims and honor all other obligations to policyholders" as stated in the Health Impact Study at 22.

[14] See Report at 14-15; Order Conditions 3, 7, 11. The Order imposes a three-year moratorium on paying upstream dividends (after the initial $300 million); requires a minimum RBC of 425% in each insurer (backed by parental guarantee, which would counter any up-streamed dividend below that level); and Chapter 145 prohibits up-streamed dividends of the system-wide health RBC if it is below 550% (calculated after payment of the annual tax assessment) per N.J.S.A. 17:48E-46.13(c).

Again, and for similar reasons, this does not benefit the interests of the policyholders when compared to the *status quo*. Horizon is currently subject to a much higher statutory minimum RBC of 550% per N.J.S.A. 17:48E-17.3. It is not a "benefit" to lower the minimum RBC requirement by 125%. The claim that this lower 425% limit is "well in excess of the statutory minima" of the newly applicable 200% RBC ignores the current higher 550%.

It also ignores the fact that the new statutory minimum of RBC of 200% will be 350% lower than the current statutory level 550%. This latter point is pertinent given the Commissioner's regulatory authority to compel the reorganized insurers to take action is only triggered when the RBC drops to 70% of the action level.[15]

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.[16] Nor does it address the fact that, following the transfer of $900 million in capital, Horizon's RBC will drop to a 448% RBC based on its 2021 financials.[17] These decreases are clearly detrimental to policyholder interests and are a direct result of the Plan; and the Order does nothing to counter such fact.

(c) 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:

> 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

[15] *See* N.J. Admin. Code § 11:2-39A.2 (""RBC level" means a health organization's Company Action Level RBC, Regulatory Action Level RBC, Authorized Control Level RBC, or Mandatory Control Level RBC where: 1. "Company Action Level RBC" means, with respect to any health organization, the product of 2.0 and its Authorized Control Level RBC; 2. "Regulatory Action Level RBC" means the product of 1.5 and its Authorized Control Level RBC; 3. "Authorized Control Level RBC" means the number determined under the risk-based capital formula in accordance with the RBC Instructions; and 4. **"Mandatory Control Level RBC"** means the product of .70 and the Authorized Control Level RBC." (Emphasis added.)

Purportedly so that the insurers "are well capitalized" and maintain a minimum 425% RBC, the Order requires the MHC to provide the "parental guarantee" between the MHC and each insurer, pledging therein to rectify any shortfalls in capital within 30 days of such expectation (as reported on a quarterly basis). Order, Condition 11, at 6. But the Order is devoid of authority or basis for the Commissioner to force the insurers to enforce this contractual guarantee so long as the insurers' RBCs exceed the lowest RBC level triggering authorized or mandatory control.

[16] *See* Section E.3 below in Chart, column 2021, row 5 (5 year average).

[17] *See Id*. at column 2021, third highlighted row.

> conditions above [dividend restraints; 425% RBC), the reorganized insurer and other insurance subsidiaries would remain sufficiently capitalized while enabling HMH to determine optimal investments for its charitable and benevolent mission consistent with the legislative intent of Chapter 145.

Report at 15 (emphasis added).

Therefore, rather than determine that the Plan actually benefits the interests of the policyholders and will not treat them inequitably, the Order relies on vague statements in the Plan regarding "areas in which the MHC expects to make substantial future investments following approval" and "initiatives" and that the Plan "explains the basis for targeting these areas of investments." Report at 10 (emphasis added). The Order and Report contain no analysis whatsoever as to 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, will 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 expressly determined that such an analysis was not necessary:

> 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.

Report at 10. 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. Absent substantial evidence to the contrary, 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 of benefit to the interests of the policyholders.[18] And, there is no evidence the policyholders will not be treated inequitably.

In short, the Order parrots the intent of Chapter 145 and the structure it affords as if that were sufficient to justify approval of the Plan. Unsupported by the facts, the Order is arbitrary, capricious and unreasonable.

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[18] 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." Report at 14. 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.

