RECORD IMPOUNDED

SUPERIOR COURT OF NEW JERSEY
APPELLATE DIVISION
DOCKET NO. A-1121-22

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.

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Argued May 1, 2023 — Decided May 31, 2023

Before Judges Whipple, Mawla, and Smith.

On appeal from the New Jersey Department of Banking and Insurance.

Jason B. Adkins (Adkins, Kelston & Zavez, PC) of the Massachusetts bar, admitted pro hac vice, argued the cause for appellants New Jersey Citizen Action, Inc., and Health Professionals and Allied Employees, Inc. (New Jersey Appleseed Public Interest Law Center, Inc., and Jason B. Adkins, attorneys; Renée Steinhagen and Jason B. Adkins, on the briefs).

G. Glennon Troublefield argued the cause for respondent Marlene Caride, Commissioner of the New Jersey Department of Banking and Insurance (Carella, Byrne, Cecchi, Olstein, Brody & Angelo, PC, and Matthew J. Platkin, Attorney General, attorneys; G. Glennon Troublefield, Brian H. Fenlon, Marc D. Mory,

and Richard E. Wegryn, Jr., Deputy Attorney General, on the brief).

Andrew I. Hamelsky argued the cause for intervenor Horizon Healthcare Services, Inc. (Stradley Ronon Stevens & Young, LLP, and Windels Marx Lane & Mittendorf, LLP, attorneys; Andrew I. Hamelsky, Antonio J. Casas, and Julie R. Tattoni, of counsel and on the brief; Zaara B. Nazir and Deenah Z. Sirota, on the brief).

PER CURIAM

Appellants New Jersey Citizen Action, Inc., and Health Professionals and Allied Employees, Inc. appeal from a November 1, 2022 order by the Commissioner of the Department of Banking and Insurance (DOBI), granting Horizon Health Services, Inc.'s (HHSI's) reorganization application. We affirm.

This lawsuit challenges the reorganization of HHSI from a mutual insurance company to a mutual insurance holding company (MHC), pursuant to P.L. 2020, Chapter 145, N.J.S.A. 17:48E-46.1 to -46.17 (Chapter 145). Chapter 145 defines an MHC as "a non-insurance, nonprofit entity without permanent capital stock organized . . . for the purpose of holding, directly or indirectly, one hundred percent interest in a reorganized insurer pursuant to a plan of

reorganization . . . ." N.J.S.A. 17:48E-46.2.[1] Prior to the reorganization, HHSI owned its subsidiaries. The reorganization envisioned the creation of Horizon Mutual Holdings (HMH), as the parent company of HHSI's subsidiaries. HHSI would then become a subsidiary stock insurance company owned by HMH.

In 2020, the Legislature enacted Chapter 145, to provide a mechanism for HHSI to reorganize as an MHC. N.J.S.A. 17:48E-46.1. The Legislature explained its intent as follows:

> It is in the interest of the subscribers of the health service corporation [HSC] and the State . . . that the [HSC] be afforded the ability to modernize its corporate structure . . . in order to meet the evolving [healthcare] needs of its subscribers, while continuing its statutory mission, and maintaining its status as a charitable and benevolent institution [pursuant to N.J.S.A. 17:48E-41].
>
> [N.J.S.A. 17:48E-46.1(a).]

[1] An MHC is "[a] corporate structure that allows insurers to retain elements of mutuality while affording them greater strategic flexibility, including a wider array of options for executing mergers and acquisitions . . . and the ability to grow ancillary and non-insurance subsidiaries while preserving the benefits of mutuality for current members." Mutual Holding Company Conversions Continue as Insurers Seek M&A Flexibility, S&P Glob. Mkt. Intel. (Sept. 22, 2020), https://www.spglobal.com/marketintelligence/en/news-insights/latest-news-headlines/mutual-holding-company-conversions-continue-as-insurers-seek-m-a-flexibility-60353763.

As an HSC, HHSI is the only insurer in New Jersey with a statutory mission to benefit its policyholders. N.J.S.A. 17:48E-3(a). It is New Jersey's largest and oldest health insurer and the only nonprofit health insurer in the State. HHSI is currently a mutual company, which is "[a] company that is owned by its customers rather than by a separate group of stockholders" or shareholders. Black's Law Dictionary 340 (10th ed. 2014).

Chapter 145 expands and modernizes HHSI's important "statutory mission . . . to provide affordable and accessible health insurance" by "encourag[ing] further innovation[,] as well as improvement and diversification of services." N.J.S.A. 17:48E-46.1(e), (f). Among Chapter 145's most significant advantages is HHSI's ability to make investments, which was restricted in its previous form. N.J.S.A. 17:48E-46.7.

Chapter 145 provides membership in the new MHC "shall be determined in accordance with the . . . articles of incorporation and bylaws and may be based upon: (1) the amount of health insurance policies in force with the reorganized insurer; (2) the amount of the health insurance premiums paid to the reorganized insurer; or (3) other reasonable factors." N.J.S.A. 17:48E-46.9. The statute also directs the voting rules for directors to be in accordance with the new company's bylaws. N.J.S.A. 17:48E-46.9(b). The Board, comprised of members elected to

the Board, and public members appointed by the Governor, Senate President, and Speaker of the General Assembly, is also set by statute. N.J.S.A. 17:48E-46.15(a).

Chapter 145 provides a mechanism for HHSI to "submit an application to the [C]ommissioner to form a[n MHC,]" which includes the submission of a plan that further includes "proposed articles of incorporation[,] . . . bylaws[,] . . . and plans of merger or consolidation" and other requirements. N.J.S.A. 17:48E-46.5(a)(1)-(8). The plan must include:

> (1) the purpose of the conversion;
>
> (2) the effect of conversion on existing subscriber contracts issued by the [HSC];
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> (3) a business plan;
>
> (4) a provision that each policyholder shall receive any rights with respect to the mutual insurer as may be prescribed by the [C]ommissioner, provided that such rights shall not exceed the rights provided to policyholders of other domestic mutual insurers authorized to transact the business of health insurance;
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> (5) a provision that each policyholder shall be notified of the conversion, which notification process shall be approved by the [C]ommissioner; and
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> (6) a provision incorporating the recovery plan established pursuant to [N.J.S.A. 17:48E-17.1].
>
> [N.J.S.A. 17:48E-46(a).]

