

Nos. 13-CV-348, 13-CV-358, 13-CV-1059

In the
District of Columbia
Court of Appeals

DISTRICT OF COLUMBIA,
DEPARTMENT OF INSURANCE, SECURITIES AND BANKING,

Petitioner-Appellee,

v.

D.C. CHARTERED HEALTH PLAN, INC.,

Respondent-Appellee,

D.C. HEALTHCARE SYSTEMS, INC.,

Party in Interest-Appellant.

*On Appeals from the Superior Court of the District of Columbia,
Civil Division No. 2012 CA2 008227 (Hon. Melvin R. Wright, Judge)*

REPLY BRIEF OF APPELLANT
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INTRODUCTION

At the outset, it is important to note what this case is not about. It is not a referendum on Jeffrey Thompson, the sole shareholder of appellant, D.C. Healthcare Systems, Inc. ("DCHSI"), which is in turn the sole shareholder of D.C. Chartered Health Plan, Inc. ("Chartered"). Rather, the focus should lie on the District's pre-rehabilitation misconduct, which has dominated the rehabilitation (and *de facto* liquidation) of Chartered, but which was – until the belated disclosure by the District of the Towers Watson Report – only known to the District.¹ Unfortunately, the trial court would not consider the Report, which establishes that the impairment of Chartered's finances was intentionally caused by the District to address its own budgetary concerns, and which should have raised serious doubts about the propriety of the rehabilitation *ab initio*, the validity of the transfer of all of Chartered's assets to AmeriHealth, and the windfall settlement to the District.

After the damning evidence in the Towers Watson Report that the District used gerryminded Medicaid contract rates to shore up budget deficits, the District's faced an untidy and potentially very messy political problem, which from the District's point of view needed fixing in as expeditious and quiet a manner as possible. The Insurers Rehabilitation and Liquidation Act (D.C. Code §§ 31-1301 *et. seq.*) ("Rehabilitation Act"), although clearly not intended for such a purpose, in this case provided the quick fix needed to keep under wraps the District's abuse of the Medicaid Contract rate setting process. Under the flimsiest cover of "rehabilitation", the District presided over the quick death of Chartered by preventing a bid on the new DHCF Contract, quickly pre-arranging the sale of all of Chartered's assets to AmeriHealth (a client of

¹ The term "District" refers to the D.C. Government and includes the Mayor's office, the Department of Insurance, Securities, and Business, and the Department of Health Care Finance. Both Department heads are selected by and serve at the pleasure of Mayor Vincent Gray.

counsel for the Rehabilitator), and finally self-negotiating a "settlement" deal to forgive some \$50 million in pre-rehabilitation debt to Chartered that the District undisputedly owed. At a very minimum, meaningful judicial oversight of a Receiver requires a reviewing court to take some cognizance of evidence – like the Towers Watson Report, which the trial court refused to even read, much less consider – which point directly to a fundamental abuse of the rehabilitation process and to check such abuses. The court abused its discretion in failing to do so.

It has been said that the "impairment of an insurer's finances is of great concern to both the public and to the remainder of the insurance industry, which will bear the adverse effects of any public suspicion as to the health of insurers." See 1 Stephen Plitt et. al, Couch on Insurance 3d § 5:5. But that concern must certainly multiply – and the court must intervene – when the impairment of an insurer's finances has been systematically manufactured by the very governmental body now tasked with "rehabilitating" the insurer. Yet not once was the trial court troubled or concerned, transfixed at it was by an improper standard of obeisance to the unsupported statements of the Receiver that a facially self-interested settlement had somehow been negotiated "at arm's length".

The indisputable fact remains: at no time during this "rehabilitation" process has the trial court or the Rehabilitator been required to confront the Towers Watson Report – the independent third party report that documented the intentional breach of contract and the systematic underpayment by the District under which scheme neither Chartered nor any other insurer could survive financially. The Rehabilitator withheld the Report and the trial court would not consider it. Who doubts that DCSHI and Thompson would have withheld their consent to the "rehabilitation" of Chartered if disclosure of the Towers Watson Report detailing the abuse in the rate setting process and the utterly defenseless position of the District

as regards its debt to Chartered, had preceded the court-ordered rehabilitation proceeding? Had the evidence uncovered in the Towers Watson Report been disclosed pre-rehabilitation the true purpose of the "rehabilitation" would have been obvious to anyone – (i) an opportunity to remove Thompson (a political hot potato) from the management of Chartered (ii) an opportunity to seize control of Chartered with a full panoply of statutory authority to favor a new insurer, AmeriHealth, and (iii) to guarantee an unsupported deep discount on the money it owed to Chartered without having to deal fairly with Chartered as regards the serious improprieties in rate setting disclosed by the Towers Watson Report and overall with no meaningful judicial oversight.

Before this Court upholds the District's misconduct and affirms the trial court's turning a blind eye to the District's misconduct, it must be remembered just how pervasive that misconduct was in this case and how it directly caused the very problem that then was used as the pretext for destroying the business of Chartered and replacing it with a competitor more to the District's liking:

- * Chartered's sole contract was with the District; it had no other source of revenues.
- * The District unilaterally added costly services to the District Contract. The District unilaterally transferred approximately 23,000 people (the "774/775 Populations") from the District's Alliance program to Chartered's Medicaid program.
- * The District, however, improperly and intentionally resisted Chartered's demands that its reimbursement rates be adjusted, retrospectively and prospectively, as required by the DHCF Contract.
- * That problem was compounded by the fact that **DHCF had directed Mercer**, the District's rate-setting actuary, "to set the MCO [Managed Care Organization, e.g., Chartered] rates for the Alliance **below** the lowest level considered actuarially sound." SA-168; see also SA-266.
- * The **DHCF Director further admitted** that the goal was to use Medicaid funds (70% of which are paid by the federal government) "to offset predicted Alliance losses," but this did not work and Chartered consequently was injured in two ways. Id. First,

because "members with higher health care costs" were transferred into the Medicaid program, "the expected margins on the Medicaid side have not materialized."² Second, "[Chartered] experienced substantial losses on their Alliance business." Id.

* As such, prior to the transfer the Alliance rates had been set below actuarially sound levels as a purposeful strategy by the District to balance its budget on the back of Chartered.

* Rather than correct the financial impairment to Chartered, the District leveraged these "substantial losses" to obtain a court order for the rehabilitation of Chartered.