Conversely, even assuming the MHC would reveal its intended investments and could establish that these are unavailable to it now in its current corporate form, the MHC could nonetheless invest in risky ventures, investing big and potentially losing big, and therefore, would not be able to honor the "parental guarantee" to the reorganized insurers, even if it wanted to. Without an assessment of the intended investments upon reorganization, the parental guarantee upon which the Order relies to bolster the minimum 425% RBC is speculative.[19] And speculative investments by insurers are not permitted, so it is contrary to law to allow it here.[20]

In this vein, the Commissioner's consultant, Manatt Health, admitted that the Commissioner will lack authority over the MHC's investments:

> 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…

Report at 21 (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, the fact remains that now, pre-reorganization, is the time the initial investments can and must be scrutinized to make the determination whether the Plan will or will not benefit the interests of policyholders or treat them inequitably. The Order utterly fails to do so.

### D. The Order incentivizes Horizon to underfund its health insurers and amass profits in the MHC.

The "system-wide" health RBC of 550% as set forth in the Order is made to look like a benefit to policyholders. In fact, because of the deficiency in the Order, it will be a mechanism to game the tax obligation to the State of New Jersey by underfunding the health insurers.

The details are this: the Order requires (1) annual RBC informational filings (Order, Conditions 5-7, at 4-5), (2) more informational financial disclosures from the MHC if the system-wide health RBC is projected to fall below 550% (Order, Conditions 8 and 10, at 5-6), and (3) prior approval of annual tax assessment payments set forth in 46.13 of the statute (Order, Condition 9, at 6). The given rationale is to enable the Commissioner to "ensure that the [MHC] has sufficient system-wide RBC to continue operations in a financially prudent manner." Report at 16; see also id. ("This condition will enable the Department to monitor the [MHC] system and

[19] The Order also relies on the parental guarantee to support the determination that prong 2 is satisfied (i.e., the Plan would not be detrimental to the safety or soundness of the reorganized insurers).

[20] Moreover, the policyholders will lose their priority, over other creditors, to have insurance claims paid in the event of a bankruptcy to the extent assets are outside the insurer. *See The Feeling's Not Mutual*, NY State Assembly Insurance Committee https://assembly.state.ny.us/Reports/Ins/199803/ at section titled "Regulatory and Legal Issues." The MHC is expressly not an insurer per N.J.S.A. 17:48E-46.3(d). Nothing in the Order addresses or ameliorates this harm.

implement measures[21] to ensure its continued financial health and its ability to pay the statutorily-mandated assessments.")

However, under the logic of her own Order, the Commissioner was obliged, but failed to do the following: require Horizon to include in its parental guarantee that the MHC would maintain a system-wide health RBC in excess of 550%. Thus, what the Order portrays as an assurance of financial-strength protecting the policyholders (setting a threshold system-wide health RBC of 550% after taxes are accounted for (Order, Condition 7, at 5)[22] is actually a detriment to the interests of the policyholders. This is because the Commissioner's failure to apply the parental guarantee to the 550% health RBC actually incentivizes the MHC to underfund the health insurers in order to drop below the 550% RBC to defer/avoid annual tax assessments. Although the MHC may be amassing substantial profits in the MHC, these profits are excluded from the system-wide health RBC calculation. (Section 46.13 (c) (refers to system-wide health RBC; Order at Conditions 4 and 7 refers to "health" RBC).[23] So the enterprise-wide profit goal becomes not returning profits downstream by keeping the system-wide health RBC below 550%. This perverse incentive renders the Plan, unmitigated by the Order, contrary to the interest of the policyholders, and certainly not of benefit to their interests (nor for that matter the State itself and the public).[24] DOBI is likely to respond that below a 550% health RBC, no dividends can be up-streamed per N.J.S.A. 17:48E-46.13(c). But this point fails to address the perverse incentive created by the Order because 1) for the first three critical years after the reorganization no dividends are permitted anyway, pursuant to the Order, so there is no incentive to maintain 550% during that period, 2) the MHC is intended to become its own profit center and will also retain the tax-savings in its capital, 3) avoiding up to $650 million in taxes is incentive to maintain a lower system-wide health RBC, and 4) this is all occurring in a regulatory regime where the Commissioner has no enforcement authority to compel the MHC to maintain that 550% (nor does the Attorney General).

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[21] Footnote added: no such "measures" are disclosed or explained, and for the reasons discussed herein, no such "measures" exist given the limitations of the Commissioner's authority here.

[22] Order, Condition 7, requires the MHC financials to "accrue any estimated annual assessments," which are payable to New Jersey the following year, in the current year per statutory insurance accounting rules.