The restructuring subjects HHSI to new tax assessments, including an initial installment of $600 million due by June 1 of the calendar year the plan becomes effective. N.J.S.A. 17:48E-46.13(a). Thereafter, the MHC "shall pay a limited duration business tax . . . for a period of seventeen years" on the June anniversary date. N.J.S.A. 17:48E-46.13(b). The total tax assessment for all eighteen payments "shall not exceed [$1.25 billion]." Ibid. The annual tax assessment contains an exception where "the [MHC] shall not pay any portion . . . for a given calendar year if the [MHC]'s system-wide health risk-based capital [(RBC)[2]] authorized control level would fall below 550 percent . . . ."

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[2] 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 obligations to policyholders.

> 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.
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> . . . .
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> If the ratio is at or above 200%, no regulatory intervention is needed. . . . If the ratio is below [seventy percent], a regulator is obligated to take over management of the company.

N.J.S.A. 17:48E-46.13(c). If the MHC does not pay an annual tax assessment based on its failure to maintain the minimum RBC, the assessment is deferred to the following calendar year. N.J.S.A. 17:48E-46.13(d).

The statute mandates the Commissioner review HHSI's plan and "hold three public hearings . . . within [ninety] days after the [C]ommissioner determines that the filing is complete, with notice provided by publication in a manner satisfactory to the [C]ommissioner." N.J.S.A. 17:48E-46.5(b).

> [T]he [C]ommissioner shall approve a plan of mutualization and reorganization unless the [C]ommissioner 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 [MHC]; or (3) does not benefit the interests of the policyholders of the [HSC] or treats them inequitably.
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> [Ibid. (the disapproval factors).]

The statute also empowers the Commissioner to "engage the services of experts and consultants to advise" and "conduct a [voluntary] health impact study of the effects of the reorganization . . . ." Ibid.

> [Risk-Based Capital, NAIC, https://content.naic.org/cipr-topics/risk-based-capital (last updated Dec. 6, 2022); see also N.J.A.C. 11:2-39A.10.]

Chapter 145 grants the Commissioner "supervisory powers with respect to the insurance holding company system[,] which . . . include the authority to monitor the [MHC] system's financial health, enterprise risk, and examine its operations . . . ." N.J.S.A. 17:48E-46.6. The Commissioner may also "order production of any records, books, or other information and papers . . . as are reasonably necessary to ascertain the financial condition . . . to determine compliance with [Chapter 145]." Ibid. Chapter 145 states HHSI's plan application "shall be a public record, except for . . . (1) documents deemed confidential by statute or regulation; (2) the business plan, capitalization plan, financial projections, and market competitive data; and (3) any other information the [C]ommissioner determines could result in harm . . . if disclosed." N.J.S.A. 17:48E-46.12.

In August 2022, HHSI submitted its application. The Commissioner released the nonconfidential portions, including: over 800 pages of exhibits; the proposed corporate structure; notice to members; the articles of incorporation; the compositions of the Board of HHSI and its subsidiaries; and balance sheets and income statements from HHSI and its subsidiaries.

The proposed articles of incorporation stated HMH "is organized as a not-for-profit corporation and will not be required to pay dividends or make any

other distributions to any member or policyholder, or to any other person, fund, or entity of any nature whatsoever . . . ." The articles established a twenty-two-member Board and provided that membership in the new company is subject to the company's bylaws.

The Commissioner deemed HMH's business plan confidential. It contained financial projections through 2024 regarding enrollment and revenue, the effect on a subsidiary's revenue as the result of increases in HHSI providing ancillary services, and another subsidiary's enrollment and revenue. The plan projected HHSI would remain stable through reorganization, and the company's recovery from the effects of the COVID-19 pandemic.

The Commissioner deemed the bylaws confidential. The bylaws detailed that only HHSI policy holders would become members of the HMH. Aside from special meetings called by the HMH Board and CEO, the bylaws require annual meetings of the membership on notice provided. Each member is entitled to one vote and may only vote on the election of HMH directors.

The Commissioner held public hearings on October 6, 11, and 17, 2022. DOBI publicized the meetings beforehand by issuing a press release, transmitting media advisories to several media outlets, postings on social media,

and notice in seven New Jersey newspapers. DOBI accepted written comments through October 18, 2022, after which the record was deemed closed.

DOBI engaged two actuarial firms specialized in the health care industry to assist it in evaluating the plan and the effects of the reorganization. On October 30, 2022, one consultant issued a health impact study on the proposed reorganization. On October 31, 2002, both consultants issued a joint post-hearing report, summary, and evaluation of HHSI's application.

The post-hearing report described Chapter 145's requirements and summarized HHSI's history and application for reorganization. It also recited the evidence considered, including the plan materials, consultant's reports, and the written and oral testimony of "approximately 600 people representing several categories of New Jersey stakeholders . . . ." Among those who testified were policyholders, consumers, non-profit entities, healthcare providers and hospitals, trade associations and business groups, insurance brokers, consultants, and consumer group coalitions, including appellants.

The report recounted procedural objections raised by appellants to: items deemed confidential; the amount of notice provided in advance of the hearings; the completeness of the application; and DOBI's failure to disclose the consultant's reports prior to the hearings. The report cited the Commissioner's

authority under Chapter 145 to designate aspects of the application confidential and noted she had "determined the maximum extent to which parts of HHSI's application could be made public under . . . Chapter 145 [and] promptly posted such documents to [DOBI's] website . . . ."

Appellants also objected to the lack of specificity regarding the proposed investments HHSI would be making and whether they benefitted the policy holders. The report responded "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."

