

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

In The
District of Columbia
Court of Appeals

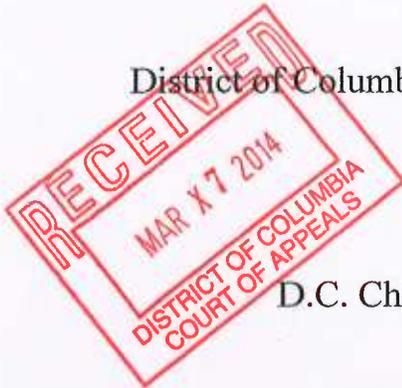
D.C. Healthcare Systems, Inc.
Party in Interest-Appellant,

vs.

District of Columbia Department of Insurance, Securities and Banking
Petitioner-Appellee,

&

D.C. Chartered Health Plan, Inc. (in rehabilitation)
Respondent-Appellee.



On Appeal from Orders of the Superior Court of the District of Columbia

BRIEF FOR APPELLEE D.C. CHARTERED HEALTH PLAN, INC.

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CERTIFICATE AS TO PARTIES

In accord with Rule 28(a)(2) of the Rules of the D.C. Court of Appeals, appellee D.C. Chartered Health Plan, Inc. hereby certifies the following:

Persons Involved in the Trial Court Proceedings

The parties in the trial court are D.C. Chartered Health Plan, Inc. (in rehabilitation), and the District of Columbia Department of Insurance, Securities and Banking, which filed the petition for Chartered's rehabilitation. The Insurance Department's Interim Commissioner, Chester A. McPherson, is Chartered's Rehabilitator, and Daniel L. Watkins is the Special Deputy Rehabilitator.

D.C. Healthcare Systems, Inc. described itself as a "party-in-interest" in the trial court proceedings.

The trial court denied the motion by MedStar Georgetown University Medical Center, Inc. and Washington Hospital Center Corporation to intervene.

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dismissed)	
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Appellee's Corporate Disclosure Statement

Appellee D.C. Chartered Health Plan, Inc. is a private corporation. Appellant D.C. Healthcare Systems, Inc. is Chartered's sole shareholder.

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STATEMENT OF THE ISSUES

I.A. Does D.C. Healthcare Systems, Inc. (“DCHSI”) have standing to appeal orders issued in D.C. Chartered Health Plan’s court-ordered rehabilitation when DCHSI was not a party to the rehabilitation by statute, never moved to intervene in the trial court, and lacks any specific legal interest in the disposition of the rehabilitation?

I.B. Is this appeal moot because this court cannot provide any effective relief to DCHSI on its challenges to:

- a court-approved asset sale that already has been completed;
- a reorganization plan that already has been implemented; and
- a settlement, the proceeds of which have been distributed to Chartered’s creditors?

II. Did the trial court abuse its discretion or fail to respect DCHSI’s due process rights when it approved (1) Chartered’s reorganization plan and (2) the sale of its assets, both of which Chartered’s Rehabilitator showed were necessary to allow uninterrupted coverage to the Medicaid clients Chartered served?

III. After considering arguments and evidence about whether the settlement was fair, adequate, and reasonable, did the trial court abuse its discretion by approving a settlement with the District’s Department of Health Care Finance in the amount of eighty percent of Chartered’s filed claims?

STATEMENT OF THE CASE

In October 2012, the trial court placed D.C. Chartered Health Plan, Inc. into rehabilitation under the District's insurance receivership statute.¹ Chartered provided HMO services to more than 100,000 of the District's most vulnerable residents who receive Medicaid and related benefits. D.C. Healthcare Systems, Inc. ("DCHSI") is Chartered's sole shareholder.

This consolidated appeal is DCHSI's challenge to the trial court's orders: (1) approving Chartered's reorganization plan; (2) approving the sale of most of Chartered's assets to another company; and (3) approving Chartered's settlement of its claims against the Department of Health Care Finance ("Health Finance"), the agency that oversees the District's Medicaid program.

A. Chartered's Order of Rehabilitation

On October 19, 2012, the District of Columbia Department of Insurance, Securities and Banking ("Insurance Department") filed an emergency consent petition for an order of rehabilitation directed at D.C. Chartered Health Plan, Inc. App. 1-7.²

¹ As used in this brief and commonly understood in the industry, "receivership" encompasses both rehabilitation and liquidation. Rehabilitation is a type of receivership, and rehabilitators sometimes are referred to as receivers (as are liquidators). D.C. Code § 31-1301 *et seq.* (2012 Repl.) therefore is a receivership statute because it addresses both rehabilitation and liquidation.

² "App." refers to volumes 1-3 of the Appendix filed in this Court by DCHSI. "SA" refers to the Supplemental Appendix filed in this Court by DCHSI. "SSA" refers to the Second Supplement Appendix filed by the Rehabilitator concurrently with this brief. "Br. I" refers to DCHSI's first appellate brief, filed June 10, 2013. "Br. II" refers to DCHSI's second brief in this appeal, filed December 30, 2013.

Chartered's Board of Directors consented to the emergency petition – that is, they agreed to rehabilitation. App. 3, ¶ 5. The petition alleged that rehabilitation was necessary “to assure continuous and uninterrupted medical and payment coverage” to Chartered's clients. App. 2.

The trial court granted the consent order for rehabilitation the same day it was filed. App. 8-11. The order appointed the Commissioner of the Insurance Department to be Rehabilitator, as required by D.C. Code § 31-1311 (2012 Repl.). App. 8. By statute and the trial court's order, the Rehabilitator assumed all powers of Chartered's directors, managers, and officers; took possession of its assets; received authority “to take such action as deemed necessary or appropriate to reform and revitalize Chartered”; and assumed management of all phases of Chartered's business. App. 8-9. The order also required that the Rehabilitator “seek Court approval of any compromise or settlement of Chartered's claim pending before the District of Columbia's Contract Appeals Board and the contemplated claim regarding capitation rates for [certain Chartered clients].” App. 9. It directed the Rehabilitator to submit either a plan of rehabilitation for the court's approval or a report explaining why such a plan was not feasible. App. 5. The Rehabilitator also appointed a Special Deputy Rehabilitator, as allowed by law. App. 9, 22-23; D.C. Code § 31-1312 (a) (2012 Repl.).

B. Rehabilitator's request to approve Reorganization Plan and partial sale

The Rehabilitator soon began submitting reports to the trial court on his activities and Chartered's status. See App. 12-54, 55-227. In his second report, in February 2013,

the Rehabilitator asked the trial court to approve on an expedited basis the Rehabilitator's proposed Reorganization Plan and an asset purchase agreement that would allow Chartered's business to continue without disruption of service to its Medicaid clients. App. 55, 61.

Along with the sale of assets, the Reorganization Plan included provisions for marshaling Chartered's other assets, including its claims against Health Finance and DCHSI. App. 61. The Reorganization Plan stated that it would use marshaled assets to pay, in order of priority: (1) rehabilitation administration expenses; (2) clients' claims; (3) providers' claims; (4) claims of federal, state, and local governments; (5) certain employee compensation; (6) general creditors; (7) claims filed after a bar date; (8) surplus or contribution notes; and (9) shareholders. App. 62-63.