[23] To the extent the Order (Conditions 8 and 10) also refers to simply "system-wide RBC," thus omitting the word "health", this may be a drafting error. Nonetheless, it creates an ambiguity rendering the Order defective. If it is not a drafting error, then it references something not provided for in the cited NAIC RBC for Health Organization methods and instructions (Condition 5), and is thus not supported by substantial evidence.

[24] This negative incentive is not ameliorated by the vague reference to Horizon having "demonstrated its ability to obtain third-party reinsurance, if needed," which purportedly "provides a backstop against unexpected material changes in the system-wide RBC that would otherwise endanger the safety and soundness of the [MHC] system." Report at 16. The perverse incentive works to preclude the MHC from ever seeking any such reinsurance.

Had the Commissioner imposed a system-wide 550% health RBC through a parental guarantee, which she did not, it would have been consistent with the statutory scheme. First, Chapter 145 eliminates Horizon's current minimum RBC of 550% applicable to all its operations. *See* Report at 14-15. But, second, the statute sets a minimum system-wide health RBC of 550% as the threshold required for annual tax assessments to be paid to the State of New Jersey, below which they are deferred.[25] Deferrals also preclude the insurers from paying upstream dividends to the MHC per N.J.S.A.17:48E-46.13(c). The State of New Jersey clearly has an interest in collecting those assessments of up to $650 million. Although by statute the new health RBC calculation will be applicable only to Horizon's health insurance operations, the statute does not exempt Horizon's new business investments from reach if necessary to bolster the health insurers as a condition of approval. (After approval the MHC's assets will be out of reach except for the limited parental guarantee currently in the Order.) Therefore, it was incumbent upon the Commissioner to ensure that the Legislature's intent, that the health RBC be maintained at 550% and that taxes would be paid, would be satisfied under the Plan. This could have been accomplished by a parental guarantee for the 550% health RBC. Having failed to do so, the Plan is contrary to, and does not benefit the interest of the policyholders and is not consistent with the Legislature's policies and goals with respect to payment of taxes to the State.

Finally, the Order does not even require the parental guarantee be executed until 90 days after the approval, and there is not even a draft of it in the record. Thus, the record is deficient and the Order lacks substantial evidence. Moreover, 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%). Order, Condition 11, at 6.[26] Omission of enforcement authority by DOBI further undermines the claimed value of the parental guarantee.

For the foregoing reasons, the Commissioner's rationales are unsupported by substantial evidence, and the Order is arbitrary, capricious and unreasonable as to prong 3 of N.J.S.A. 17:48E-46.5(b).

**E. The Order fails to establish by substantial evidence that the Plan satisfies the standard in the second prong, 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 substantial evidence. The Report provides a single

[25] The statute provides for up to $650 million in annual tax assessments paid over 17 years (or up to 25 years if there are annual deferrals resulting from an RBC below 550%. N.J.S.A. 17:48E-46.13(b)-(d)(1). The statute states further that assessments shall cease to exist 25 years after the "effective time." *Id.* . The Commissioner set the "effective time" as November 1, 2021. Order at 7.

[26] *See also* Report at 17 (DOBI "… is imposing a requirement that [the MHC] provide a parental guarantee to its insurance company subsidiaries to ensure they are able to maintain these RBC levels.").

basis to conclude that the Plan would not be detrimental to the safety or soundness of the reorganized insurers: each insurer will be required to maintain a minimum RBC of 425% (backed by a parental guarantee from the MHC to maintain that level).[27] Report at 17. It fails to meet the standard for the following reasons:

1. As a preliminary matter, the lack of scrutiny over the MHC's initial investments renders the parental guarantee of only speculative, unsubstantiated value. *See* Section C *supra*.

2. The Commissioner misuses the RBC in her Order contrary to law.

The RBC is not a magic bullet and the Commissioner misuses it as a measure of financial strength. 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.

*See* NAIC RBC Topics, https://content.naic.org/cipr-topics/risk-based-capital. (emphasis added) The NAIC RBC calculation formula is codified in the NAIC's Risk-Based Capital (RBC) For Insurers Model Act, and codified by regulation N.J.A.C. 11:2-39A *et seq.*. This N.J. 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

[27] Report at 17 ("… 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.")

amount of capital that an insurer would need to hold to meet its objectives." *See* NAIC RBC Topics, *supra*. The RBC is merely one tool to indicate whether it 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". Report at 15.