Appellants raised concerns about HMH's governance structure, contending that the reorganization would not enable HHSI to maintain its charitable mission, and HMH would cede control to third parties via joint ventures whose priorities were not aligned with its charitable mission. Addressing these points, the Commissioner's report noted these arguments did not demonstrate that the reorganization would be contrary to law, and therefore, did not constitute grounds for disapproval. Regardless, the Attorney General submitted a public comment letter reiterating his role "'as protector, supervisor, and enforcer of charitable trusts and . . . corporations, which includes Horizon

in its current form and in any new, future corporate form.' . . . [And] that 'Chapter 145 does not diminish the Attorney General's oversight power.'"

The report further noted Chapter 145 did not mandate HHSI's "policyholders control the board of HMH just that HMH exist and operate for the benefit of [the] policyholders." Appellants' arguments regarding the Board's structure and control of HHSI's assets were addressed by Chapter 145, which "was explicitly designed to enable HHSI to more robustly invest through HMH, including in for-profit entities,[] while specifically maintaining a charitable and benevolent mission at the MHC level.[]"

The report addressed the health impact study, noting its purpose was to "examine[] the statutory mission and charitable status issues in regard to HHSI's restructuring" and its "impact on policyholders and the general public." The report noted the impact study examined: the needs and costs of subscribers; the availability of quality care to underserved and vulnerable individuals; health insurance markets; provider networks and compensation; claim processing and payment; and "the health care needs of all New Jerseyans and the promotion of the public interest . . . ." The impact study concluded the restructuring "would maintain the policyholder benefits associated with HHSI's unique status in the

New Jersey market, including explicit Horizon commitments to both its statutory mission and charitable status."

The report also noted DOBI staff and consultants attended all the public meetings, read the public commentary, and reviewed HHSI's application in light of the health impact study and concluded there was no reason to disapprove of the plan under Chapter 145. The consultants made several observations and recommended the Commissioner "impose certain conditions on any potential approval to provide a greater measure of assurance that Horizon operate" consistent with the goals of Chapter 145, "in the interest of policyholders and maintain safe and sound insurance subsidiaries."

The observations were that HMH preserve Horizon's charitable mission, offer comprehensive individual coverage in every county, and not increase policyholder premiums. Additionally, the consultants observed there was concern HHSI's charitable assets would be used to support for-profit entities without benefitting policyholders or New Jerseyans, and that allowing for such distributions without sufficient controls would harm policyholders by depriving the insurer of funds to pay claims. They noted neither Chapter 145 nor HHSI's application explained what would happen "if HMH fail[ed] to maintain a system-wide health RBC of 550%, or fail[ed] to maintain an investment-grade

group credit rating," and had to defer an annual assessment required by Chapter 145.

In response to these observations, the report found Horizon's plan preserves its charitable mission because Chapter 145 requires any MHC created "shall not be established as a company organized for pecuniary profit and shall retain the [HSC's] designation as a charitable and benevolent institution." (alteration in original). The articles of incorporation further require in the event of dissolution, residual assets are to be distributed "'to one or more charitable and benevolent institutions in furtherance of the purposes' of HMH."

In response to the concern about medical coverage in each county, the report recommended the imposition of a condition that Horizon continue to offer comprehensive medical coverage in every county. The report found no evidence premiums would increase. Rather, there was evidence Horizon's new premium tax liability "would be reduced to one-eighth of what it currently pays, and such savings could be passed on to policyholders in the form of decreased premiums."

The report found a $300 million distribution required by the statute from Horizon to fund HMH could be regulated through a dividend moratorium,

minimum RBC requirements, and a parental guarantee.[3] Although Chapter 145 required an RBC of 200%, the report recommended that each of HMH's subsidiaries, HHSI, Horizon Healthcare of New Jersey (HHNJ), and Horizon Insurance Company (HIC), be subject to a 425% RBC. Further, HMH would sign a parental guarantee perpetually guaranteeing the minimum RBCs of each subsidiary. In addition to having to file the RBC every year and provide quarterly estimates, HMH would have to satisfy shortfalls within thirty days of the annual filing, and DOBI would have to approve any changes to the guarantees. Additionally, there would be a three-year moratorium on the payment of a dividend by any HMH subsidiary to HMH or an affiliate. In this way, HMH would not accumulate cash unnecessarily and would have the flexibility to invest the $300 million to serve its charitable purpose.

Given these conditions, the report rejected the assertion HHSI had to specify how the $300 million distribution would be deployed because the public comments showed HHSI properly invested its money to "bolster access to

[3] A parental guarantee is a promise from the parent company, in this case HMH, to pay the obligations of the subsidiary, here HHSI, in the event the subsidiary is unable to meet its obligations. Parent Company Guarantee Law and Legal Definition, USLegal, https://definitions.uslegal.com/p/parent-company-guarantee/ (last visited Apr. 27, 2023).

behavioral health, address social determinants of health, and empower minority and underserved communities in New Jersey." Moreover, the Attorney General would exercise his "oversight and investigational authority to protect the public interest . . . ."

In response to concerns about the RBC, the report recommended the imposition of three conditions. Horizon would have to annually report its system-wide financial health, and HMH would have to notify DOBI if the RBC dropped below 550% or failed to maintain a BBB credit rating. HMH would annually file allocations of the annual assessments before making such payments and, if necessary, obtain third-party reinsurance in the event changes in the system-wide RBC "endanger the safety and soundness of the [MHC] system."

The report concluded Horizon's plan did not trigger any of the disapproval factors under N.J.S.A. 17:48E-46.5(b). Indeed, no element of the plan was contrary to law. N.J.S.A. 17:48E-46.5(b)(1). In addition to Attorney General oversight, the plan and the conditions would ensure Horizon continued its charitable mission.

Further, "the capital distributions contemplated in the [p]lan, together with the substantial restrictions on future distributions, do not form a basis to conclude that the [p]lan would be detrimental to the safety or soundness of the

proposed reorganized insurer" under N.J.S.A. 17:48E-46.5(b)(2). In addition to the parental guarantee,

> the [c]onditions ensure that the reorganized insurer and the two other . . . subsidiaries of the MHC will maintain RBC levels [of] at least 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 . . . subsidiaries.