C. Trial court's approval of the Reorganization Plan and sale, and denial of stay pending appeal

DCHSI opposed the Rehabilitator's request to approve the Reorganization Plan and sale. App. 228-29. DCHSI asked the trial court to delay ruling on the Rehabilitator's requests, claiming that DCHSI lacked notice that the motion would be heard at the March 1, 2013 hearing. App. 246:8-11, 253:3-9.

The Rehabilitator challenged DCHSI's standing to object to the Plan and sale, noting that DCHSI was merely a self-described "party in interest" and had not moved to intervene in the rehabilitation action. App. 232-33.

The trial court approved the asset sale and Reorganization Plan at the March 1, 2013 hearing and issued an order that same day, stating that the sale “would prevent serious disruption for Chartered’s enrollees, address the interests of Chartered’s employees and provide funds that will help Chartered satisfy its liabilities. The court further f[ound] that the Agreement and Plan of Reorganization are necessary and appropriate and are fair and equitable to all parties concerned.” App. 294-95. The trial court did not address the issue of DCHSI’s standing.³

Five days later, DCHSI submitted a thirty seven-page motion for stay of the order approving the sale, which contained all of DCHSI’s legal arguments opposing the sale and Reorganization Plan. App. 298-338. DCHSI accompanied this motion with 323 pages of exhibits and evidence, including information used to solicit bidders for Chartered, Chartered’s financial statements, information from DCHSI’s unsuccessful appeal to the D.C. Contract Appeals Board seeking to block AmeriHealth’s bid for a Medicaid contract, and information about the purported insufficiency of reimbursements that Health Finance paid to Chartered. App. 344-668. The Rehabilitator opposed the stay, DCHSI replied, and the Rehabilitator filed a sur-reply, all supported by hundreds more pages of evidence and exhibits. App. 669-913.

The trial court denied DCHSI’s motion to stay. App. 914-18. It concluded that DCHSI was unlikely to prevail on the merits of its claim because the Rehabilitator had

³ DCHSI also filed a bid protest with the District of Columbia Contract Appeals Board, seeking to invalidate AmeriHealth’s bid for the Medicaid contract. App. 517-33. The Board dismissed DCHSI’s protest for lack of standing. App. 579-84.

acted in Chartered's best interests. App. 915. It also ruled that DCHSI had failed to show that it would be harmed irreparably if no stay were granted, reasoning that Chartered would have lost its Medicaid contract if the sale had not been approved. App. 917. The trial court rejected DCHSI's argument that the court had authority to delay the bidding process and extend expiring Medicaid contracts; it also ruled that, even if it had that authority, it would not exercise that authority in the circumstances of this case. App. 916-17.

DCHSI quickly filed a notice of appeal on April 4, but then did not file a motion for stay with this court until April 29. On May 8, 2013, this court refused to stay the trial court's orders.

D. Trial court approves the settlement with Health Finance

While the disputes with DCHSI about the asset sale were going on, the Rehabilitator continued to pursue Chartered's claims against other entities. These included Chartered's claims against Health Finance, one of which had been filed before the rehabilitation was initiated.

On July 25, 2013, the Rehabilitator moved the trial court to approve on an expedited basis a settlement covering all of Chartered's claims against Health Finance. SA 39-77. DCHSI opposed both the expedited schedule and the settlement, which it called "preposterously short of reasonable." SA 78-82, 96-196; SA 222-308. The Rehabilitator again pointed out that DCHSI was not a party to the rehabilitation action. SA 40.

At the August hearing on the Rehabilitator's motion, the trial court declined to accept additional evidence from DCHSI, ruling that DCHSI lacked standing. SA 315:17-21. The trial court approved the settlement, finding it fair, adequate, reasonable, and an appropriate exercise of the Rehabilitator's discretion. SA 317:5-318:24. The trial court further told DCHSI that, despite ruling that it lacked standing, "I've considered all the things that you would have raised, had you been granted standing." SA 329:16-17. The trial court issued its order approving the settlement on August 22, 2013, stating that it "ha[d] not been presented with any evidence of an abuse of discretion on the part of the Rehabilitator in negotiating this settlement on behalf of Chartered with the District of Columbia." SA 341-42.

STATEMENT OF FACTS

A. Chartered and the need for rehabilitation

1. Chartered's HMO business

Chartered is a health maintenance organization under D.C. Code § 31-3401 *et seq.* (2012 Repl.). App. 2. It is incorporated in the District of Columbia. App. 3, ¶ 1. DCHSI is its only shareholder. *Id.* at ¶ 3. Jeffrey E. Thompson is the only shareholder of DCHSI. *Id.* at ¶ 4. Chartered's sole business has been the District's Medicaid program, through which Chartered provided managed care services for more than 100,000 of the District's poorest residents, comprising families and individuals, including children, seniors, pregnant women, and people with disabilities.⁴ App. 3-4, ¶ 7. Chartered

⁴ Chartered's contract with the District encompassed populations entitled to Medicaid coverage as well as enrollees in the D.C. Healthcare Alliance program, which provides medical

provided Medicaid HMO services under contracts with Health Finance, and Chartered's Medicaid clients depended on those HMO services to obtain vital care. Delays or interruptions in Chartered's services would mean delayed or interrupted care for the Medicaid clients who relied on coverage. Chartered's last contract with Health Finance was for a three-year period ending April 30, 2013. App. 14.

DCHSI knew that Chartered was engaged in a highly regulated enterprise and that Chartered was subject to statutory rehabilitation or liquidation if it had significant financial trouble. *E.g.*, D.C. Code §§ 31-1310, -1315 (2012 Repl.). DCHSI also knew that the contract with Health Finance – which was set to expire in the spring of 2013 – was Chartered's sole source of revenue, and that losing that revenue stream would be disastrous. Br. I at 33; App. 244:13-20; App. 303.

2. Lead-up to rehabilitation

Chartered has been regulated by the Insurance Department since its inception, but the Department's scrutiny intensified in 2012 when regulatory filings showed that Chartered had incurred an operating loss of \$15 million in 2011 and its unaudited financial reports listed just \$1.4 million in capital and surplus at the end of 2011. App. 671, ¶ 3. Although D.C. law required each insurer's Risk-Based Capital level to be 200

services for certain District residents who are not eligible for Medicaid, including childless adults and those with incomes up to 200 percent of the federal poverty level. App. 846; SA 24. For ease of reference in this brief, both programs are referred to collectively as the "Medicaid program" and references to "Medicaid clients" also include Alliance clients.

percent, Chartered's was only 10.3 percent as of December 31, 2011.⁵ *Id.* (citing D.C. Code § 31-3851.01 *et seq.* (2012 Repl.)). In response to this deficiency, the Insurance Department initiated a targeted financial examination of Chartered and required that it submit a corrective action plan to remedy its Risk-Based Capital deficiency. *Id.* at ¶¶ 4-5; App. 832-37, 843-901; D.C. Code § 31-3851.06 (2012 Repl.).

Chartered's auditor, KPMG, resigned in April 2012. App. 671, ¶ 2. Five months later, Chartered's new auditors reported that the December 31, 2011 financial statements had been too optimistic; Chartered's capital and surplus were at least \$3.7 million lower than the \$1.4 million that had been reported, meaning that Chartered's capital and surplus would have had a negative value on December 31, 2011. App. 672, ¶ 8.