This misuse is indicative of why RBC ratios are not generally suited to establish that the Plan would not be detrimental to the safety or soundness of the insurers. However, in the context of the Legislative intent contained in Chapter 145 – that Horizon pay $1.25 billion in special tax assessments over 17 years – the statute 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 used, is the legislated level deemed to make the insurers safe and sound. Therefore, the Order falls short and fails to satisfy prong 2, and is contrary to Chapter 145 for this reason as well. Given the express limitations of the RBC ratio, which are fatal to the Commissioner's rationale, the Order is unsupported by substantial evidence.

3. 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 dropping materially below 550% in each. *See* Chart below at third highlighted row.

| **Horizon Healthcare Services, Inc.** | | | | | |
|---|---|---|---|---|---|
| | 2017 | 2018 | 2019 | 2020 | 2021 |
| Total Adjusted Capital | $ 2,772,209,433 | $2,985,261,367 | $2,732,680,378 | $3,069,235,420 | $ 3,133,240,870 |
| ACL | $ 436,103,798 | $ 443,016,430 | $ 414,141,418 | $ 420,990,063 | $ 498,895,715 |
| | | | | | |
| RBC % | 636% | 674% | 660% | 729% | 628% |
| 5 year median | | | | | 660% |
| Net Investment Gain | $ 104,075,169 | $ 119,230,902 | $ 89,450,312 | $ 71,120,433 | $ 157,160,517 |
| Total Assets | $ 5,437,934,860 | $5,527,795,121 | $5,684,866,572 | $6,592,985,671 | $ 6,715,367,857 |
| | | | | | |
| | | | | | |
| | | | | | |
| TAC Less $600 million | $ 2,172,209,433 | $2,385,261,367 | $2,132,680,378 | $2,469,235,420 | $ 2,533,240,870 |
| ACL | $ 436,103,798 | $ 443,016,430 | $ 414,141,418 | $ 420,990,063 | $ 498,895,715 |
| RBC % | 498.09% | 538.41% | 514.96% | 586.53% | 507.77% |
| | | | | | |
| Percentage of Lost Assets | 11.03% | 10.85% | 10.55% | 9.10% | 8.93% |
| Lost Investment Income (% Lost Assets x Net Investment Gain) | $ 11,483,238 | $ 12,941,605 | $ 9,440,888 | $ 6,472,373 | $ 14,041,868 |
| | | | | | |
| TAC Less $900 million | $ 1,872,209,433 | $2,085,261,367 | $1,832,680,378 | $2,169,235,420 | $ 2,233,240,870 |
| ACL | $ 436,103,798 | $ 443,016,430 | $ 414,141,418 | $ 420,990,063 | $ 498,895,715 |
| RBC % | 429.30% | 470.70% | 442.53% | 515.27% | 447.64% |
| | | | | | |
| Percentage of Lost Assets | 16.55% | 16.28% | 15.83% | 13.65% | 13.40% |
| Lost Investment Income (% Lost Assets x Net Investment Gain) | $ 17,224,857 | $ 19,412,408 | $ 14,161,332 | $ 9,708,559 | $ 21,062,802 |
| | | | | | |
| TAC at 425% RBC | $ 1,853,441,142 | $1,882,819,828 | $1,760,101,027 | $1,789,207,768 | $ 2,120,306,789 |
| TAC in excess of 425% | $ 918,768,292 | $1,102,441,540 | $ 972,579,352 | $1,280,027,652 | $ 1,012,934,081 |
| | | | | | |
| Percentage of Lost Assets | 16.90% | 19.94% | 17.11% | 19.41% | 15.08% |
| Lost Investment Income (% Lost Assets x Net Investment Gain) | $ 17,584,059 | $ 23,778,938 | $ 15,303,354 | $ 13,808,027 | $ 23,705,811 |

Source: Public Exhibit 5-B: HHSI 2021 Annual Statement, 5-year historical page at 27.