* As rehabilitator, the District controlled whether Chartered would bid on the new District Contract (it did not).

* As purchaser, the District controlled who would win the new District Contract. Amerihealth won the bid on the new District Contract, an entity not surprisingly represented by counsel for the District as Rehabilitator.

* As rehabilitator, the District sold Chartered's assets to Amerihealth and helped Amerihealth prepare its bid for the District Contract using the information the District obtained from Chartered (in connection with Chartered preparing its own bid) after it assumed control of Chartered in rehabilitation.

* As rehabilitator, the District forgave itself the "substantial losses" that it caused Chartered to suffer.

* As rehabilitator, the District put Chartered out of business and gutted any value of the company to its sole shareholder and lessor, DCHSI, while pocketing more than \$50 million.

If, in all this, the trial court must only provide nothing more than a cursory review of the District's actions, and DCHSI must stand idly by as the District loots its company in liquidation having secured its consent under false pretenses to a rehabilitation, then the statutory protections under the Rehabilitation Act mean nothing. The Act and any notion of due process would simply be trifling lip service in favor of the caprice of the District.

Should this Court not act nothing will stand in the way of a repetition in the future of what the District has accomplished here; the District intentionally and systematically

² These margins failed to materialize, of course, due to the increased costs imposed due to the 774 and 775 Populations, and because the District set unsound rates for these groups.

underpaying a target health insurer, thus unlawfully imposing substantial losses on that insurer; leveraging those substantial losses to obtain the keys to the insurer through a "receivership" that is really a liquidation; rewarding a pre-designated favorite by transferring the assets of the target insurer; and awarding the new contract to the new favorite, wiping away the substantial losses it imposed through fraudulent rate-setting with a "negotiated" stroke of pen that only District officials control, thus robbing the shareholder of the target insurer of any value in its business while at the same time significantly enhancing the District purse.

DCHSI'S STANDING

DCHSI's standing to bring these issues before the trial court and this appellate court rests on three very simple grounds: (1) statutory; (2) constitutional/prudential; and (3) a *de facto* party. First, the Rehabilitation Act grants DCHSI the statutory "right to resist" any of the orders in rehabilitation. See D.C. Code § 31-1305(c). "Resist" means "to withstand the force or effect of ... to exert oneself to check or defeat ... to exert force in opposition." See Webster's New Encyclopedic Dictionary, 867 (1993). Whatever procedures the trial court adopted had to comport with the basic requirements of due process. 26 Eric M. Holmes, Appleman on Insurance 2d § 161.6[b].³ Interested and protected parties – like the sole shareholder of Chartered – must be given accurate information regarding the rehabilitation plan and the effects of the plan on DCHSI's rights in advance of a hearing and an opportunity to be heard especially here (where the order directed to the rehabilitator to revitalize Chartered, but the rehabilitator proposed Chartered's termination and the zeroing out of DCHSI's equity value in Chartered as sole shareholder). Id. citing Gersenson v. Pennsylvania Life & Health Ins. Guar. Ass'n, 729 A.2d

³ See also, 9 Jeffrey E. Thomas, New Appleman on Insurance Law Library Edition § 100.05[2][a] (claimant must be provided with notice and opportunity to be heard before its rights are taken away) citing Prunty v. State, 226 So. 2d 448, 449-450 (Fla. Dist. Ct. App. 1969).

1191, 1196 (Pa. Super. Ct. 1999). Yet at every step the trial court has obstructed DCHSI's statutory right to oppose the "sale" of Chartered to AmeriHealth and the "settlement" between the District and itself. The trial court ignored DCHSI's opposition to the District's motion for an expedited status hearing and request for a briefing schedule to address the District's plan to transfer all of Chartered's assets to AmeriHealth and ignored that the District did not bid on the new DHCF Contract in violation of the rehabilitation order and assisted AmeriHealth with the bid using Chartered's material and personnel.

Instead, at a status conference on March 1, 2013, not a motions hearing, the trial court ruled on the merits of the transfer of all of the assets without any briefing or competent evidence to make a legitimate ruling that any such transfer was in fact fair and equitable to all parties, including the sole shareholder of Chartered – the trial court expressly rejecting DCHSI's argument that any legitimate consideration of the plan, which would result in the termination of Chartered, and therefore DCHSI as well, should not be made without any briefing and without any evidentiary record other than the District's unsworn and untested factual assertions. The trial court next promptly denied DCHSI's motion to stay the transfer pending an appeal and for an injunction. That denial occurred of course without a hearing.

In the same vein, with respect to the "settlement" of District debt, the trial court would not review the Towers Watson Report (a report obtained not by DCHSI, but by the District) simply because DCHSI was submitting the Report for consideration, and not the District. Nor would the trial court listen to any testimony by an expert about the implications of the Towers Watson Report. Nevertheless, the statute is clear DCHSI as the owner of Chartered has a right to oppose the entry of both orders. Furthermore, given the statutory requirement imposed upon the trial court to approve, disapprove, or modify a rehabilitation plan that is fair and equitable to *all*

parties (D.C. Code § 31-1312(e)), it begs the question how the trial court can exclude the sole shareholder of Chartered and entertain only the self-interested District's view of what is fair and equitable?

Second, without delving into the whether Article III of the Constitution limits a District of Columbia court to hearing cases or controversies,⁴ DCHSI satisfies both constitutional and prudential limitations on the exercise of the Superior Court's jurisdiction.⁵ To satisfy constitutional standing, DCHSI has (1) suffered an injury in fact (the loss of Chartered, its wholly owned subsidiary); (2) which is fairly traceable to the defendant's conduct (the District intentionally impaired Chartered financially to set up a rehabilitation and fraudulently induced DCSHI to consent to a rehabilitation); and (3) that a favorable decision would have redressed the injury (this point is obvious).⁶ While no single rule governs every issue of prudential standing, see Clarke v. Sec. Indus. Ass'n, 479 U.S. 388, 400 n.16 (1987), DCHSI satisfies any prudential requirements including the prohibition of asserting the rights of third parties (DCHSI is asserting its rights as Chartered's lessor and sole shareholder), the requirement of individualized rather than generalized harm (the District has gutted the equity value of Chartered), and the position of DCHSI within the zone of interests to be protected (see e.g., D.C. Code §§ 31-1305(c), 31-1312(e), and 31-1340 (1)(B), (6) & (8)). Other jurisdictions have so held. See Fewell v. Pickens, 344 Ark. 368, 374, 39 S.W.3d 447, 451 (Ark. 2001) ("Holdingsco is the parent company of American Investors, and Fewell is the owner of Holdingsco. The pecuniary interest of the appellants is real and considerable. We conclude that the appellants have a pecuniary interest

⁴ See e.g., John W. Curran, Who's Standing in the District After Grayson v. AT&T Corp.? The Applicability of the Case-or-Controversy Requirement in D.C. Courts., Am. Univ. L. Rev. 62, No. 3:739-762 (2013).