The new auditors also found irregular or unsupported related-party transfers between Chartered and DCHSI. *Id.*, ¶ 8. Chartered's CFO and Controller were fired within days after those findings. *Id.*, ¶ 9. Health Finance threatened to terminate its contract with Chartered because of the auditor's findings and Chartered's shaky financial position. *Id.*, ¶ 10. Since March 2012, the press had also been reporting that Jeffrey

⁵ Risk-Based Capital ("RBC") is a method to measure the minimum amount of capital appropriate for a managed care organization to support its overall business operations in consideration of its size and risk profile. App. 42. "RBC limits the amount of risk a company can take. It requires a company with a higher amount of risk to hold a higher amount of capital . . . [as] a cushion . . . against insolvency. RBC is intended to be a minimum regulatory capital standard and not necessarily the full amount of capital that an insurer would want to hold to meet its safety and competitive objectives." National Association of Insurance Commissioners ("NAIC"), Risk-Based Capital (last updated Dec. 9, 2013), available at http://www.naic.org/cipr_topics/topic_risk_based_capital.htm. The District follows the RBC standards for HMOs formulated by the NAIC. *See* D.C. Code § 31-3851.01 (15) (2012 Repl.).

Thompson, DCHSI's sole shareholder, was being investigated by law enforcement. App. 817, ¶ 6.

DCHSI had months to find a solution to Chartered's problems. App. 671-72. Finding a buyer, an investor, or some other beneficial partnership for Chartered; improving Chartered's revenue flow from Health Finance; or crafting some other solution could have addressed Chartered's deteriorating finances and perhaps prevented receivership, but DCHSI was unable to accomplish any of these steps.

B. Rehabilitation, Reorganization Plan, and the asset sale to AmeriHealth

1. Rehabilitation and the need for immediate action by the Rehabilitator

Given Chartered's statutorily deficient Risk-Based Capital level and inability to correct it, the Insurance Department was required to place Chartered under regulatory control. D.C. Code § 31-3851.06 (2012 Repl.). The receivership proceedings authorized by the D.C. Code expressly apply to Chartered, which is incorporated in the District and serves the District's Medicaid population, just as it applies to "[a]ll insurers who are doing, or have done, an insurance business in the District, and against whom claims arising from that business may exist now or in the future...." D.C. Code § 31-1302 (1) (2012 Repl.).

When the trial court ordered rehabilitation in October 2012, the Rehabilitator was faced with an immediate problem – Chartered's Medicaid contract with the District, Chartered's only source of revenue, would expire April 30, 2013, and any bid for the next five-year contract was due December 3, 2012.

App. 674. Health Finance's Request for Proposals for the new Medicaid contract included a section setting forth the "Minimum Requirements" that any successful bidder had to meet, including a section titled "Authority to Operate." App. 703 § C.3.1.6. That section required that the "Contractor shall ... remain in compliance with all [Insurance Department] requirements concerning equity, capitalization, reserves, and insurance coverage throughout the term of the Contract." *Id.*

Because of its financial infirmity, Chartered was not qualified to be awarded a new contract under the criteria set by the District. App. 675, 703 § C.3.1.6. Moreover, Health Finance indicated that it would not award Chartered a new contract in any event unless Chartered were under new ownership and out of rehabilitation by mid-January 2013. App. 14, 675. A successful bid by Chartered was further hampered by the fact that, as of November 28, 2012, Health Finance was requiring a Corrective Action Plan from Chartered to address the quality and level of some services it provided clients. *Id.*

2. Finding a buyer or investor

Once the court entered the Rehabilitation Order, the Rehabilitator immediately initiated a process to find a buyer or investor that could provide Chartered with the wherewithal to succeed in a bid for the new Medicaid contract. He engaged Keefe, Bruyette & Woods, an investment bank, to assist in finding a buyer or investor. App. 676. The investment bank had discussions with seventeen potential investors, of which thirteen executed non-disclosure agreements allowing them access to Chartered's financial statements. App. 677. These entities were asked to provide information on

their sources of financing and expertise in the Medicaid managed care industry. *Id.* Seven entities provided that information. *Id.* The investment bank and Special Deputy Rehabilitator had in-person meetings with the three prospects deemed best based on their financial strength, Medicaid expertise, and other factors. *Id.*

Several factors deterred potential buyers and investors. There was considerable uncertainty about Chartered's ability to obtain a new contract with Health Finance. App. 14. Chartered's financials showed that it had almost no capital or surplus and would need a cash infusion of at least \$30 million to correct its capital deficiency. App. 15. It had a claim against Health Finance for underpayments based on its existing Medicaid contract, but recovery on that claim was uncertain and involved suing the party with which it sought a new contract. *Id.* Potential buyers also were wary because of speculation relating to a law enforcement investigation of DCHSI's owner, Jeffrey Thompson; auditors' identification of related-party transactions between Chartered and DCHSI unsupported by requisite documentation; and concerns about the fact that DCHSI had filed no consolidated tax returns for the previous two years.⁶ *Id.*; App. 272.

To obtain more time to address these uncertainties and encourage additional investors, the Rehabilitator asked Health Finance to extend the deadline for submitting bids beyond December 3, 2012 and, concurrently, to extend Chartered's current contract

⁶ The Rehabilitator has asserted a claim against DCHSI and its sole shareholder, Jeffrey Thompson, in a separate lawsuit to address the irregular or unsupported related-party transfers and income tax refund receivable due from DCHSI. App. 57-58; *D.C. Chartered Health Plan, Inc. v. Jeffrey E. Thompson & D.C. Healthcare Sys., Inc.*, Civil Action No. 2013 CA 003752 B (D.C. Super. Ct. filed May 30, 2013).

until the bidding process was completed. App. 676. Health Finance declined this request. *Id.*

Given Chartered's financial situation and the other considerable uncertainties, the Rehabilitator could not find any entity willing to purchase or invest in Chartered in the limited amount of time available. App. 678.

3. The sale to AmeriHealth

The Rehabilitator decided that an arrangement with AmeriHealth was the best available alternative to address Chartered's dire straits and serve its clients, providers, and employees. AmeriHealth had significant Medicaid contracting experience, sufficient financial resources to provide the capital to qualify in the District's bidding process, and personnel with the necessary expertise to complete a quality bid response by December 3. *Id.* The Rehabilitator signed a non-binding letter of intent with AmeriHealth. App. 16. The letter of intent contemplated the sale of certain Chartered assets to AmeriHealth, and it positioned AmeriHealth to take over Chartered's business by submitting a bid to Health Finance for the new Medicaid HMO contract that would commence after Chartered's contract expired. App. 16, 58.⁷

In the proposed transaction, AmeriHealth would pay \$5 million (and provide important transition services) to purchase Chartered's name; its contracts with hospitals, physicians, and other providers; certain intellectual property and computer systems; and

⁷ AmeriHealth created a new subsidiary (AmeriHealth District of Columbia, Inc.) to obtain the license and administer business in the District, but this brief uses the name AmeriHealth as a matter of simplicity. App. 681.

other items. App. 59. AmeriHealth's obligation to close the sale was contingent upon specified closing conditions, including: (1) court approval of the Reorganization Plan; (2) Health Finance's approval of AmeriHealth as a managed care provider for Medicaid recipients; (3) transfer of Chartered's existing Medicaid contract and current clients to AmeriHealth; and (4) licensure of AmeriHealth as a health maintenance organization in the District. App. 60. AmeriHealth also anticipated hiring most of Chartered's employees. App. 61.