Per this chart, the bottom line is that the transfer of $300 million to the MHC, on top of paying the initial taxes, would have rendered Horizon's system-wide health RBC well below even 500% in four of the last five years, including 2021. *See* Chart (third highlighted row). Thus, Horizon would have been able to defer paying its first annual tax assessment of $100 million, and would be below the Legislature's deemed level of safety and soundness.[28] If history is prologue, then 2022 (not yet complete) will be no different. And in any event, only 2021 financial data is in the record. Thus, based on the record evidence, approval of the Plan with the proposed $300 million transfer (above the mandatory $600 million tax) is contrary to the Legislative intent and lacks substantial evidence that it would not be detrimental to the safety or soundness of the insurers.

4. The Order fails to reconcile HHSI's low RBCs following the removal of so much capital in removing the subsidiaries.

Under the Plan, based on Horizon's financial statements, HHSI 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 the parent insurer HHSI, as are those in the individual market.) This assessment is based on HHSI's most recent 628% RBC ratio[29] which calculation 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.[30] As a result, $1.27 billion of surplus will be removed from HHSI upon reorganization, thereby reducing its RBC to 405% before the payment of any tax assessments. The following chart is based on its 2021 financial statements.

| | HHSI Year End 2021 | Insurance Subsidiary Capital To Be Removed | HHSI Year End 2021 After Removal of Subsidiary Capital |
|---|---|---|---|
| Total Adjusted Capital | $ 3,133,240,870 | $ (1,269,286,569) | $ 1,863,954,301 |
| Authorized Control Level | $ 498,895,715 | $ (38,074,926) | $ 460,820,789 |
| RBC Ratio | 628% | | 405% |

Source: Public Exhibit 5-B: from each subsidiary's 2021 Annual Statements, 5-year historical page at 27.

At 405% RBC, it will be below the 425% threshold established in the Order. The loss of $1.27 billion in capital would also reduce HHSI's 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.

[28] Even if the insurers retained the $300 million (after the $600 million tax) the system-wide health RBC would still have been below 550% (excepting only in 2020). Id. (first highlighted row).

[29] As reported in HHSI's 2021 Annual Statement, 5-year historical page at 27, Public Exhibit 5-B.

[30] *Compare* Organizational charts at Public Exhibit 1-A (current) *with* Public Exhibit 1-B (proposed).

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 $900 million transfer).

5. The Order fails to reconcile Horizon's significant underwriting losses under the second prong.

The above facts leave HHSI in a difficult position. In four of the last five years, Horizon (including its insurance subsidiaries) has suffered underwriting losses, meaning that its medical/hospital, claims adjustment and administrative expenses have exceeded its premium income. As the chart below shows, Horizon suffered $440 million in such underwriting losses in 2021 alone, and $650 million in such losses in total the last five years.

| **Horizon Healthcare Services, Inc.** | | | | | |
|---|---|---|---|---|---|
| | *2017* | *2018* | *2019* | *2020* | *2021* |
| Total Revenues | $12,222,785,696 | $12,456,477,106 | $11,547,551,033 | $12,275,703,270 | $13,763,295,809 |
| Total Medical & Hospital Expenses | $10,691,103,748 | $10,763,210,799 | $10,105,717,753 | $10,140,213,223 | $12,145,080,163 |
| Claims Adjustment Expenses | $ 294,133,728 | $ 286,400,721 | $ 344,960,254 | $ 375,185,928 | $ 342,422,343 |
| Total Administrative Expenses | $ 1,269,261,202 | $ 1,499,377,079 | $ 1,330,523,114 | $ 1,625,934,229 | $ 1,706,418,130 |
| Net Underwriting Gain (loss) | $ (31,712,982) | $ (92,511,493) | $ (233,650,088) | $ 134,369,890 | $ (430,624,827) |

Source: Public Exhibit 5-B: HHSI 2021 Annual Statement, 5-year historical page at 27.