The report found no "basis to determine that the [p]lan does not benefit the HSC's policyholders or treats them inequitably" under N.J.S.A. 17:48E-46.5(b)(3). This is because "the [c]onditions reinforce the statutory requirement that HHSI . . . offer individual market coverage in every county in the [S]tate." The plan contained no provisions that would lead to an increase in premiums, and instead, the evidence showed premiums would decrease. Additionally, the limitations on the distributions from subsidiaries to MHC, the RBC levels, and conditions associated with them "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."

The Commissioner ordered the health impact study "to understand whether this reorganization would carry out the goals of Chapter 145 without negatively impacting the long-standing policyholder and public benefits

stemming from Horizon's statutory mission and charitable status . . . ." The study analyzed the pressures and possible benefits to Horizon as a BCBSA[4] licensee from other BCBSAs who have merged or acquired other licensees. The study noted Horizon is the ninth largest BCBSA in the nation and its reorganization into a "new holding company structure would give [it] a range of strategic opportunities," including acquiring another licensee, diversifying within New Jersey, or focusing on deepening its commitment to serve all health insurance markets in New Jersey. The study recommended DOBI "closely monitor Horizon to ensure [improving health] outcome[s] and prevent Horizon from acting in ways that are not consistent with its statutory mission under Chapter 145."

The study concluded "the proposed transaction does achieve the legislative intent of enabling modernization while maintaining the policyholder benefits associated with Horizon's unique status in the New Jersey market, including explicit Horizon commitments to both its statutory mission and its charitable status." The study opined "there is a firm basis for [DOBI] to approve the proposed transaction under the applicable legal standards of [N.J.S.A. 17:48E-46.5(b).]"

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[4] Blue Cross Blue Shield Association.

On November 1, 2022, the Commissioner entered an order allowing the reorganization and mutualization of Horizon, subject to the following conditions:

> 1. One or more insurers controlled by HMH shall at all times continue to offer [c]omprehensive [m]edical coverage, compliant with all appropriate state and federal laws and regulations, in the individual market in each county in the State of New Jersey.
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> 2. HHSI may transfer an amount not more than $300 million concurrent with the formation of the [MHC] system from HHSI, . . . HHNJ[,] . . . HIC . . . , or Horizon Healthcare Dental, Inc. ([]HHD[]) to HMH.
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> 3. After the initial capitalization of HMH . . . , HHSI and any other direct or indirect insurance subsidiary or affiliate of HMH shall not, without the express prior written approval of the Commissioner, declare or pay any dividend (ordinary or extraordinary) to HMH or any HMH subsidiary or affiliate for a period of three years following the effective date of the mutualization and reorganization.
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> 4. Following the mutualization and reorganization, HHSI, HHNJ and HIC shall each be subject to a minimum . . . RBC . . . of 425% of authorized control level (ACL) RBC and that HHD shall be subject to a minimum RBC of 200% of ACL RBC.
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> 5. HMH's system-wide health RBC shall be calculated using the NAIC [RBC] for [h]ealth [o]rganizations methods and instructions, HMH shall value all investments in accordance with such instructions, and HMH shall file such an RBC report to [DOBI] annually with its annual statement.

6. Consistent with the requirements of N.J.S.A. 17:48E-46.11, HMH shall submit its financial statements in accordance with the NAIC [a]nnual [s]tatement [b]lank and [i]nstructions annually.

7. Following the end of the first quarter after the effective date of the mutualization and reorganization, HMH and all insurer subsidiaries and insurer affiliates shall file their first estimates of the system-wide health RBC with [DOBI] with their quarterly statements, and shall continue to file such RBC estimates each quarter thereafter with their quarterly statements, except for at calendar year-ends when the annual statements and annual RBC calculations are filed with [DOBI]. The HMH annual and quarterly statements shall accrue any estimated annual assessments to the State of New Jersey in accordance with Statement of Statutory Accounting Principles No. 5R and as approved in advance by [DOBI], for which the annual assessments shall be paid by June 1 of the following calendar year.

8. HMH shall notify [DOBI] within five business days in the event that its officers anticipate that HMH's system-wide RBC will drop below 550% or that HMH shall fail to maintain a BBB credit rating, and, in such case, the officers will file financial statements and RBC projections in a form and timeframe satisfactory to [DOBI], which statements and projections shall include, for each of the subsequent eight quarters, for HMH and for each of the insurers, a projected balance sheet, income statement, statement of cash flows, and statement of changes in surplus, with detailed assumptions and explanations for the current financial position and the results of operations, in each case in accordance with statutory accounting principles (which projections will include, but not be limited to, (1) HMH-level projected [t]otal [a]djusted [c]apital, ACL

RBC, and RBC as percent of ACL; (2) each insurers' projected premiums, claims, general administrative expenses, taxes and fees, assessments, and net income (loss); (3) revenues, expenses, taxes, and net income (loss) for any non-insurance businesses that consolidate within HMH).

9. HMH shall file annually with [DOBI] on or before February 1 and shall obtain prior approval by [DOBI] of any allocations of the annual assessments required by N.J.S.A. 17:48E-46.13, consistent with the authority assigned to the Commissioner by N.J.S.A. 17:27A-4.

10. To the extent HMH's RBC is less than 550% upon any quarterly or annual filing, HMH shall submit for the following quarter a confidential information filing in accordance with paragraph [eight] above concerning the projected RBC for HMH and the insurance subsidiaries.

11. HMH and its officers shall provide to the Commissioner a fully executed written copy of, within [ninety] days of the date of this [o]rder, a parental guarantee, in a form approved in advance by the Commissioner, from HMH to the regulated entities to maintain their minimum RBCs as stated in paragraph [four] above, which guarantee shall meet the following requirements: (1) the RBCs are perpetual; (2) the annual RBC filing shall be filed by March 1 of each year, and the first, second, and third quarter estimates of each insurer's RBC shall be filed within [forty-five] days after each quarter end; (3) the parent must fully correct and rectify any shortfalls within [thirty] days after the annual RBC filing or quarterly estimate is delivered; and (4) [DOBI] must approve in advance any modifications of the parental guarantee.