AmeriHealth and Chartered worked to prepare an application in the District's Medicaid contracting process, which was presented in AmeriHealth's name and made use of Chartered's personnel and assets. App. 679-80. The Rehabilitator concluded that a bid submitted under Chartered's name (either solely or jointly) would not fare well in the process for several reasons, including that Chartered did not meet the minimum capitalization and financial qualifications required in the request for bids. App. 679.

The Special Deputy Rehabilitator issued a public statement and answers to questions on December 3, 2012 regarding the decision not to submit a bid on the Medicaid contract on behalf of Chartered itself. App. 16-17. The statement reported that Chartered had instead signed a letter of intent with AmeriHealth. The Insurance Department published the statement on its website and the Rehabilitator provided a copy to DCHSI's counsel. App. 680, ¶ 29.

Given the contingencies that had to be met for the Reorganization Plan to work, the Rehabilitator was obligated to seek expedited approval of the sale. Chartered's

contract with Health Finance was about to expire, and AmeriHealth had to act quickly to participate in the District's selection process for new Medicaid contractors to ensure that Chartered's clients – some of the District's most vulnerable residents – had uninterrupted health care coverage. App. 233-34.

DCHSI took a different tack. Upset that the Rehabilitator had delayed some of Chartered's administrative claims for additional Medicaid payments until the Rehabilitator could consolidate all of Chartered's claims, DCHSI asked the trial court to order the Rehabilitator to move more quickly on the claims. SA 12; SSA 1-2. DCHSI apparently wanted a quick resolution so that it could argue that Chartered itself could bid for a contract with Health Finance – assuming the bidding process could be reopened and Chartered could be quickly recapitalized through a judgment against Health Finance. *Id.* The Rehabilitator countered that the decision to consolidate all of Chartered's Medicaid claims preserved Chartered's assets by limiting duplicative discovery, hearings, and attorneys' fees. SSA 11-12. The trial court agreed and denied DCHSI's motion. SA 10, 12.

AmeriHealth's bid for the Medicaid contract was successful. App. 814. AmeriHealth assumed Chartered's client population and nearly all of its medical providers; it also continued to employ most of Chartered's employees, assuring continuity for important constituencies of Chartered and uninterrupted medical care for its clients. SSA 6-7; SSA 20. Transfer of Chartered's Medicaid business to AmeriHealth did not liquidate Chartered. After the sale, Chartered still had significant assets,

including approximately \$15 million in cash, its claims against Health Finance, and \$14 million that was pledged as collateral for a loan from Cardinal Bank to DCSHI. *Id.*; App. 678, 681, ¶ 31(b).

C. Health Finance settlement

1. Chartered's claims against Health Finance and the Towers Watson report

After addressing the needs of Chartered's clients, providers, and employees through the AmeriHealth transaction, the Rehabilitator turned to Chartered's claims against other entities, including its multi-million dollar claims against Health Finance under the expiring Medicaid contract. Before entering rehabilitation, Chartered had filed claims contending that its Medicaid reimbursement rate was not actuarially sound, seeking \$25.8 million in additional reimbursements under its contract. App. 15, SA 44, 57.

The Rehabilitator went further, hiring Towers Watson (formerly Towers Perrin), a respected actuarial firm, to evaluate Chartered's main claim, called the "Pharmacy Claim," alleging that Health Finance had made material, unilateral changes to the contract with Chartered and failed to pay contractually required capitation rates for services provided to new Medicaid program members, including 23,000 people the District transferred to Chartered, and for the existing Medicaid population. SA 25-26, 236-37. Even before Towers Watson's analysis, the Rehabilitator had increased Chartered's existing claim from \$25.8 million to \$51 million. SA 44, 58-59. The Rehabilitator added a second claim for over \$2.2 million, the "Dental Crown Claim,"

seeking an equitable adjustment for another alleged material change to the contract for additional dental benefits mandated by the District. SA 25. He also added a third claim for over \$9 million, the “Alliance Claim,” alleging that Health Finance had failed to pay actuarially sound capitation rates for Alliance program members between July 2010 and July 2011. SA 25-26. The Rehabilitator’s claims thus totaled over \$62 million – more than doubling the claim that Chartered itself had elected to assert before its rehabilitation. SA 44-45.

The Rehabilitator investigated additional grounds for possible claims. SA 46. He negotiated with Health Finance concerning Chartered’s claims and communicated about them with the District’s Attorney General, the federal Centers for Medicare and Medicaid Services, and the District of Columbia Council. SA 45.

2. Settlement terms and rationale

After hard-fought negotiations involving the Special Deputy Rehabilitator and counsel, Chartered reached a settlement with Health Finance under which Health Finance agreed to pay Chartered \$48 million to settle all claims; the District would execute a covenant not to sue Chartered for recovery or indemnification of any payments under the settlement; and Chartered would release Health Finance and the District from all claims. SA 60, 64-65. The settlement “avoid[ed] the risks, uncertainties, and substantial costs of litigation measured in years, not months,” and allowed Chartered promptly to pay providers more than 80 percent of what they were owed for delivering medical care to Chartered’s clients. SA 49, 53. The Rehabilitator explained to the trial court that the

settlement represented almost eighty percent of the value of the claims already filed against Health Finance and “roughly 60% of Chartered’s outside estimate of its actual damages,” including all possible unasserted claims. App. 49.

The Rehabilitator also asked for expedited approval of the settlement, so that the settlement could be paid from already appropriated 2013 funds and health care providers could be paid quickly. SA 52-53, 55. Prompt payment of providers was equally vital to Health Finance, whose director stated that approval of the settlement “sends a clear message to our providers that they are not only important to the beneficiaries they serve, but that they are considered an integral part in the system that contributes to the health and well-being of the District’s most vulnerable population.” Health Fin. Press Release, Judge Approves Settlement for Chartered Health’s Unpaid Claims (Aug. 21, 2013), available at <http://dhcf.dc.gov/release/judge-approves-settlement-chartered-health’s-unpaid-claims>.

3. Conflict over timing of settlement approval

DCHSI opposed the settlement and the request to act expeditiously on the motion to approve it. It argued that the settlement was not bargained at arm’s length because, with the Rehabilitator on one side and Health Finance on the other, “it is the product of a negotiation the District *had with itself*.” SA 78 (emphasis in original). DCHSI also argued that there would be money available to fund the settlement in the next fiscal year, although it provided no support for that assertion. SA 80, 91.

The Rehabilitator responded that time was of the essence because Chartered's health care providers had been waiting months for payment. SA 90-91. By August 2013, Chartered had processed \$48 million in unpaid provider claims (and reasonably expected about \$12 million more), but it had suspended provider payments as of April 2013. SSA 7, ¶ 3; 26-27, ¶ 2(c); SSA 29-30.

4. Positions of DCHSI and Rehabilitator regarding settlement approval

On the merits of the settlement, DCHSI argued that the trial court should reject the settlement because, according to DCHSI, Health Finance had no defense to paying the entire amount claimed, and therefore any discount to facilitate a compromise was improper. SA 108. DCHSI's position relied on an accounting report commissioned by the Insurance Department, called the Rector Report, which opined that Chartered could account for some of its claims against Health Finance as assets on its balance sheet because its contract with Health Finance was retrospectively rated, meaning that material changes in the contract required retroactive rate adjustment based on actual loss experience. SA 110.