⁵ See Speyer v. Barry, 588 A.2d 1147, 1160 (D.C. 1991) (plaintiffs must meet both constitutional prudential prerequisites of standing).

⁶ See Bennett v. Spear, 520 U.S. 154, 162 (1997).

affected by the circuit judge's action and, thus, have standing to bring this appeal."); Koken v. Legion Ins. Co., 831 A.2d 1196, 1201 (Pa. Commw. Ct. 2003) ("The ultimate controlling shareholder of Legion and Villanova, Mutual Risk Management, Ltd. (MRM), was granted intervention to contest the liquidation of these insurers.")

Third, from the beginning – when DCHSI was classified together with Thompson as "the interested parties in this matter"⁷ – DCHSI participated, and was permitted to participate as if it had intervened, and was treated on all sides, including by the trial court, at least until the Eleventh Hour, as a party.⁸ See In re Orshansky, 804 A.2d 1077, 1090 (D.C. 2002); Wright & Miller, Federal Practice and Procedure: Jurisdiction and Related Matters § 3902.1 ("Appeals by those who participated as if parties are frequently entertained despite a failure to achieve formal status as a party") (citations omitted)⁹.

DISTRICT ABUSE

It is polite to characterize what the District has done here as an abuse of discretion. An agency or department abuses its discretion if it acts without any rational basis, as a result of self-dealing, bias or ill-will, or through a misapplication of the law. See Johnson v. United States, 398

⁷ See 1-AA-3 at ¶4. See also, New Appleman on Insurance Law Library Edition § 100.08[3][d] ("Interested parties remain entitled to judicial review").

⁸ See also Lockhart v. Cade, 728 A.2d 65, 69 (D.C. 1999) ("when a judge unexpectedly departs from the terms of a prior order, any party prejudiced by that departure . . . should be entitled to redress"); cf. Boling v. United States, 39 Fed. Cl. 252, 253 (Fed. Cl. 1997) ("fundamental fairness dictate[d]" that plaintiffs, who were "misled" by court's earlier statements, have restored to them an opportunity to pursue their challenge after court reached a different ultimate determination); Robinson v. Evans, 554 A.2d 332, 335 (D.C. 1989).

⁹ See also SEC v. Forex Asset Mgmt. LLC, 242 F.3d 325, 329 (5th Cir. 2001) (standing when "the non-party actually participated in the proceedings below, the equities weigh in favor of hearing the appeal, and the non-party has a personal stake in the outcome."); Commodity Futures Trading Comm'n v. Topworth Int'l, Ltd., 205 F.3d 1107, 1113 (9th Cir. 1999) (standing when a non-party creditor had a legitimate interest, participated adequately by timely filing his claim, filing objections, and attending the hearing on the claim); Curtis v. City of Des Moines, 995 F.2d 125, 128 (8th Cir. 1993); Communications Workers of Am. v. N.J. Dep't of Personnel, 282 F.3d 213, 219 (3d Cir. 2002).

A.2d 354, 363 (D.C. 1979); Ario v. Fid. Mut. Life Ins. Co., 935 A.2d 55, 62 (Pa. Commw. Ct. 2007); Koken v. Fid. Mut. Life Ins. Co., 803 A.2d 807, 812 (Pa. Commw. Ct. 2002). The facts of the pre- and peri-rehabilitation reek of bad faith, fraud, capricious action and an abuse of power that demanded the trial court's intervention. See 1 Couch on Insurance 3d at § 5:23 (citations omitted). Compounding the abuse by the District, the trial court abused its discretion in ignoring a raft of evidence that should have stalled the transfer of Chartered's assets to AmeriHealth as well as the District's self-forgiveness of its obligations owed to Chartered.

A brief recital of the critical underlying circumstances is therefore essential if this Court is to decide that the trial court was simply to perform a detached ministerial function, serving merely as a rubber stamp for the District and if DCHSI could not object to the District's misconduct or appeal from the trial court's order affirming the District's misconduct.

The trial court ignored the fact that the District wrongfully obtained DCHSI's consent to the rehabilitation of Chartered by three material misrepresentations. Instead, the trial court wrongly relied upon DCHSI's consent to deny DCHSI standing to submit the Towers Watson Report and to question the District's "settlement". SA-325-327 (Aug. 21, 2013 Tr.).

In early October 2012, DCHSI gave its consent to a rehabilitation of Chartered based on three representations by the Special Deputy to the Rehabilitator and his counsel (i) that the Rehabilitator would provide information to and consult and cooperate with DCHSI during the course of the rehabilitation; (ii) that Chartered would respond in its own right to the RFP for the impending new five-year District Contract; and (iii) implicit in the initial two representation was the *rehabilitation* of Chartered, not a liquidation. SA-345-347 (Glover Aff.). DCHSI would not have consented to the rehabilitation if the Special Deputy to the Rehabilitator had not made these

representations that DCHSI would play an active role in the rehabilitation of Chartered, which was dependent upon Chartered responding to the RFP. Id.

From October 19, 2012 through January 11, 2013, prior to the District's request for the trial court to approve the transfer the assets to AmeriHealth, DCHSI repeatedly requested information from the Special Deputy to the Rehabilitator and the Rehabilitator's counsel with respect to the status of the proposed rehabilitation plan for Chartered, including structure, value, and other key terms of a potential transaction, details regarding the status of negotiations with buyers and the District Government, and details regarding timing. Id. Not surprisingly, and consistent with the District's current position that DCHSI should have no voice, the Special Deputy to the Rehabilitator and his counsel did not provide information to, consult with, or cooperate with DCHSI. Id. The representation that DCHSI would be included in the rehabilitation process could not have been true when it was made.