> 12. The [e]ffective [t]ime of the reorganization into a[n MHC] structure and the plan of reorganization shall be November 1, 2022.

Appellants requested the Commissioner stay the order.[5] They argued: 1) the notice of the proceedings was contrary to the law and treated policyholders inequitably; 2) the Commissioner applied the incorrect legal standard under N.J.S.A. 17:48E-46.5(b)(3); 3) the order failed to establish by substantial evidence that the plan benefits policyholders or does not treat them inequitably, pursuant to N.J.S.A. 17:48E-46.5(b)(3); 4) the order incentivizes Horizon to underfund its health insurers and amass profits in the MHC; 5) the order failed to establish by substantial evidence that the plan would not be detrimental to the safety or soundness of the proposed reorganized insurers pursuant to N.J.S.A. 17:48E-46.5(b)(2); 6) the public record concerning the plan was incomplete and violated Chapter 145; and 7) the Commissioner had to apply the statutory standard of approval under N.J.S.A. 17:48E-46.5(b) properly, in order to preserve Horizon as a non-profit, charitable corporation in the event of a future hostile acquisition.

[5] Simultaneously, appellants also filed their appeal and an emergent application before us with a request for a stay, which we denied.

The Commissioner denied the stay and issued a written decision on December 23, 2022. She concluded she "adhered to Chapter 145's requirements for public notice and hearing and made efforts to provide as much notice and opportunity for comment as is reasonable." This included the press release, newspaper commissions, and social media advisories of the three hearings, in person and virtually, at different times. She pointed out the notice provisions of N.J.S.A. 17:48E-46.5(b) and N.J.S.A. 17:48E-46(a)(5) contained different standards, and the requirement of notifying each policyholder of the "conversion . . . plainly does not require prehearing notice . . . ." She found notice of the conversion could not be completed until it has been approved, as there would be no conversion to provide notice of.

Responding to appellants' assertions she applied the wrong legal standard to N.J.S.A. 17:48E-46.5(b)(3), the Commissioner found that the statute "creates a presumption of approval unless [she] finds that the plan does not benefit the policyholders' interests . . . [and] does not require [her] to make an affirmative finding that the reorganization would benefit policyholders' interests . . . ." The presumption of approval requires "substantial evidence" the plan would not benefit policyholders or would treat them inequitably, which appellants did not establish.

The Commissioner rejected appellants' underfunding argument reasoning "the 550% [RBC] threshold is measured against all capital 'system-wide' whether held directly by HMH or its regulated or non-regulated subsidiaries." Therefore, "the incentives [petitioners] hypothesize do not exist." Similarly, the Commissioner rejected the argument she erred in finding the plan would not be detrimental to the safety or soundness of the proposed reorganization under N.J.S.A. 17:48E-46.5(b)(2). She examined the entire record and "the minimum RBCs, the dividend moratorium and the parental guarantee, together with [DOBI]'s ongoing oversight of all insurance companies, . . . led [DOBI] to conclude the [p]lan is not detrimental to the safety and soundness of the regulated insurers."

The Commissioner found appellant's claims the record was incomplete and undermined the public hearing process, were without merit because they failed to cite or explain where the record was lacking. She noted DOBI took steps to publish all information required by Chapter 145 and gave the public access to the record by establishing a website. The application was publicly available and she exercised her discretion to designate certain documents as confidential, "consistent with the law[, N.J.S.A. 17:48E-46.12(a),] and [DOBI's] customary practices."

The Commissioner found appellants' argument she erred because she did not consider the possibility of a future hostile acquisition of one or more of HMH's insurance entities did not prove she misapplied Chapter 145 to the facts presented. She concluded appellants' "comments as to any possible future events do nothing to alter the statutory provisions that were followed."

We granted appellants' motion to compel a statement of the items comprising the record, pursuant to Rule 2:5-4, and directed the parties to confer regarding the provisions of a protective order for those portions of the record DOBI considered confidential. The parties entered an order designating the following documents confidential: the board of directors' minutes and resolution concerning the reorganization plan; the proposed bylaws of HMH and the reorganized HHSI; Horizon's business plan; Horizon's capital account and RBC following reorganization; the consultants' original reports; and excerpts from HHSI's 2022 annual statement. The parties filed supplemental briefs re-addressing their arguments pursuant to the documents received under the confidentiality order.

On appeal, appellants argue the Commissioner's decision should be reversed because it is contrary to law and unsupported by substantial evidence in the record. They reiterate the Commissioner erred because she misinterpreted

and misapplied Chapter 145 by: providing inadequate notice of the proceedings; applying the wrong legal standard to N.J.S.A. 17:48E-46.5(b)(3), and failing to assess whether the plan "meets the actual 'benefit the interests of the policyholders' or does not 'treat[] them inequitably'" (alteration in original); failing to assess whether there was substantial evidence that the plan is not contrary to law under N.J.S.A. 17:48E-46.5(b)(1); and failing to consider whether the plan would not be detrimental to the safety or soundness of the proposed reorganized insurers pursuant to N.J.S.A. 17:48E-46.5(b)(2).

Appellants further assert the Commissioner abused her discretion by "excluding essential documents" from the public record, including the bylaws, which explain the membership and voting rights of the MHC. They reiterate the Commissioner did not consider the Legislature's intent to protect policyholders by preventing a future hostile acquisition of Horizon.

I.

We review a State agency decision under the arbitrary and capricious standard. In re Camden Cnty. Prosecutor, 394 N.J. Super. 15, 22-23 (App. Div. 2007) (internal quotations omitted) (quoting Cnty. of Gloucester v. Pub. Emp. Rels. Comm'n, 107 N.J. Super. 150, 156 (App. Div. 1969)). Our inquiry is limited to:

> (1) whether the agency's action violates the enabling act's express or implied legislative policies; (2) whether there is substantial evidence in the record to support the findings on which the agency based its actions; and (3) whether, in applying the legislative policies to the facts, the agency clearly erred by reaching a conclusion that could not reasonably have been made on a showing of the relevant factors.
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> [N.J. Coal. of Health Care Pros. v. Dep't of Banking & Ins., 323 N.J. Super. 207, 231 (App. Div.), certif. denied, 162 N.J. 485 (1999) (quoting In re Warren, 117 N.J. 295, 296-97 (1989)).]