The Rehabilitator responded that the Rector Report labeled the issue of retrospective rating "a very close question" and that the accounting recommendation "pertained solely to the treatment of Chartered's claim for accounting purposes, not to Health Finance's ultimate liability to pay the claim." SA 209, 301. The Rector Report was provided to the Insurance Department, which in its regulatory capacity had responsibility for overseeing Chartered's financial reports. *See* D.C. Code § 31-208

(2012 Repl.). The report had no binding effect on Health Finance, which “fiercely” disputed that the contract was retrospectively rated at all. *Id.* The report concluded that the contract had no mechanism for calculating a specific amount due Chartered for its claims. SA 209-210. The Rehabilitator also pointed out that DCHSI significantly overstated the total claims Chartered might have against Health Finance by including a \$30 million claim involving MedStar, which had been resolved for \$8 million. SA 210.

The Rehabilitator told the trial court that the negotiations he conducted with Health Finance were “vigorous, often contentious, and at all times at arm’s length.” SA 47. The Rehabilitator’s experienced counsel engaged in prolonged, hard-fought negotiations, informed by actuaries’ analyses. SA 51. Chartered and Health Finance both recognized the risks and substantial monetary and other costs inherent in continuing to litigate the dispute. SA 53. The Rehabilitator also pointed out that, when DCHSI had control of Chartered, it had settled a similar claim against Health Finance for 50 percent of the total claim, significantly less than the 80 percent of filed claims (or 60 percent of the outside limit of all possible potential claims) that the Rehabilitator had negotiated. SA 211-12. In other words, DCHSI wanted to hold the Rehabilitator to a different standard than DCHSI had applied to itself. *Id.*

The trial court approved the settlement, and nearly all of the funds from the Health Finance settlement now have been distributed to providers. SA 341-42; SSA 47.

SUMMARY OF ARGUMENT

This court should dismiss the appeal because DCHSI lacks standing to bring it. Non-parties in the trial court generally are not permitted to appeal. DCHSI was not a party in the trial court by operation of law, nor did it seek party status by moving to intervene. The statutory rehabilitation scheme does not make creditors or shareholders parties, but rather depends on the rehabilitator, acting subject to trial court supervision, to maximize the estate's assets for the benefit of all constituents – policyholders, providers, general creditors (including taxing authorities), and shareholders. Nor is DCHSI a “party aggrieved” under D.C. Code § 11-721 (b) (2012 Repl.) because none of its specific legal rights is being determined in the rehabilitation proceeding.

This court also should dismiss the appeal as moot. DCHSI has not argued that this court can provide any relief in this appeal that would actually benefit DCHSI; rather, it has asked only that the trial court's orders be reversed. First, as to the trial court's order approving the asset sale to AmeriHealth and Reorganization Plan, the sale has taken place, the assets have been transferred, and AmeriHealth has become the Medicaid HMO provider to more than 100,000 of the District's neediest residents. The sale and contract cannot be undone, there is no effective relief available to DCHSI even if it could show error below. Second, as to the trial court's order approving the \$48 million settlement with Health Finance, nearly all of the money already has been disbursed to Chartered's creditors. The money cannot realistically be recouped, so this court is not in a position to render any effective relief on that claim either.

On the merits, the trial court did not abuse its discretion in approving the asset sale and Reorganization Plan. The sale was the only reasonable way to continue health care services without significant disruption to Chartered's Medicaid clients, and it was the only solution that could be implemented in the compressed time frame dictated by Health Finance's bidding schedule. The trial court's approval of the sale did not violate DCHSI's due process rights. DCHSI knew about the sale for nearly ninety days before the trial court's hearing and had eight days' notice of the hearing, yet it came to the hearing unprepared. And after the trial court's order, DCHSI was provided additional process in the form of hundreds of pages of briefs and evidence it filed in the stay proceedings (in the trial court and this court), which would have put the sale on hold had it been successful. DCHSI's due process rights were respected throughout.

The trial court also did not abuse its discretion in approving the settlement with Health Finance. The settlement represented a reasonable compromise of hotly disputed claims; it was negotiated at arm's length among experienced counsel; and it fairly reflected the strength of the parties' claims and defenses. DCHSI's claim that the Rehabilitator should not have settled for less than 100 percent of Chartered's claims is baseless. Health Finance had defenses to Chartered's claims, and the litigation process would have been costly and protracted and could have left Chartered with far less than it got in the settlement. DCHSI's accusation that the Rehabilitator and Health Finance conspired to lowball the settlement is supported by no evidence and ignores the

presumption that the officials involved with the rehabilitation acted in good faith to promote appropriate public policy goals.

ARGUMENT

I. **The court should dismiss DCHSI's appeal because DCHSI lacks standing to appeal and the appeal is moot.**

This court should dismiss the appeal without reaching DCHSI's substantive questions of law because threshold justiciability problems preclude substantive review: DCHSI does not have standing to appeal and, even if it did, its appeal is moot. Standing and mootness are questions of law that are considered *de novo*, with the underlying factual determinations reviewed under the clearly erroneous standard. *See, e.g., In re Delaney*, 819 A.2d 968, 1002 (D.C. 2003) ("Whether appellants have standing is a question of law which we consider on appeal *de novo*. We review the underlying factual determinations under the clearly erroneous standard."); *Thorn v. Walker*, 912 A.2d 1192, 1195 (D.C. 2006) (dismissing appeal as moot where, as here, question of mootness hinged on events occurring after the trial court's orders).

A. **DCHSI lacks standing to bring this appeal.**

DCHSI lacks standing to bring this appeal. It was not a party below, and generally only parties in the trial court have standing to appeal. *Am. Archives' Counsel. v. Bittenbender*, 345 A.2d 487, 490 (D.C. 1975) ("Because an order is appealable, however, it does not necessarily follow that a nonparty may appeal it."), *overruled on other grounds by In re Chuong*, 623 A.2d 1154 (D.C. 1993); *United States v. Monzel*, 395 U.S. App. D.C. 162, 175, 641 F.3d 528, 541 (D.C. 2011) ("[T]he general rule is that one who

is not a party or has not been treated as a party to a judgment has no right to appeal therefrom.”) (internal quotation omitted).

The rehabilitation statute does not give DCHSI any formal role in litigation; the Rehabilitator acts on behalf of all stakeholders in the rehabilitation, including the creditors and shareholders. DCHSI never sought to intervene, nor is it a “party aggrieved” entitled to appeal under D.C. Code § 11-721 (b) (2012 Repl.) because it lacks any specific, cognizable, legal interest in the disposition of the rehabilitation estate.