As for the second misrepresentation, while fundamental to the rehabilitation of Chartered, no RFP for the new five year District Contract was provided on behalf of Chartered. The then-existing District Contract was scheduled to expire on April 30, 2013 and the bidding process on the new five-year District Contract was to begin in early November 2012, with initial bids due in early December 2012. Under the Rehabilitator, and despite the representation necessary to induce DCHSI's consent to rehabilitation, Chartered did not bid on the new DHCF Contract. At least by November 26, 2012, Chartered by the Rehabilitator decided to enter into an agreement with AmeriHealth to work with AmeriHealth "to complete a response to the DHCF RFP in AmeriHealth's name (utilizing key Chartered personnel and experience in the response) and to negotiate a definitive agreement with AmeriHealth." 1-AA-16 at ¶ 6. That representation of Chartered's bid on the new District Contract could not have been true when it was made.

In November 2012, only one month after the entry of Rehabilitation Order, the Rehabilitator solicited interested parties "to respond to a preliminary request for information in connection with ... a potential acquisition and recapitalization of [Chartered]" ("Chartered RFP"). 2-AA-463. The Chartered RFP directed all responses by November 14, 2012 – only two business days after the letter was sent – and indicated that a limited number of respondents would be selected to submit a binding letter of intent by December 1, 2012. 2-AA-464. The Chartered RFP required bidders to submit "a detailed response" providing a variety of information including *inter alia*: (i) because Chartered "has received the [Medicaid RFP]," executing "a binding letter of intent prior to [Chartered] submitting a response to the RFP" and indicating all due diligence required "prior to executing a **binding** letter of intent on December 1, 2012"; and (ii) requiring bidders to agree to Chartered's response to the Medicaid RFP. Id.

At least by November 26, 2012 – but likely prior to obtaining consent from DCHSI and Thompson in October 2012 – the District had decided to enter into an agreement with AmeriHealth to work with AmeriHealth "to complete a response to the DHCF RFP in AmeriHealth's name (utilizing key Chartered personnel and experience in the response) and to negotiate a definitive agreement with AmeriHealth." 1-AA-16 at ¶ 6.

On November 30, 2012, and contrary to the explicit requirements on the face of the Chartered RFP, AmeriHealth and Chartered entered into a ***non-binding*** letter agreement, instead of the required binding letter agreement, reflecting that Chartered (in rehabilitation) agreed to provide "its own resources, assets and know how in support of" AmeriHealth's own bid for the DHCF contract in exchange for \$5 million if AmeriHealth won the bid. 2-AA-468-470 (Chartered/AmeriHealth Letter Agreement).

Contrary to the Chartered RFP, the Rehabilitator picked AmeriHealth even though AmeriHealth did not submit a *binding* letter of intent, did not agree to recapitalize Chartered, and did not approve a response by Chartered to the DHCF contract bid. Moreover, AmeriHealth avoided altogether the stated requirement of providing in excess of \$30 million in financing to Chartered. Thus, within six weeks from DCHSI's consent to the entry of rehabilitation order, the Rehabilitator had effectively put Chartered out of business and sold its intellectual property for only \$5 million to allow AmeriHealth make what should have been Chartered's bid on the DHCF contract.

The critical decision in November 2012 not to have Chartered bid on the renewal of the DHCF Medicaid Contract represented the *de facto* liquidation of Chartered, as the District Contract was Chartered's only method of producing income. 3-AA-751 at ¶24 (Serio Aff.). The representation that Chartered would be rehabilitated rather than liquidated could not have been true when it was made in October 2012. Yet at no time did the District seek any review by or approval of the Superior Court for any transformation of a rehabilitation order into a liquidation order as required under the prevailing statutory authority. The District assumed – and rightly so as it turned out – that the reviewing court would not care to inquire too closely into the details beyond what the Receiver represented.

AmeriHealth's \$5 million purchase price is the same \$5 million to be paid under the November 30, 2012 letter agreement, which obligated Chartered to assist AmeriHealth win the Medicaid RFP. Upon information and belief, AmeriHealth did not pay any additional

consideration – meaning AmeriHealth received Chartered's assets for no additional payment. The Rehabilitator gave the balance of the company for free.¹⁰

Thus, within six weeks from DCHSI's consent to the entry of rehabilitation order, the Rehabilitator had effectively destroyed DCHSI's shareholder value in Chartered. The transfer of Chartered's assets to AmeriHealth left Chartered with no ability to conduct business, no ability to satisfy its obligations to DCHSI under its lease, yet with liabilities remaining to providers, and perhaps whatever furniture or supplies AmeriHealth, in its sole discretion, decided to leave behind. 1-AA-134-136 at §7.02. DCHSI was left with owning a shell company that holds liabilities and a lease with no ability to collect rent from Chartered. In the end, the rehabilitation of Chartered was the death of Chartered, contrary to the purpose of a rehabilitation. 3-AA-749 at ¶ 18, 3-AA-750 at ¶ 6.

REHABILITATION VS. LIQUIDATION

The District's distinction between rehabilitation versus liquidation is a bit of a canard really. The emperor here has no clothes. The District's conduct has very little to do with rehabilitation or liquidation under the Rehabilitation Act; the Act has simply served – with the trial court's acquiescence – the District's purposes of disposing of Chartered (DCHSI and Thompson), setting up a new favorite, and not having to pay tens of millions of dollars for past services rendered. These realities could not have been constructed by simply awarding the new DHCF contract to AmeriHealth. AmeriHealth needed Chartered's prepared bid to secure the DHCF contract, and a turnkey operation to service it. But the real plum for the District under the

¹⁰ The Agreement's stated purchase price is \$5 million, all of which is subject to an indemnification provision. 3-AA-100 at §2.05, 3-AA-138 at §8.02. Assuming the Agreement is the definitive agreement that the parties agreed to enter, then AmeriHealth received Chartered's assets *for no additional payment*. As it is, the District has left Chartered a shell, with no basis to determine fair value.

Rehabilitation Act was the ability to sit on both sides of a negotiation over what it owed to the company it now controlled by court order. ¹¹

Nevertheless, examining the District's conduct under the rubric of rehabilitation versus liquidation exposes the pretense of the rehabilitation. The purpose of rehabilitating Chartered (or any insurer for that matter) would have been "to conduct the insurer's business and remove the conditions that made rehabilitation necessary" to stabilize Chartered's financial condition, return it to normal operating conditions, and to "return [the insurer] to former management." ⁹ New Appleman on Insurance Law Library Edition §§ 96.02[1][c], 96.03[8], Couch on Insurance 3d § 5:18 (2005) (citations omitted); D.C. Code 31-1314(c). If the Rehabilitator was truly rehabilitating Chartered, his aim would have been to "strengthen and preserve [Chartered] to the point where the insurer can resume the possession of its property and conduct its affairs" and his "guiding principle" would have been "effectively manage [Chartered's] affairs such that it can re-emerge in the marketplace" as a viable insurer while minimizing financial harm to interested parties. ⁹ New Appleman on Insurance Law Library Edition §§ 100.01[1][a], 100.04[9], and 100.06[3].