The underwriting losses were even worse for HHSI as a stand-alone insurer (without its insurance subsidiaries). Those underwriting loss were $670 million in 2021 alone, totaling $1.3 billion over the last six years as shown here:

| **Horizon Healthcare Services, Inc.** | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Underwriting Gain/(Loss)** | *2016* | *2017* | *2018* | *2019* | *2020* | *2021* | | *All Years* |
| *Comprehensive (Hospital & Medical)* | $ (142,163,793) | $ (151,751,891) | $ (127,588,329) | $ (169,058,269) | $ (92,179,755) | $ (660,332,268) | | $ (1,343,074,305) |
| *Dental* | $ 13,454,020 | $ 18,967,898 | $ 10,756,740 | $ 11,477,173 | $ 22,525,862 | $ 9,880,379 | | $ 87,062,072 |
| *Federal Employee Health Ben.* | $ (5,925,953) | $ (1,857,464) | $ (26,183,857) | $ (14,163,387) | $ (10,909,956) | $ (8,220,464) | | $ (67,261,081) |
| *Other Health* | $ 5,016,316 | $ (2,539,382) | $ 2,563,693 | $ 3,865,695 | $ 6,021,104 | $ (11,548,087) | | $ 3,379,339 |
| | $ (129,619,410) | $ (137,180,839) | $ (140,451,753) | $ (167,878,788) | $ (74,542,745) | $ (670,220,440) | | $ (1,319,893,975) |

Source: Public Exhibit 5-B: HHSI Annual Statement at 7, and 2016-2020 HHSI Annual Statement at 7.[31] Note: chart applies principally to HHIS (stand-alone) which accounts for virtually all these financials.

These underwriting losses do not include other losses or other income such as investment income. However, the loss of so much surplus will reduce that investment income in the future. *See, e.g.*, Section E.3 *supra*. at Chart (second and fourth highlighted rows for the health insurers combined loss of investment income). Given that investment income is expected to increase in

[31] Publicly available on DOBI's website at https://www.state.nj.us/dobi/division_insurance/solvency/annualstatements/index.html.

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' financial data 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 surplus will be substantially reduced beyond what its financials can support and what Chapter 145 and the Order demand in terms of RBC levels – which is especially problematic because HHSI already operates with significant underwriting losses.

**F. The Public Record is Incomplete.**

The Commissioner's decision to withhold information from the public record concerning the Plan during the public hearing process was overbroad and contrary to the statute. For example, she withheld information regarding Horizon's projected RBC ratios despite their foundational role in the Order and such information did not fall into the exceptions provided for by Chapter 145. Indicative of its overreach, DOBI treated as confidential the MHC's proposed bylaws despite their containing essential information as to the rights and interests of the policyholders as spelled out in Chapter 145.[32] The overreach is further reflected in the confidential treatment of all the amended bylaws listed in the Report at 6-7. In addition, the recovery plan required by N.J.S.A.17:48E-46 was not in the public record. If the recovery plan does not exist, then that is in violation of the requirement, and if it does exist, then it should have been referenced in the record and produced. Appellants have reason to believe that many other such documents have been improperly withheld as well.

DOBI's decision to withhold essential non-privileged information from the public record prejudiced the Appellants' ability to fully participate in the public hearings, undermined the purpose of those hearings, and violated Chapter 145.

**G. Enforcement of the Statutory Standards for Approval is Vital to Securing the Legislative Intent in Protecting Policyholders, and Preserving Horizon as a New Jersey Non-Profit, Charitable Corporation in Any 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, there is one unfavorable scenario – acquisition of Horizon by a for-profit insurer…" *Id*. at 28. 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.[33]

[32] *See* N.J.S.A. 17:48E-46.4 (c), which governs membership interests to be held "in the manner set forth in the articles of incorporation and bylaws" of the MHC; Section 46.9 (a) stating the MHC bylaws may provide the basis for the number of votes for various members; Section 46.9 (b) stating the MHC bylaws will govern election of directors; Section 46.15 (c) stating directors shall have 3 year terms for up to 2 or three successive terms "and as provided for in the bylaws."

[33] *But see* N.J.S.A.17:27A-2 (d)(1) ("The commissioner shall approve any merger or other acquisition of

It follows that to best deter the consultant's for-profit acquisition scenario, and preserve Horizon as a New Jersey charitable institution into the future, **the statutory standard of review must be properly applied now.** Dilution of legal standards in these proceedings would create bad precedent thereby weakening the Legislature's intent to prevent such an outcome in the future. *See* N.J.S.A, 17:48E-46.1(f) ("it is also in the interest of the subscribers of the [HSC and State of N.J.] that the important statutory mission of the [HSC] continues to be upheld following [] reorganization…."); see also Order at 2 ("Chapter 145 requires that any nonprofit [MHC] formed pursuant to Chapter 145 retain its mission as a charitable and benevolent institution and not convert to a for-profit stock holding company…")

## IRREPARABLE HARM REQUIRING A STAY

Appellants will suffer irreparable harm if the requested Stay is not granted for at least the following reasons:

1) Time is of the essence. After December 15, 2022, Horizon may seek to implement the Plan in order to complete the transaction before the end of the year and before the merits of Appellants' appeal can be heard by the Appellate Division on the merits. The rushed regulatory review process is indicative of this intent.