1. The rehabilitation statute does not grant party status to creditors or shareholders like DCHSI.

Nothing in the rehabilitation statute makes DCHSI a party, either as a creditor of Chartered or as the shareholder of Chartered.⁸ *See* D.C. Code §§ 31-1301 to -1357 (2012 Repl.). The rehabilitation statute gives principal responsibility to a disinterested rehabilitator, who acts under court supervision to protect the interests of all stakeholders. *See, e.g.*, D.C. Code § 31-1312 (2012 Repl.). The rehabilitator is vested with exclusive standing to assert and settle common claims on behalf of the company, its creditors, and policyholders. *See, e.g.*, D.C. Code § 31-1313 (a) (2012 Repl.) (mandating that, with respect to pending litigation, the rehabilitation shall take “any action . . . deemed

⁸ The District’s rehabilitation law is based on national model legislation, which does not make policyholders, creditors, or shareholders parties to a receivership proceeding. *See, e.g.*, D.C. Council, Report on Bill 10-123 (May 25, 1993), available at http://dcclims1.dccouncil.us/images/00001/CP10/062314506_1.PDF (indicating that the bill underpinning what became D.C. Official Code § 31-1301 *et seq.* was “part of a package of 13 model bills dealing with insurance matters” that were drafted by the National Association of Insurance Commissioners). Although not binding on this court, case law from other jurisdictions interpreting substantially similar receivership statutes may be persuasive. *E.g.*, *Thomas v. United States*, 650 A.2d 183 (D.C. 1994) (using authority from other jurisdictions to interpret language of uniform statute).

necessary in the interests of, justice and for the protection of creditors, policyholders, and the public.”).⁹

Here, the court properly recognized the rehabilitator’s primacy. Every class of claimants could argue that its recovery is diminished by distributions to classes ahead of it or by some other failure of the rehabilitator to maximize the rehabilitation estate. But granting each of those classes standing to challenge or scuttle a court-approved rehabilitation plan would subvert the statutory scheme. *See Corcoran v. Frank B. Hall & Co.*, 545 N.Y.S.2d 278, 284-85 (App. Div. 1989) (recognizing that (1) the receiver is charged with the duty to ensure the equitable distribution of the insurer’s assets and (2) the purpose of the statutory framework is to avoid multiple lawsuits by various policyholders and creditors).

The only statutory reference to parties is to guaranty associations, not creditors or shareholders.¹⁰ D.C. Code § 31-1313 (2012 Repl.) gives a guaranty association standing to appear in a rehabilitation if the guaranty association is likely to become liable for the troubled insurer’s obligations. This exclusive reference indicates legislative intent that

⁹ *See also Four Star Ins. Agency, Inc. v. Hawaiian Elec. Indus., Inc.*, 974 P.2d 1017, 1025 (Haw. 1999) (acknowledging that receiver has exclusive standing to assert policyholder and creditor claims); *Cordial v. Ernst & Young*, 483 S.E.2d 248, 257 (W. Va. 1996) (“[T]he Insurance Commissioner, while acting as Receiver for an insurer, acts as the representative of interested parties, such as the defunct insurer, its policyholders, creditors, shareholders, and other affected members of the public. . . .”); *In re Am. Mut. Liab. Ins. Co.*, 632 N.E.2d 1209, 1213 (Mass. 1994) (finding that receiver may settle claims on behalf of policyholders).

¹⁰ Guaranty associations are created by statute to protect insureds when an insurance company’s estate is insufficient to cover the insurance company’s obligations. *E.g.*, D.C. Code § 31-5401, -5403 (a) (2012 Repl.) (creating District of Columbia Life & Health Guaranty Association).

shareholders and creditors ordinarily are not to be parties to rehabilitation actions. *See, e.g., Odeniran v. Hanley Wood LLC*, 985 A.2d 421, 427 (D.C. 2009) (applying the canon that “when a legislature makes express mention of one thing, the exclusion of others is implied”). DCHSI’s reliance on D.C. Code § 31-1305 (c) is misplaced. Br. II at 26. That subsection does not purport to convey standing in the absence of any pre-existing rights.

2. DCHSI never sought to intervene, so it did not become a party by intervention.

DCHSI never moved to intervene under Super. Ct. Civ. R. 24, despite warnings from both the Rehabilitator and the trial court that it was not a party. SA 15 (Trial Court Dkt., Notice of Appearance at 1 (filed Jan. 14, 2013)) (describing DCHSI as a “part[y] in interest in this proceeding ... filing this Notice of Appearance in order to receive copies of all pleadings, documents and correspondence that are served and filed in this matter.”). The Rehabilitator first questioned DCHSI’s standing to participate in the rehabilitation proceeding without formally intervening in one of the first papers he filed and flagged the issue again in connection with the Health Finance settlement. App. 233; SA 40. The trial court also questioned DCHSI’s status at the March 1, 2013 hearing. App. 254:11-20. Had DCHSI moved to intervene and been denied, it could have appealed that denial. *See, e.g., Alternative Research & Dev. Found. v. Veneman*, 347 U.S. App. D.C. 296, 301, 262 F.3d 406, 411 (2001); *see also* 15A Charles. Allen Wright, *et al.*, *Fed. Prac. & Proc. Juris.* § 3902.1 n.15 (2d ed. 1992) (collecting cases). But for the reasons cited in Part

I.A.1, *supra*, an appeal of denial of intervention would not succeed because the rehabilitation statute provides no party status for an entity in DCHSI's situation.¹¹

DCHSI relied on *Consedine v. Penn Treaty Network Am. Ins. Co.*, 63 A.3d 368 (Pa. Commw. Ct. 2012), as a rehabilitation in which shareholders were parties, but it is not persuasive authority in this case. First, while the shareholders of the insurers in rehabilitation in *Penn Treaty* were granted intervenor status, unlike here, they had moved in the trial court to intervene and the rehabilitator had consented to their intervention. Answer of the Rehabilitator to Pet. of Woznicki and PTAC to Intervene, at 7, *In re Amer. Network Ins. Co. in Rehabilitation*, 1 ANI 2009, (Pa. Commw. Ct. Nov. 9, 2009); Answer of the Rehabilitator to Pet. of Woznicki and PTAC to Intervene at 7, *In re Penn. Treaty Network Amer. Ins. Co. in Rehabilitation*, 1 PENN 2009 (Pa. Commw. Ct. Nov. 9, 2009). Second, the facts of *Penn Treaty* are different. The *Penn Treaty* trial court concluded after lengthy evidentiary proceedings that, unlike Chartered, the two insurers in that case had renewing books of business, were paying claims timely, and would be able to continue doing so for years. *Penn Treaty, supra*, 63 A.2d at 460-61. The *Penn Treaty* insurers' business was not about to expire as Chartered's was here. The *Penn*

¹¹ While DCHSI elected not to seek to intervene, another creditor of Chartered's did. Health care provider MedStar moved to intervene in the trial court proceeding on April 4, 2013. SA 12 (Trial Court Dkt., Mot. of Wash. Hospital Ctr. Corp. and Medstar Georgetown Med. Ctr. to Intervene as Interested Parties, *District of Columbia v. DC Chartered Health Plan, Inc.*, Case No. 2012 CA 008227 2 (filed Apr. 4, 2013)). The trial court denied MedStar's motion, finding that it was not timely because it was filed five months after the rehabilitation commenced and that it failed to show that the Rehabilitator had abused his discretion and had not adequately protected MedStar's interest in the rehabilitation process. SA 10 (Trial Court Dkt., Order Denying Medstar's Mot. to Intervene at 1-2, *District of Columbia v. DC Chartered Health Plan, Inc.*, Case No. 2012 CA 008227 2 (filed May 9, 2013)).