Rehabilitation is not a process of winding down of the company's affairs or dissolution, but a liquidation "with a goal similar to a Chapter 7 Bankruptcy" does involve the winding down of the insurer's affairs and the marshalling and liquidating the insurer's assets in the most

¹¹ The District as well as DHCF in its brief *amicus curiae* protest that the negotiations leading to the settlement were "vigorous and often contentious" and "frankly, hard-fought". DHCF Brief at 8. But where is there any evidence of this in the record beyond the bald, self-serving representations of the two related parties? Where did the trial court request (or permit) any evidence, discovery, examination or cross-examination related to this alleged "vigorous and often contentious" or "hard-fought" negotiation such as would overcome the **presumption of fraud** that attaches to a self-interested bargain struck by two self-interested and related parties cutting themselves (and their boss, the Mayor) a huge, multi-million dollar contractual windfall? Where is the record from which this Court can determine that the trial court exercised **any** meaningful oversight on this critical issue at all?

efficient manner possible to ensure an equitable distribution of the insurer's assets to creditors. Id. at §§ 100.01[1][a], 101.01[2]. In a liquidation, the shareholder equity value typically declines in value "and might be eliminated altogether" because the equity holder will only receive a distribution of residual assets, if any, after all priority claims have been paid in full. Id. at § 100.09[4][d]; see also, Eden Financial Group, Inc. v. Fidelity Bankers Life Ins. Co., 778 F. Supp. 278, 282 (E.D. Va. 1991) ("At the end of the liquidation, the insurer ceases to exist"). The liquidation and corporate dissolution of Chartered in favor of AmeriHealth and the District are not actions that stabilize Chartered's financial condition, return it to normal operating conditions, and then return it to former management unless one adopts a Kevorkian view that the death of Chartered is, or should be, its normal business operation.¹² Circling back to the fraudulent inducement of DCHSI's consent, DCHSI did not consent to the death of Chartered. DCHSI's consent may be a means to a rehabilitation of Chartered, "but it is not a means to a conversion of a rehabilitation into a liquidation." See Koken v. Legion Ins. Co., 831 A.2d 1196, 1229-1230 (Pa. Commw. Ct. 2003).

The District is compelled to take the position that the death of Chartered is not a liquidation because neither District nor the trial court complied with the original Order of Rehabilitation, which required Chartered to be reformed and revitalized (1-AA-9), and neither complied with the statutes in the Rehabilitation Act that govern the liquidation of Chartered. Instead, the trial court, ignoring its own order, permitted the Rehabilitator to liquidate Chartered without satisfying any of the statutory prerequisites. D.C. Code § 31-1314(a) specifies the

¹² Section 31-13-1(5) defines "doing business" as: (A) The issuance or delivery of contracts of insurance to persons resident in the District; (B) The solicitation of applications for the contracts, or other negotiations preliminary to the execution of the contracts; (C) The collection of premiums, membership fees, assessments, or other consideration for the contracts; (D) The transaction of matters subsequent to execution of the contracts and arising out of them; or (E) Operating under a license or certificate of authority, as an insurer, issued by the District.

procedure and grounds for the conversion of an insurance company rehabilitation into a liquidation:

Whenever the Commissioner believes further attempts to rehabilitate an insurer would substantially increase the risk of loss to creditors, policyholders, or the public, or would be futile, the Commissioner may petition the Superior Court of the District of Columbia for an order of liquidation. A petition under this subsection shall have the same effect as a petition under § 31-1315. The Superior Court of the District of Columbia shall permit the directors of the insurer to take any action reasonably necessary to defend against the petition and may order payment from the estate of the insurer of the costs and other expenses of defense as justice may require.

That section requires the District to file a separate petition for a liquidation order and permits the directors of Chartered to defend against the petition for liquidation. See D.C. Code § 31-1314(a). None of this happened and yet both the court and the District as rehabilitator can only exercise those powers which have been conferred by the Rehabilitation Act. See D.C. Code § 31-1303(b). In this case under the order of rehabilitation, the District accomplished the liquidation of Chartered. But a rehabilitation plan – which in this case did not contemplate the revitalization of Chartered as ordered – "cannot impose harsher consequences than a liquidation." Foster v. Mut. Fire, 531 Pa. 598, 613, 614 A.2d 1086, 1093 (Pa. 1992) citing Neblett v. Carpenter, 305 U.S. 297, 59 S. Ct. 170 (1938).

Departing from the original rehabilitation order and the express statutes governing the liquidation of Chartered, the trial court's naked deference is not the standard of review of the transfer of all of Chartered's assets and revenues to AmeriHealth who won the new Contract using Chartered's previously prepared bid. See 26 Appleman on Insurance 2d at § 161.7; Koken v. Legion Ins. Co., 831 A.2d 1196, 1232 (Pa. Commw. Ct. 2003) ("Deference is not appropriate where, as here, the Court must apply specific statutory standards to the evidence presented by the Rehabilitator, MRM and by the Policyholder Intervenors that oppose liquidation. To apply

deference to the job of factfinding would undermine this Court's responsibility to act upon the Rehabilitator's petition in a fair and neutral manner. Further, to apply the deference standard as proposed by the Rehabilitator would shift the burden of proof, improperly, to those opposing a petition to liquidate.").¹³

THE TOWERS WATSON REPORT

On April 4, 2011, DHCF informed the Mayor Vincent Gray that Chartered's rates under the DHCF Contract had been set by the District "**below** the lowest level considered actuarially sound" and that Chartered had predictably experienced losses. SA-266. No corrective action was authorized or taken. Instead, the die was cast; the fate of Chartered, DCHSI, and Thompson was sealed. One year later, under the guise of capital depletion, DISB and DHCF requested that Thompson step down from Chartered's board of directors and DCHSI's consent to a rehabilitation of Chartered.