"The actions of an administrative agency are presumed to be valid and reasonable if they are within the authority delegated to the agency." Id. at 229 (citing Bergen Pines Cnty. Hosp. v. N.J. Dep't of Hum. Servs., 96 N.J. 456, 477 (1984)). "The burden of demonstrating that the agency's action was arbitrary, capricious[,] or unreasonable rests upon the [party] challenging the administrative action." In re Adoption of Amends. to Ne., Upper Raritan, Sussex Cnty., 435 N.J. Super. 571, 582 (App. Div. 2014) (second alteration in original) (quoting In re Arenas, 385 N.J. Super. 440, 443-44 (App. Div.), certif. denied, 188 N.J. 219 (2006)).

"'We afford [an] agency great deference' in reviewing its 'interpretation of statutes within its scope of authority' in recognition of the agency's 'specialized expertise.'" McClain v. Bd. of Rev., Dep't of Lab., 451 N.J. Super. 461, 466-67

(App. Div. 2017), aff'd, 237 N.J. 445 (2019) (first alteration in original) (quoting N.J. Soc'y for Prevention of Cruelty to Animals v. N.J. Dep't of Agric., 196 N.J. 366, 385 (2008)). Wide discretion is accorded to administrative agencies to decide "how best to approach legislatively assigned administrative tasks . . . ." In re Failure by the Dep't of Banking & Ins. to Transmit a Proposed Dental Fee Schedule to OAL, 336 N.J. Super. 253, 262 (App. Div. 2001) (citing Dougherty v. Dep't of Hum. Servs., 91 N.J. 1, 6 (1982)). "[P]owers expressly granted to an administrative agency should be liberally construed so that the agency can fulfill the Legislature's purpose . . . ." Bd. of Educ. of Upper Freehold Reg'l Sch. Dist. v. State Health Benefits Comm'n, 314 N.J. Super. 486, 492 (App. Div. 1998) (quoting In re Request for Solid Waste Util. Customer Lists, 106 N.J. 508, 516 (1987)). "[A]n agency's express authority is augmented by such incidental authority as may be reasonably necessary or appropriate to effectuate the expressly delegated authority." Ibid. (quoting In re Request for Solid Waste, 106 N.J. at 508).

Thus, "an agency's authority encompasses all express and implied powers necessary to fulfill the legislative scheme that the agency has been entrusted to administer." In re Virtua-W. Jersey Hosp. Voorhees for Certificate of Need, 194 N.J. 413, 422-23 (2008). Administrative agencies hold wide discretion and

authority to select the means and procedures by which to meet their statutory objectives. Texter v. Dep't of Hum. Servs., 88 N.J. 376, 383 (1982).

However, we are "not bound by an agency's determination on a question of law." Garden State Check Cashing Serv., Inc. v. Dep't of Banking & Ins., 237 N.J. 482, 489 (2019) (quoting Hargrove v. Sleepy's, LLC, 220 N.J. 289, 301-02 (2015)). We "apply de novo review to issues of statutory interpretation." Id. at 489 (citing Kocanowski v. Twp. of Bridgewater, 237 N.J. 3, 10 (2019)).

Pursuant to these principles, we affirm substantially for the reasons expressed in the Commissioner's decision. The record amply demonstrates the decision was neither arbitrary, capricious, nor unreasonable, but instead based on a thorough analysis of the evidence in the record, the arguments raised by appellants, and concerns asserted by others, including the consultants relating to Horizon's plan and its effects on policyholders. We add the following comments to address the statutory interpretation arguments.

II.

"The Legislature's intent is the paramount goal when interpreting a statute and, generally, the best indicator of that intent is the statutory language." DiProspero v. Penn, 183 N.J. 477, 492 (2005) (citing Chasin v. Montclair State Univ., 159 N.J. 418, 426-27 (1999)). When determining legislative intent from

a statute's language, "words and phrases shall be read and construed with their context, and shall, unless inconsistent with the manifest intent of the [L]egislature or unless another of different meaning is expressly indicated, be given their generally accepted meaning, according to the approved usage of the language." State v. Hupka, 203 N.J. 222, 232 (2010) (quoting N.J.S.A. 1:1-1). Words within a statute should be construed "in context with related provisions so as to give sense to the legislation as a whole," and if the plain language is clear, that meaning should be applied, ending the inquiry. DiProspero, 183 N.J. at 492.

"Another important guidepost is the bedrock assumption that the Legislature [does] not use 'any unnecessary or meaningless language,' . . . so a court 'should try to give effect to every word of [a] statute . . . [rather than] construe [a] statute to render part of it superfluous . . . .'" Jersey Cent. Power & Light Co. v. Melcar Util. Co., 212 N.J. 576, 587 (2013) (internal citations omitted) (second, third, and fourth alterations in original). "Accordingly, '[w]e must presume that every word in a statute has meaning and is not mere surplusage.'" Ibid. (alteration in original) (quoting Cast Art Indus., LLC v. KPMG LLP, 209 N.J. 208, 222 (2012)). A reviewing court shall "not 'rewrite a plainly-written enactment of the Legislature [or] presume that the Legislature

intended something other than that expressed by the plain language.'" In re H.D., 241 N.J. 412, 418 (2020) (alteration in original) (quoting State ex rel K.O., 217 N.J. 83, 91-92 (2014)).

A.