Treaty court thus could at least contemplate the shareholders' stepping back in after the companies were revitalized. That scenario was not possible here.

3. DCHSI also lacks standing to appeal because it is not a “party aggrieved” under D.C. Code § 11-721 (b).

DCHSI has not established that it is a “party aggrieved” under D.C. Code § 11-721 (b) (2012 Repl.), which states (subject to exceptions not applicable here), “a party aggrieved by an order or judgment specified in subsection (a) of this section, may appeal therefrom as of right to the District of Columbia Court of Appeals.” This court has explained that “[a] person is ‘aggrieved’ when that person’s legal rights have been infringed or denied. If a person has suffered no injury to his legal rights or to some legally protected relationship, he has no standing to appeal.” *Delaney, supra*, 819 A.2d at 1003 (dismissing probate appeal by former legatee who no longer had a legal interest in the estate). District courts “construe ‘aggrieved,’ as used in D.C. Code § 11-721 (b), to mean ‘suffering from an infringement or denial of legal rights.’” *In re C.T.*, 724 A.2d 590, 595 (D.C. 1999) (quoting *Webster’s Third New Int’l Dictionary* 41 (1976)) (denying standing to appeal of non-biological father in termination of parental rights case because he lacked parental rights); *see also Fisher v. Gov’t Employees Ins. Co.*, 762 A.2d 35, 38 (D.C. 2000) (denying subrogee standing to appeal to a person who failed to prove she had a right to assert subrogation); *Briggs v. United States*, 597 A.2d 370, 373 (D.C. 1991) (denying standing to appeal to an *amicus curiae* in the trial court because he was not a party and had no other legal interest).

DCHSI cannot show that it is “aggrieved” because it cannot demonstrate that any of its specific legal rights has been infringed in this rehabilitation proceeding. DCHSI has no specific legal interest at stake – it is just one of a long line of claimants against Chartered’s rehabilitation estate, and it will be paid in due course if sufficient resources remain after all the claims in classes ahead of it are paid. In this rehabilitation, shareholders are the last priority class; they do not have a direct interest in any asset of the receivership. If a last priority creditor were held to have a direct interest, then all claimants would have a sufficient interest to support intervention, thwarting the efficacy of rehabilitation and liquidation statutes. *State of Okla., ex rel. Crawford v. Am. Standard Life & Accident Ins. Co.*, 37 P.3d 971 (Okla. Civ. App. 2001) (holding that shareholders, who were also creditors, of insurer in receivership lacked standing to intervene); *see also Metcalf v. Investors Equity Life Ins. Co.*, 910 P.2d 110 (Haw. 1996) (recognizing that shareholder lacks standing to oppose liquidation petition); *Hartnett v. S. Am. Fire Ins. Co.*, 495 So. 2d 902, 903 (Fla. Dist. Ct. App. 1986) (affirming the trial court’s holding that shareholders of an insolvent insurance corporation did not have standing to participate in delinquency proceedings); *Ainsworth v. Old Sec. Life Ins. Co.*, 685 S.W.2d 583, 586 (Mo. Ct. App. 1985) (finding sole shareholder not permitted to intervene in insurer delinquency proceeding because proceeding was not an “action”).

DCHSI relies on *In re Orshansky*, 804 A.2d 1077 (D.C. 2002), in which this court allowed a person to appeal because she participated below as if she had been a party. *In re Orshansky, supra*, at 1090. *Orshansky* appears to be the only case applying this

doctrine in the District, and it relied upon a treatise and a Fifth Circuit case. *In re Orshansky, supra*, at 1090. But the treatise clarifies that this doctrine usually applies to persons who “seem to have been treated *on all sides* as de facto parties,” and that persons who participated below may be denied standing to appeal when they had no legal right to participate below. Charles Allen Wright, *et al., supra*, § 3902.1 (emphasis added). Here, DCHSI was not treated as a party by all sides because the Rehabilitator objected twice to its participation as a party, the trial court ruled that it lacked standing, and it had no legal right to participate below.

Similarly, the Fifth Circuit case on which *Orshansky* is based, *SEC v. Forex Asset Management, LLC*, 242 F.3d 325 (5th Cir. 2001), does not help DCHSI. The Fifth Circuit required three prerequisites for standing to appeal: (1) that the person participated in the trial court; (2) that the person has a personal stake in the outcome; and (3) that the equities weigh in favor of hearing the appeal. In this case, only the first factor is present. *SEC, supra*, 242 F.3d. at 329-30. DCHSI has no legal interest in the outcome of this appeal, and the equities weigh in favor of dismissing the appeal, saving the resources currently being spent on it (which would otherwise go to pay creditors), and moving toward termination of the rehabilitation proceeding. This appeal should be dismissed because DCHSI lacks standing to appeal.

B. Even if DCHSI had standing, this court should dismiss the appeal as moot because the trial court's orders have been fully carried out and no effective relief may be provided to DCHSI even if it were to succeed on appeal.

DCHSI has not explained and cannot articulate what effective relief this court could render for the obvious reason that there is none; hence this case is moot because no case or controversy remains to be adjudicated. See Br. I at 25. "If, pending an appeal, an 'intervening event' makes it impossible for the court to grant a prevailing party 'any effectual relief whatever', the appeal must be dismissed as moot." *NBC-USA Hous., Inc. v. Donovan*, 400 U.S. App. D.C. 86, 89, 674 F.3d 869, 872 (2012) (internal quotation omitted). It is well-settled that if an event occurs while an appeal is pending that renders relief impossible or unnecessary, the matter at issue is moot. *Stutsman v. Kaiser Found. Health Plan*, 546 A.2d 367, 371 (D.C. 1988); accord, *Thorn, supra*, 912 A.2d at 1195. In deciding whether an issue is moot, the court must determine whether it can fashion effective relief. *Smith v. Wells Fargo Bank*, 991 A.2d 20, 24 (D.C. 2010).

DCHSI's first claim is that the trial court erroneously approved the sale of certain of Chartered's assets to AmeriHealth without according due process to DCHSI. Both the trial court and this court denied DCHSI's motions to stay consummation of the transaction, and the transaction closed. The Rehabilitator sold certain of Chartered's assets to AmeriHealth. SSA 20, ¶ 2(b). Health Finance awarded AmeriHealth a new contract to provide Medicaid benefits to over 100,000 residents of the District, most of whom had been Chartered's clients but some of whom are new. App. 814. Most of Chartered's other assets have been marshaled (including by settlements with Health

Finance and others), and the proceeds have been used to pay providers and other creditors of Chartered. SSA 47. DCHSI has not explained how this court conceivably could undo all that has happened or otherwise provide any relief that would benefit DCHSI if this court were to find that the trial court denied DCHSI due process or abused its discretion.

DCHSI's second claim concerning the settlement with Health Finance similarly is moot because the settlement cannot be unwound. *See In re Marmarinos*, 464 B.R. 498, 501 (B.A.P. 1st Cir. 2012) (finding moot appeal from bankruptcy court's order authorizing trustee to compromise claims against credit union where debtor never sought stay of order and settlement was fully consummated). The trial court approved the settlement. DCHSI did not seek any stay, and the settlement was consummated. The terms of the settlement have been carried out, and \$46 million of the \$48 million settlement proceeds has already been disbursed to Chartered's providers. SSA 47. As a practical matter, it is not possible to recoup tens of millions of dollars of settlement funds from hundreds of health care providers and return them to Health Finance. The settlement cannot be unwound and the appeal therefore should be dismissed as moot.