On or about June 11, 2013, the Rehabilitator obtained an actuarial opinion from Towers Watson Pennsylvania, Inc., ("Towers Watson Report") SA-233-291.¹⁴ The Towers Watson Report was limited in time and scope and examined only one of numerous categories of the District's underpayments to Chartered and breaches of the DHCF contract (and as to that one category alone relating to only twenty-one months out of a sixty month contract). The Report concluded as to that one category that the District owed Chartered over \$51.4 million and further

¹³ See also, LaVecchia v. HIP of N.J., Inc., 734 A.2d 361, 364 (N.J. Super. Ct. Ch. Div. 1999) (holding that trial court must determine if entry of an order of liquidation is appropriate and **rejecting Insurance Commissioner's contention that an order of liquidation should be entered absent a showing of abuse of discretion by the Commissioner** in her determination to seek liquidation); Florida Dep't of Ins. v. Cypress Ins. Co., 660 So. 2d 1177, 1182-1183 (Fla. Dist. Ct. App. 1995) **the court is not required to give deference to the Department's findings regarding the necessity of liquidation**); Angoff v. Casualty Indem. Exch., 963 S.W.2d 258, 263 (Mo. Ct. App. 1997) (same).

¹⁴ The rehabilitator did not provide the Report to the trial court.

that the District had breached key components of the DHCF Contract.¹⁵ SA-240, 245. What company, private or public, in any industry, could survive a \$50 million hit from its only source of revenues? But that District-imposed deficit rendered Chartered easy pickings and opened the door for the District to never have to pay this amount or risk having their intentional misconduct and contractual breaches discovered through discovery or depositions or evidentiary hearings. Applying actuarially sound rates retroactively would have reduced Chartered's losses by \$47.2 million, negating the basis upon which the District relied in bad faith to seek the rehabilitation of Chartered. SA-245. That the trial court has facilitated this misconduct through lethargy, a surreal notion of discretionary oversight, and an absolute refusal to entertain any evidence is deeply troubling.

RIPENESS OF DCHSI'S APPEAL

The District's objection to judicial review – i.e., what is done is done – is entirely unsatisfactory factually and contradicts existing case law. This Court will refuse to dismiss an appeal as moot when resolution of the legal issues might affect a separate action, actual or prospective, between the parties. See In re A.C., 573 A.2d 1235, 1241 (D.C. 1990). Collateral to this matter, the rehabilitator has filed a separate action against DCHSI and Thompson to recover monies allegedly owed to the Chartered estate (Civil Action No.: 2013 CA 003752 B). Initial dispositive motions have been filed by both parties, but not heard, and no answer or counterclaims have yet been filed. Prior to the settlement now at issue in this appeal, it had been DCHSI's contention in the collateral action the settlement amount (assuming the rehabilitator

¹⁵ In addition to the single underpayment category that Towers Watson calculated, the Defendants also underpaid Chartered in *seven other significant categories*. DCHSI's expert, Drew Joyce, using the best data available because discovery was not permitted, has estimated that the impact of most of these categories of underpayment would be result in a retrospective rate adjustment **exceeding \$82 million**. SA-120-129, 293.

recovered what was owed to Chartered) would have rendered the lawsuit against the parent company and its shareholder moot, or a nullity for all practical purposes – since the collateral action would be recovering funds *for* Chartered's sole shareholder *from* Chartered's sole shareholder and the amount due to Chartered from the District would wipe out any claim the District would otherwise have. The resolution of the legal issues on this appeal in favor of another judicial review of the District settlement will affect the collateral action. This appeal is therefore not moot.

Even if this appeal were truly moot and had no collateral consequences, this Court should nevertheless elect to hear it because what the District has done in solving its budgetary and political problems through the pretextual rehabilitation of Chartered, coupled together with the reverential review by the trial court, is "capable of repetition, yet evading review." *Id.* at 1242 citing Lynch v. United States, 557 A.2d 580, 582-583 (D.C. 1989) (*en banc*); United States v. Edwards, 430 A.2d 1321, 1324 n.2 (D.C. 1981) (*en banc*). If the District is to remain unchecked by judicial oversight, then the Rehabilitation Act becomes the key to open every insurer's larder at least when the District is the contracting party and any contract in which the District agrees to set and then pay actuarially sound rates becomes meaningless. Quite frankly, not even AmeriHealth will be safe.

The District's position throughout the "revitalization" of Chartered (as ordered in the rehabilitation order) and now in its various briefs is akin to a victim receiving her stolen car back; it is totaled, non-drivable, unrecognizable, but the car payments remain due, and here is a bill for towing the car. DCHSI is not asking this Court to do the impossible. In fact, the District confuses the issue of the District settlement, which does not concern what payments have been made, and in what *pro rata* amounts, to which class of Chartered creditors (which would include

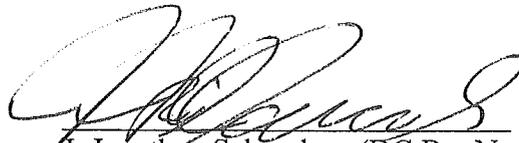
DCHSI). This appeal would not require the unwinding of any of those payments. The issue is whether the District owes substantially more money -- with no defense at all, as confirmed by the Towers-Watson Report -- than its bogus,, self-interested settlement recognized and whether the review (or lack thereof) undertaken by the trial court, as evidenced by the record (or lack thereof) is sufficient to determine that in fact proper judicial review of the Receiver's conduct occurred under the specific facts of this case. Nothing prevents that review and relief.

As regards the transfer of Chartered's assets and business to AmeriHealth, the District claims that this is now *fait accompli* and cannot be unwound. To the extent this situation has come to exist as a result of the fraudulent conduct of the District, that same party pleading the benefit of its own wrongdoing is hardly persuasive. Besides, "unwinding" the transaction is a loaded term. The issue is really one related to what entity **controls** the provision of the health care services. Transferring control of those services does not mean unwinding any services. Chartered, for instance, successfully managed and controlled the provision of those same health care services for over two decades before being ousted by the District's fraudulent rate-setting conduct. Should it be a just and required outcome, the transfer of control is hardly an impossible task.

Finally whether such a transfer can or cannot be accomplished, monetary damages are available to compensate one party or the other (Chartered and/or Amerihealth) for any damage caused by the wrongful acts by the District in bringing this situation about and having it rectified. Supervising the quantification of those damages and their administration, in the first instance, is the proper office of the trial court. For purposes of this appeal, however, it is hardly a situation that qualifies as impossible or permits the District to escape the damage and injury caused by its own wrongdoing by hiding behind the doctrine of mootness.