2) Unwinding the mutualization and reorganization provided for under the Plan would be impossible or nearly so. The Plan involves an enormously complex series of transactions, including the formation of nearly a dozen new corporations and the transfer of billions of dollars in assets between companies. The depth and complexity of these transactions are evident by the 22 pages of charts showing the dozens of intricate steps necessary to enact the corporate transformation. [34] *See* Exhibit 1 attached hereto.

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control… unless, after a public departmental hearing thereon, he finds that: … (III) The financial condition of any acquiring party is such as might… prejudice the interest of its policyholders; (v) The plans or proposals which the acquiring party has to liquidate the insurer, sell its assets or consolidate or merge it with any person… are unfair and unreasonable to policyholders of the insurer and not in the public interest; (vi) The competence, experience and integrity of those persons who would control the operation of the insurer are such that it would not be in the interest of policyholders of the insurer and of the public; or (vii) The acquisition is likely to be hazardous or prejudicial to the insurance buying public.") (emphasis added.)

[34] Courts have applied the "unscrambling the eggs" analogy to difficulty of unwinding tender offers and other corporate transactions that fundamentally reorganize the entity. Ronson Corp., 483 F.2d at 851 (3d Cir.1973) (dispute concerning prospective tender offer); Baron v. Strawbridge & Clothier, 646 F. Supp. 690, 697 (E.D. Pa. 1986) (shareholder-director dispute over common stock voting rights); Consolidated Gold Fields PLC v. Minorco, S.A., 871 F.2d 252, 254, 261 (2d Cir.1989) (foreign tender offer impacting market domination); Miller v. LeSea Broad., Inc., 927 F. Supp.1148, 1152 (E.D. Wis. 1996) (sale of television station. stayed where danger existed of intervening sale prior to appellate decision). Similarly, it has long been the law of this State that status quo restraints may also properly be imposed **if the subject matter of the suit may otherwise be destroyed or seriously impaired**. Naylor v. Harkins, 11 N.J. 435, 446 (1953); Christiansen v. Local 680 of Milk Drivers, etc.,127 N.J. Eq. 215, 220 (E. & A. 1939); Haines

3) Because it would be nearly impossible to "unscramble the eggs" once the corporate transformation occurred, the policyholders right to appeal the Order would be prejudiced as Appellants seek only equitable relief and no money damages. *See* Crowe v. DeGioia, 90 N.J. 126, 132-133 (1982) ("Harm is generally considered irreparable in equity if it cannot be redressed adequately my monetary damages."). Moreover, even if it were possible to unwind the transformed corporation, it would be enormously inefficient and costly to do so, which wasteful cost is inconsistent with Horizon's duty to operate as a non-profit, charitable and benevolent health services corporation.

4) The issues here are of utmost public interest given that Horizon is New Jersey's largest health insurer and its only health services corporation, the loss of which would have significant adverse implications for its millions of policyholders and the public, including all insured of Horizon administered self-funded plans who rely on its safety and soundness, if Appellants' analysis of the serious deficiencies in the Plan and Order approving it are vindicated by the Court. *See e.g*., Garden State Equality v. Dow, 216 N.J. 314, 321 (2013) (When a case presents an issue of "significant public importance," a court must consider the public interest in addition to the traditional Crowe v. DeGioia standards for a preliminary injunction).

5) Conversely, Horizon will suffer no harm in allowing the NJCA's and HPAE's appeal to be heard on the merits. The stakes for the public are simply too high compared to the convenience of the reorganizing entity. Moreover, in this case DOBI has an interest in making sure its decision adequately protects the policyholders, the State's interest in receiving future tax payments, and the public's interest in a sound and secure insurer that is able to satisfy its charitable mission to keep insurance accessible and affordable to all New Jersey residents. There is little doubt the "relative hardships to the parties reveals that greater harm would occur if a stay is not granted than if it were." McNeil v. Legis. Apportionment Comm'n, 176 N.J. 484, 486 (2003) (LaVecchia, J., dissenting) (citing Crowe, *supra*, 90 N.J. at 132-34).