We reject appellants' assertion the Commissioner misinterpreted the notice provision of the statute, N.J.S.A. 17:48E-46(a)(5). They claim the Commissioner erred because she allowed individual notice to the policyholders up to 180 days after approval of the plan. They allege the Commissioner's finding the term "conversion" in N.J.S.A. 17:48E-46(a)(5), meant notice issued post-reorganization was incorrect because "the only statutory definition of 'conversion' that does not repeat the term conversion as part of the definition appears in N.J.S.A. 18:48E-49[,] which defines conversion as a 'process.'" Appellants assert this "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." Appellants contend the misinterpretation of the notice requirement "enabled Horizon to send direct notice to only some of its policyholders in order to manufacture testimony in

support of its [p]lan" resulting in submissions that did not reflect the sentiments of actual policyholders, thereby tainting the proceedings and the outcome.

N.J.S.A. 17:48E-46.5(b) requires the Commissioner to "hold three public hearings on the plan to form a[n MHC] within [ninety] days after the [C]ommissioner determines that the filing is complete, with notice provided in a manner satisfactory to the [C]ommissioner." (Emphasis added). These hearings "shall also address the plan of reorganization to the [MHC] system required by [Chapter 145]." Ibid. N.J.S.A. 17:48E-46.5(a) incorporates the requirements of N.J.S.A. 17:48E-46(a), which mandates the plan to form an MHC must include "a provision that each policyholder shall be notified of the conversion, which notification process shall be approved by the [C]ommissioner . . . ." N.J.S.A. 17:48E-46(a)(5).

Chapter 145 does not define conversion. Rather, the term is codified at N.J.S.A. 17:48E-45 (Chapter 196). Chapter 196 states "'[c]onversion' means the conversion of a[n HSC] to a domestic mutual insurer in accordance with the provisions of [N.J.S.A. 17:48E-46 to -48]." N.J.S.A. 17:48E-45.

"The Legislature knows how to draft a statute to achieve [a] result when it wishes to do so." State v. W. World, Inc., 440 N.J. Super. 175, 198 (App. Div. 2015) (quoting Zabilowicz v. Kelsey, 200 N.J. 507, 517 (2009)). Where the

Legislature employs terminology in a specific section of a statute, but does not do so elsewhere, reading in such a requirement would "fly in the face of the . . . language the Legislature employed . . . ." Sanchez v. Fitness Factory Edgewater, LLC, 242 N.J. 252, 266 (2020).

Pursuant to the plain language of the applicable statutes, the notice provision governing Horizon is different than the provisions concerning the notice DOBI must provide before deciding whether to approve Horizon's plan. We discern no error on the issue of notice, especially considering the lengthy post-notice proceedings affording the public, including appellants, ample opportunity to be heard before the conversion was sanctioned by the Commissioner. If we read the notice requirements in the way appellants urge, the process of submitting the plan for approval would itself be litigated. Having reviewed Chapter 145, we find no express or implied legislative intent supporting the notion that the pre-approval process required notice and policyholder participation. Doing so would impinge on DOBI's agency review of the plan before it proceeded through the process of public scrutiny.

Appellants also challenge the nature of the notice provided and assert it was targeted to solicit commentary in favor of the plan. This argument lacks

merit. Nothing about the notice provided by the Commissioner leads us to the conclusion it targeted only pro-plan commentators.

B.

Appellants also challenge the Commissioner's analysis of N.J.S.A. 17:48E-46.5(b) factors and argue her findings there would be coverage in every county, premiums would not increase, and her reasoning regarding the sufficiency of the RBC are unsupported by the evidence in the record. They repeat their challenges to the tax assessment Horizon will pay, the membership of the new MHC, Horizon's investment rationale, and the veracity of the parental guarantee. We reject these arguments and affirm for the reasons expressed in the Commissioner's decision.

Appellants claim the Commissioner misinterpreted N.J.S.A. 17:48E-46.5(b)(3) because this factor requires her to approve the plan "unless [she] finds the plan . . . does not benefit the interests of the policyholders" and the Commissioner instead found the plan "is neither contrary to the interests of the policyholders . . . nor would it treat them inequitably." Appellants argue the "not contrary to" standard is a lesser standard than the one contemplated by the Legislature and was improperly relied upon by the consultants and the Commissioner. They also claim the Commissioner wrongly relied on the

preamble of Chapter 145 and ignored her obligation to determine whether the plan benefitted policyholders.

N.J.S.A. 17:48E-46.5(b)(3) states "the [C]ommissioner shall approve a plan of mutualization and reorganization unless [she] finds the plan . . . does not benefit the interests of the policyholders of the [HSC,] or treats them inequitably." Appellants' argument ignores the plain wording of N.J.S.A. 17:48E-46.5(b)(3) and alters its meaning to require the Commissioner find a benefit to the policyholders that does not exist anywhere in the statute. The Legislature enacted Chapter 145 to allow Horizon, as the State's only HSC, to reorganize because it "will facilitate increased utilization of [twenty-first] century technologies and tools to better address current challenges, improving both the State's healthcare infrastructure and its readiness to address future crises such as those resulting from the ongoing COVID-19 pandemic." N.J.S.A. 17:48E-46.1(b). The Legislature envisioned the reorganization "also will promote vital investments and growth in health services and diversified businesses for the benefit of its members and the State." Ibid.

The Legislature's finding that Horizon's reorganization would be beneficial, see N.J.S.A. 17:48E-46.1, informs our understanding of N.J.S.A. 17:48E-46.5(b). The statute establishes a presumption of validity of the

reorganization, by stating the plan "shall" be approved "unless the [C]ommissioner finds the plan . . . does not benefit the interests of the policyholders . . . ." Ibid.

Although the preamble of a statute is generally not considered part of the act it precedes, "[a] court may turn to a statute's preamble as an aid in determining legislative intent." Calabotta v. Phibro Animal Health Corp., 460 N.J. Super. 38, 62 (App. Div. 2019) (quoting DiProspero, 183 N.J. at 496). "To the extent that the preamble is at variance with the clear and unambiguous language of the statute, the preamble must give way." DiProspero, 183 N.J. at 497.