Dated: March 28, 2014

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ADDENDUM

D.C. Code § 31-1303 - Jurisdiction and venue

(a) No delinquency proceeding shall be commenced under this chapter by anyone other than the Commissioner of the Department of Insurance, Securities, and Banking and no court shall have jurisdiction to entertain, hear, or determine any proceeding commenced by any other person.

(b) No court of the District of Columbia shall have jurisdiction to entertain, hear, or determine any complaint praying for the dissolution, liquidation, rehabilitation, sequestration, conservation, or receivership of any insurer; or praying for an injunction or restraining order or other relief preliminary to, incidental to, or relating to these proceedings other than in accordance with this chapter.

(c) In addition to other grounds for jurisdiction provided by law of the District, the Superior Court of the District of Columbia has jurisdiction over a person served pursuant to the Superior Court Rules of Civil Procedure or other applicable provisions of law in an action brought by the receiver of a domestic insurer or an alien insurer domiciled in the District:

(1) If the person served is an agent, broker, or other person who has at any time written policies of insurance for or has acted in any manner whatsoever on behalf of an insurer against which a delinquency proceeding has been instituted, in any action resulting from or incident to such a relationship with the insurer;

(2) If the person served is a reinsurer who has at any time entered into a contract of reinsurance with an insurer against which a delinquency proceeding has been instituted, or is an agent or broker of or for the reinsurer, in any action on or incident to the reinsurance contract;

(3) If the person served is or has been an officer, director, manager, trustee, organizer, promoter, or other person in a position of comparable authority or influence over an insurer against which a delinquency proceeding has been instituted, in any action resulting from or incident to such a relationship with the insurer;

(4) If the person served is or was at the time of the institution of the delinquency proceeding against the insurer holding assets in which the receiver claims an interest on behalf of the insurer, in any action concerning the assets; or

(5) If the person served is obligated to the insurer, in any way whatsoever, in any action on or incident to the obligation.

(d) If the court, on motion of any party, finds that any action should as a matter of substantial justice be tried in a forum outside the District, the court may enter an appropriate order to stay further proceedings on the action in the District.

(e) All action authorized in this section shall be brought in the Superior Court of the District of Columbia.

D.C. Code § 31-1305 - Cooperation of officers, owners, and employees.

(a) Any officer, manager, director, trustee, owner, employee, or agent of any insurer, or any other persons with authority over or in charge of any segment of the insurer's affairs, shall cooperate with the Commissioner in any proceeding under this chapter or any investigation preliminary to the proceeding. For the purposes of this section, the term "person" shall include any person who exercises control directly or indirectly over activities of the insurer through any holding company or other affiliate of the insurer. The term "to cooperate" shall include, but shall not be limited to, the following:

- (1) To reply promptly in writing to any inquiry from the Commissioner requesting such a reply; and
- (2) To make available to the Commissioner any books, accounts, documents, or other records or information or property of or pertaining to the insurer and in his possession, custody, or control.

(b) No person shall obstruct or interfere with the Commissioner in the conduct of any delinquency proceeding or any investigation preliminary or incidental thereto.

(c) This section shall not be construed to abridge otherwise existing legal rights, including the right to resist a petition for liquidation, other delinquency proceedings, or other orders.

(d) Any person included within subsection (a) of this section who fails to cooperate with the Commissioner, or any person who obstructs or interferes with the Commissioner in the conduct of any delinquency proceeding or any investigation preliminary or incidental thereto, or who violates any order of the Commissioner issued validly under this chapter may:

- (1) Be sentenced to pay a fine not exceeding \$10,000 or imprisonment for a term of not more than 1 year, or both; or
- (2) After a hearing, be subject to the imposition by the Commissioner of a civil penalty not to exceed \$10,000 and be subject further to the revocation or suspension of any insurance license issued by the Commissioner.

D.C. Code § 31-1312 - Powers and Duties of the Rehabilitator.

(a) The Commissioner as rehabilitator may appoint 1 or more special deputies, who shall have all the powers and responsibilities of the rehabilitator granted under this section, and the Commissioner may employ any counsel, clerks, and assistants deemed necessary. The compensation of the special deputy, counsel, clerks, and assistants and all expenses of taking possession of the insurer and of conducting the proceedings shall be fixed by the Commissioner, with the approval of the court, and shall be paid out of the funds or assets of the insurer. The persons appointed under this section shall serve at the pleasure of the Commissioner. The Commissioner, as rehabilitator, may, with the approval of the court, appoint an advisory committee of policyholders, claimants, or other creditors, including guaranty associations, should

that committee be deemed necessary. The advisory committee shall serve at the pleasure of the Commissioner and shall serve without compensation other than reimbursement for reasonable travel and per diem living expenses. No other committee of any nature shall be appointed by the Commissioner or the court in rehabilitation proceedings conducted under this chapter.

(b) In the event that the property of the insurer does not contain sufficient cash or liquid assets to defray the costs incurred, the Commissioner may advance the costs so incurred out of any appropriation for the maintenance of the Department of Insurance, Securities, and Banking. Any amounts so advanced for expenses of administration shall be repaid to the Commissioner for the use of the Department of Insurance, Securities, and Banking out of the first available money of the insurer.

(c) The rehabilitator may take such action as deemed necessary or appropriate to reform and revitalize the insurer. The rehabilitator shall have all the powers of the directors, officers, and managers, whose authority shall be suspended, except as they are redelegated by the rehabilitator. The rehabilitator shall have full power to direct and manage, to hire and discharge employees subject to any contract rights they may have, and to deal with the property and business of the insurer.

(d) If it appears to the rehabilitator that there has been criminal or tortious conduct, or breach of any contractual or fiduciary obligation detrimental to the insurer by any officer, manager, agent, broker, employee, or other person, he or she may pursue all appropriate legal remedies on behalf of the insurer.