## CONCLUSION

Under New Jersey law, applications for a stay pending appeal are governed by the familiar standard outlined in Crowe v. De Gioia, 90 N.J. 126 (1982) *See, e.g*., N.J. Election Law Enforcement Commission v. DiVincenzo, 445 N.J. Super. 187, 195-196 (App. Div. 2016); Matter of Comm'er of Ins. In Deferring Certain Claim Payments by N.J. Auto. Full Ins. Underwriting Ass'n, 256, N.J. Super. 553, 559 (App. Div. 1992). A party, such as NJCA and

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v. Burlington County Bridge Commission, 1 N.J. Super.163, 174 (App. Div. 1949); Costello v. Thomas Cusack Co., 96 N.J. Eq. 83, 90 (Ch. 1924).

HPAE, seeking a stay must demonstrate that (1) relief is needed to prevent irreparable harm; (2) the applicant's claim rests on settled law and has a reasonable probability of succeeding on the merits; and (3) balancing the "relative hardships to the parties reveals that greater harm would occur if a stay is not granted than if it were." McNeil v. Legis. Apportionment Comm'n, 176 N.J. at 486.

The moving party has the burden to prove each of the Crowe factors by clear and convincing evidence. Brown v. City of Paterson, 424 N.J. Super. 176 (App. Div.2012). However**, in acting only to preserve the status quo,** such as the case herein, the deciding body may "place less emphasis on a particular Crowe factor if another greatly requires the issuance of the remedy." *Ibid*. *See also* New Jersey Elec. Law Enforcement Comm'n v. DiVincenzo, *supra*, 445 N.J. Super. at 196; Waste Management of New Jersey, Inc. v. Morris County Mun. Utilities Authority, 433 N.J. Super. 445, 453-4 (App. Div. 2013); Packanack Lake Country Club & Community Assoc. v. Alexander D. Doig Dev. Co. 72 N.J. Super. 360, 368 (Ch. Div. 1962); and Peters v. Public Service Corp. of N.J., 132 N.J. Eq. 500, 511 (Ch. 1942).

Moreover, when a case presents an issue of "significant public importance," such as the case herein, the Commissioner or court must consider the public interest in addition to the traditional Crowe factors. Dow, *supra*, 216 N.J. at 321; McNeil, *supra*, 176 N.J. at 484. *See also* Sheppard v. Township of Franklin, 261 N.J. Super 5 (App. Div. 1992)(interests of others, including the public an important factor); J.H. Renarde, Inc. v. Sims., 312 N.J. Super. 195 (Ch. Div. 1998) (same).

For all the foregoing reasons delineated in this letter brief, NJCA and HPAE have met the standards to secure a stay in this matter pending their appeal on the merits. The potential negative impact of the Commissioner's decision on Horizon's current policyholders, the State (who expects to receive future tax payments for 17 years in exchange for enabling a reorganization to a mutual holding company), and the public's interest in ensuring that its largest health insurer is able to satisfy its charitable mission to keep insurance accessible and affordable to all New Jersey resident cannot be emphasized enough. The truncated public process and the obvious rush to get this done, without satisfying the Legislature's clear interests and legal standards to protect the policyholders and the public, cannot be condoned. The Commissioner now has the ability to get this decision right; a stay must be issued to protect all the residents of New Jersey.

Respectfully Submitted,

/s/Renée Steinhagen
Renée Steinhagen, Esq.
New Jersey Appleseed PILC
renee@njappleseed.org

/s/ Jason B. Adkins
Jason B. Adkins, Esq
John Peter Zavez, Esq
Adkins, Kelston & Zavez, P.C.
90 Canal Street, Suite 100
Boston, MA 02445
(617) 308-5392
Jadkins@akzlaw.com

Cc : Justin Zimmerman, Chief of Staff
Kavin Mistry, DAG

Attachment: Exhibit 1
(Horizon Public Exhibit regarding multi-step reorganization process)