The statute's preamble does not conflict with the standard of review the Commissioner must apply under N.J.S.A. 17:48E-46.5(b), and aids us "in determining the legislative intent." Calabotta, 460 N.J. Super. at 62 (citing DiProspero, 183 N.J. at 496). We discern that intent as requiring the Commissioner to approve the plan unless she found a detriment. The statute does not require the Commissioner to affirmatively find the positive aspects of the reorganization to approve it because the Legislature already made those findings in the enactment itself. N.J.S.A. 17:48E-46.5(b). The Commissioner followed her mandate to execute the law as written. See Karcher v. Kean, 190

N.J. Super. 197, 213 (App. Div. 1983), aff'd in part, rev'd in part, 97 N.J. 483 (1984) (finding the Executive branch's mandate to follow the law as written extends to administrative agencies).

Furthermore, the substantial evidence in the record leads us to conclude that the Commissioner correctly applied N.J.S.A. 17:48E-46.5(b)(3) to the evidence in order to determine that Horizon's plan was not against "the interests of the policyholders of the [HSC] or treats them inequitably." The Commissioner's finding that the reorganization would neither eliminate individual coverage nor raise premiums essentially preserved the status quo, and therefore, could not be deemed detrimental to the policyholders.

The purpose of the RBC level is to ensure the company has sufficient funds to pay out the policyholders. See Risk-Based Capital, NAIC, https://content.naic.org/cipr-topics/risk-based-capital (last updated Dec. 6, 2022). The Commissioner requiring HHSI to have an RBC level of 425%, resulting in a capitalization level over double the required amount for a private

health insurer,[6] and subjecting HMH to the 550% requirement,[7] further convinces us the plan was not detrimental to the policyholders.

C.

Next, appellants challenge the Commissioner's interpretation of N.J.S.A. 17:48E-46.5(b)(1). They read Chapter 145 as "set[ting] a 'system-wide health RBC' . . . target of 550% . . . [and i]f this 'system-wide health RBC' falls below 550%," it triggers under N.J.S.A. 17:48E-46.13(c), a deferment of the annual tax assessment and a freeze on upstream dividends. Appellants contend this RBC level "must apply to the combined reorganized health insurance companies[, such as HHSI,] to ensure that they are adequately capitalized for their policyholders . . . ." They claim the Commissioner approved the plan contrary to law, by not imposing the 550% requirement on lower capitalized insurers such as HHSI, and only imposing the high RBC on MHC.

The Legislature's imposition of the 550% RBC intended it apply only to the MHC. There is no language in Chapter 145 suggesting the MHC's subsidiaries were also subject to the 550% requirement. N.J.S.A. 17:48E-

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[6] See N.J.A.C. 11:2-39.2 (defining an insufficient RBC level requiring company or regulatory action to be less than a ratio of 2.0, or 200%, and 1.5 or 150%, respectively).

[7] See N.J.S.A. 17:48E-46.13(c).

46.3(b) states "[t]he [MHC] shall not be considered a[n HSC,]" relieving the MHC of the HSC obligations under N.J.S.A. 17:48E-17.3(a). The only mention of "system-wide health [RBC]" is contained in N.J.S.A. 17:48E-46.13(c), which states HMH would not be subject to the annual tax assessment if, between all the subsidiaries in the system, the RBC fell below 550%. For these reasons, the Commissioner did not misinterpret the statute by declining to read into it a similar RBC requirement for the MHC.

D.

Lastly, appellants contend "the Commissioner abused her authority in withholding vital information from the public record concerning the [p]lan during the public hearing process[,]" particularly the bylaws, which determine membership and voting rights in the MHC. They contend this information, which they later received under the confidentiality order, "burdened [their] effort to be heard, and deprived the record of pertinent testimony, thus delegitimizing the hearing process and biasing the [o]rder and findings."

N.J.S.A. 17:48E-46.12 states:

> a. The application submitted pursuant to [N.J.S.A. 17:48E-46.5] shall be a public record, except for the following documents, which shall be confidential and not public records:

> (1) documents deemed confidential by statute or regulation;
>
> (2) the business plan, capitalization plan, financial projections, and market competitive data; and
>
> (3) any other information the [C]ommissioner determines could result in harm to the [HSC], [MHC], reorganized insurer or other insurance entity within the [MHC] system, or the public interests, if disclosed.

The Commissioner deemed the proposed bylaws confidential pursuant to N.J.S.A. 17:48E-46.12(a)(1). The law relied upon by the Commissioner as the basis for confidentiality is N.J.S.A. 17:27A-6, which states "all information reported pursuant to . . . [N.J.S.A. 17:27A-2] . . . [is] recognized by this State as being proprietary and containing trade secrets, and shall be confidential by law and privileged . . . ." N.J.S.A. 17:27A-2 governs "instances in which [a] party seeking to divest or . . . acquire a controlling interest in an insurer[,]" and states "[t]he information shall remain confidential until the conclusion of the transaction . . . ."

This reorganization was a vehicle for the MHC to acquire a 100% interest in HHSI, see N.J.S.A. 17:48E-46.4(e), (f), and (h); N.J.S.A. 17:48E-46.2, which met the definition under N.J.S.A. 17:27A-2's of a "party seeking to . . . acquire a controlling interest . . . ." For these reasons, the Commissioner's decision to designate the proposed bylaws confidential before the plan's approval fell

squarely within the powers granted to her by the Legislature under N.J.S.A. 17:48E-46.12(a)(1).

Finally, we are unpersuaded any of the documents the Commissioner designated as confidential, including the bylaws and other materials, which have been provided to appellants, was dispositive. As Horizon correctly noted at oral argument, on the critical issue of membership in the new MHC, the statute controls. For these reasons, based on the facts presented, we are unconvinced the revelation of this information at the public hearings would have led to a different result.

To the extent we have not addressed an argument raised on the appeal, it is because it lacks sufficient merit to warrant discussion in a written opinion. R. 2:11-3(e)(1)(E). The November 1, 2022 order is affirmed because it is supported by sufficient credible evidence on the record as a whole. R. 2:11-3(e)(1)(D).

Affirmed.