(e) If the rehabilitator determines that reorganization, consolidation, conversion, reinsurance, merger, or other transformation of the insurer is appropriate, the rehabilitator shall prepare a plan to effect the changes. Upon application of the rehabilitator for approval of the plan, and after any notice and hearings the court may prescribe, the court may either approve or disapprove the plan proposed, or may modify it and approve it as modified. Any plan approved under this section shall be, in the judgment of the court, fair and equitable to all parties concerned. If the plan is approved, the rehabilitator shall carry out the plan. In the case of a life insurer, the plan proposed may include the imposition of liens upon the policies of the company, if all rights of shareholders are first relinquished. A plan for a life insurer may also propose imposition of a moratorium upon loan and cash surrender rights under policies, for such a period and to such an extent as may be necessary.

(f) The rehabilitator shall have the power under §§ 31-1324 and 31-1325 to avoid fraudulent transfers.

D.C. Code § 31-1314 – Termination of Rehabilitation

(a) Whenever the Commissioner believes further attempts to rehabilitate an insurer would substantially increase the risk of loss to creditors, policyholders, or the public, or would be futile, the Commissioner may petition the Superior Court of the District of Columbia for an order of liquidation. A petition under this subsection shall have the same effect as a petition under § 31-1315. The Superior Court of the District of Columbia shall permit the directors of the insurer to

take any action reasonably necessary to defend against the petition and may order payment from the estate of the insurer of the costs and other expenses of defense as justice may require.

(b) The protection of the interests of insureds, claimants, and the public requires the timely performance of all insurance policy obligations. If the payment of policy obligations is suspended in substantial part for a period of 6 months at any time after the appointment of the rehabilitator and the rehabilitator has not filed an application for approval of a plan under § 31-1312(e), the rehabilitator shall petition the court for an order of liquidation on grounds of insolvency.

(c) The rehabilitator may at any time petition the Superior Court of the District of Columbia for an order terminating rehabilitation of an insurer. The court shall also permit the directors of the insurer to petition the court for an order terminating rehabilitation of the insurer and may order payment from the estate of the insurer of the costs and other expenses of the petition as justice may require. If the Superior Court of the District of Columbia finds that rehabilitation has been accomplished and that grounds for rehabilitation under § 31-1310 no longer exist, it shall order that the insurer be restored to possession of its property and the control of the business. The Superior Court of the District of Columbia may also make that finding and issue that order at any time upon its own motion.

D.C. Code § 31-1340 Priority of Distribution

The priority of distribution of claims from the insurer's estate shall be in accordance with the order in which each class of claims is set forth in this chapter. Every claim in each class shall be paid in full or adequate funds retained for the payment before the members of the next class receive any payment. No subclasses shall be established within any class. The order of distribution of claims shall be:

- (1) Class 1. The costs and expenses of administration during rehabilitation and liquidation, including, but not limited to the following:
 - (A) The actual and necessary costs of preserving or recovering the assets of the insurer;
 - (B) Compensation for all authorized services rendered in the rehabilitation and liquidation;
 - (C) Any necessary filing fees;
 - (D) The fees and mileage payable to witnesses;
 - (E) Authorized reasonable attorney's fees and other professional services rendered in the rehabilitation and liquidation; and
 - (F) The reasonable expenses of a guaranty association or foreign guaranty association for unallocated loss adjustment expenses.

- (2) Class 2. All claims under policies including the claims of the federal or any state or local government for losses incurred ("loss claims"), including third party claims and all claims of a guaranty association or foreign guaranty association. All claims under life insurance and annuity policies, whether for death proceeds, annuity proceeds, or investment values, shall be treated as loss claims. That portion of any loss, indemnification for which is provided by other benefits or advantages recovered by the claimant, shall not be included in this class, other than benefits or advantages recovered or recoverable in discharge of familial obligation of support, by way of succession at death, as proceeds of life insurance, or as gratuities. No payment by an employer to his or her employee shall be treated as a gratuity.
- (3) Class 3. Claims of the federal or any state or local government, except those under Class 2. Claims, including those of any governmental body for a penalty or forfeiture, shall be allowed in this class only to the extent of the pecuniary loss sustained from the act, transaction, or proceeding out of which the penalty or forfeiture arose, with reasonable and actual costs occasioned thereby. The remainder of the claims shall be postponed to the class of claims under paragraph (8) of this section.
- (4) Class 4. Reasonable compensation to employees for services performed to the extent that they do not exceed 2 months of monetary compensation and represent payment for services performed within one year before the filing of the petition for liquidation or, if rehabilitation preceded liquidation, within one year before the filing of the petition for rehabilitation. Principal officers and directors shall not be entitled to the benefit of this priority except as otherwise approved by the liquidator and the court. This priority shall be in lieu of any other similar priority that may be authorized by law as to wages or compensation of employees.
- (5) Class 5. Claims under nonassessable policies for unearned premium or other premium refunds and claims of general creditors, including claims of ceding and assuming companies in their capacity as general creditors.
- (6) Class 6. Claims filed late or any other claims other than claims under paragraphs (7) and (8) of this section.
- (7) Class 7. Surplus or contribution notes, or similar obligations, and premium refunds on assessable policies. Payments to members of domestic mutual insurance companies shall be limited in accordance with law.
- (8) Class 8. The claims of shareholders or other owners in their capacity as shareholders.

District of Columbia Court of Appeals

Nos. 13-CV-348, 13-CV-358, 13-CV-1059

DISTRICT OF COLUMBIA, DEPARTMENT OF
INSURANCE, SECURITIES AND BANKING,
Petitioner-Appellee,

v.

D.C. CHARTERED HEALTH PLAN, INC.,
Respondent-Appellee,

D.C. HEALTHCARE SYSTEMS, INC.,
Party in Interest-Appellant.

CERTIFICATE OF SERVICE

I, John C. Kruesi, Jr., being duly sworn according to law and being over the age of 18, upon my oath depose and say that:

Counsel Press was retained by SANS ANDERSON, PC, counsel for Appellant, to print this document. I am an employee of Counsel Press.

On the **28th Day of March, 2014**, I served the within **Reply Brief of Appellant** upon:

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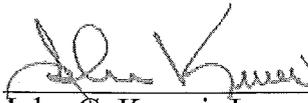
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via Express Mail, by causing a true copy of each to be deposited, enclosed in a properly addressed wrapper, in an official depository of the U.S. Postal Service.

Unless otherwise noted, 4 copies have been sent to the Court on the same date as above via hand delivery.

Additionally, a pdf copy has been emailed to the Court to briefs@dcappeals.gov. The pdf has been scanned for virus using VIPRE.

March 28, 2014


John C. Kruesi, Jr.
Counsel Press