II. The trial court's orders approving the asset sale to AmeriHealth and the Reorganization Plan were within the trial court's discretion and followed the law.

The trial court's approval of the asset sale and Plan of Reorganization is reviewed under an abuse of discretion standard. This court should affirm the trial court's orders "as long as the [trial] court reviewed the relevant facts; applied a proper standard of law; and using a rational process, reached a reasonable conclusion." *In re Ambac Assurance*

Co., 841 N.W.2d 482, 494 (Wis. Ct. App. 2013) (applying same model statute); *see also Foster v. Mut. Fire, Marine and Inland Ins. Co.*, 614 A.2d 1086, 1092 (Pa. 1992) (applying abuse of discretion standard of review for insurance rehabilitations based on model receivership statute). This standard is appropriate in light of a trial court's supervisory role in rehabilitation proceedings.

A. The trial court did not abuse its discretion by approving the Reorganization Plan and asset sale.

The trial court correctly approved the asset sale because it represented a reasonable – indeed, probably the only – way to minimize injury to Chartered's clients and to the health care providers serving those clients. The Rehabilitator's priority at the beginning of the rehabilitation was to address clients' needs in light of the impending termination of Chartered's Medicaid contract and Chartered's inability to qualify financially for a contract in Health Finance's next bid process. App. 675. Without quick action, the health care of more than 100,000 of the District's poorest residents was in jeopardy. App. 674. The Rehabilitator immediately set out to find a buyer or investor. App. 676-77. When none could be found, he instead partnered with a well-respected Medicaid HMO to bid to retain Chartered's previous business and prevent disruption of medical care to its clients. The Rehabilitator protected Chartered's clients, health care providers, and employees through his agreement with AmeriHealth, which had the Medicaid HMO experience and financial wherewithal to secure a new contract and prevent a significant disruption in the District Medicaid market. App. 678.

Under the uniform insurance receivership law adopted in the District, the “rehabilitator is granted authority to make judgments and take actions he believes to be in the public interest. The trial court’s primary role is a supervisory one and the standard of the court’s review of the rehabilitator’s actions is one of abuse of discretion.” *Ky. Cent. Life Ins. Co. v. Stephens*, 897 S.W.2d 583, 587-88 (Ky. 1995) (applying uniform statute).¹² The trial court correctly applied this standard, concluding that the Rehabilitator’s proposal “would prevent serious disruption for Chartered’s enrollees, address the interests of Chartered’s employees and provide funds that would help Chartered satisfy its liabilities.” App. 295. The trial judge stated that the sale “appears to be fair based upon all the facts and circumstances that have been addressed in the ...[rehabilitator’s] first and second report[s].” App. 276.

The Rehabilitator’s approach contained an element of risk, but the Rehabilitator had no less risky alternative. Potential buyers, funders, and partners were rightly concerned about Chartered’s poor financial condition, questionable audit findings, and

¹² Courts across the country agree that a rehabilitator’s actions should be reviewed for abuse of discretion, a highly deferential standard. *See, e.g., Ario v. Fid. Mut. Life Ins. Co.*, 935 A.2d 55, 62 (Pa. 2007) (“[W]e are to review Insurance Department actions integral to implementation of a rehabilitation plan for potential abuses of discretion.”); *In re Am. Investors Assurance Co.*, 521 P.2d 560, 563 (Utah 1974) (“trial court in its supervisory ... role may not substitute its judgment for that of the Commissioner, but may ... intervene or restrain when it is made to appear that the Commissioner is manifestly abusing the authority and discretion vested in him and/or is embarking upon a capricious, untenable or unlawful course.”); *Kueckelhan v. Fed. Old Line Ins. Co.*, 444 P.2d 667 (1968) (holding that the decision of a rehabilitator to rehabilitate the insolvent business of an insurer is within the sound discretion of the rehabilitator and should not be rejected by the reviewing court absent abuse of discretion); *In re Mills v. Fla. Asset Fin. Corp.*, 818 N.Y.S.2d 333, 334 (App. Div. 2006) (“The courts will ... disapprove the rehabilitator’s actions only when they are shown to be arbitrary, capricious or an abuse of discretion.”).

other clouds on its reputation. App. 14-15, 272. The Rehabilitator evaluated the available potential partners in the effort to find a way to bid for Chartered's continued Medicaid business, and AmeriHealth provided the best combination of Medicaid HMO experience and financial resources. App. 678.

The Rehabilitator's approach was vindicated when the District awarded AmeriHealth the new Medicaid contract for Chartered's patient population. App. 814. By implementing the Reorganization Plan and pursuing the sale to AmeriHealth, the Rehabilitator protected Chartered's clients, its health care providers (which could continue to serve the same patients under the Chartered provider contracts assigned to AmeriHealth), and most of Chartered's employees. DCHSI complains several times in the statement of facts in its first brief that the agreement with AmeriHealth was "secret" or "secretly implemented," Br. I at 4, 6, but that is not so. One of the prerequisites to implementing the agreement was that it be approved by the trial court. Even if Chartered and AmeriHealth took certain preliminary steps before public announcement of the agreement, the agreement was not final until court approval, and any actions already taken could have been undone if the trial court denied approval. See App. 60.

The trial court also properly approved the Reorganization Plan, which included not only the sale, but also marshaling Chartered's other assets (mostly claims against Health Finance, DCHSI, and its shareholder). These assets allowed payment of Chartered's outstanding liabilities – including those to health care providers that had serviced Chartered's clients – according to the priority set forth in the plan. App. 61-63. "The

courts will generally defer to the rehabilitator's business judgment and disapprove the rehabilitator's actions only when they are shown to be arbitrary, capricious, or an abuse of discretion." *In re Ambac Assurance Co.*, *supra*, 841 N.W.2d at 494 (quoting *In re Mills*, *supra*, 818 N.Y.S.2d at 334). Once the sale took place and the immediate needs of clients, providers, and employees were addressed, a reasonable next step was to focus on Chartered's assets and financial health with the goal of maximizing resources to be distributed to creditors and the shareholder. The asset sale and Reorganization Plan were a reasonable way for the Rehabilitator to achieve the rehabilitation's goals, including continued service to clients, paying providers, and looking out for employees' interests. The trial court acknowledged that under the statute and his order, "the rehabilitator [had] the right, based upon the statute, to marshal the assets, and to seek rehabilitation ... [and] I think they've acted appropriately," and it approved the Plan under this standard. App. 275.

B. The trial court's approval of the Reorganization Plan, including the sale to AmeriHealth, was consistent with due process.

The trial court's orders approving the Reorganization Plan and allowing the sale of Chartered's assets to AmeriHealth were consistent with due process because – assuming DCHSI had a protected interest – the orders were issued as part of proceedings that gave DCHSI ample notice and an opportunity to be heard.

When property interests are at stake, a person is entitled to notice and an opportunity to be heard. *Dusenbery v. United States*, 534 U.S. 161, 167 (2002). For due process purposes, the question is whether notice is "reasonably calculated, under all the

circumstances, to apprise interested parties of the pendency of the action and afford them an opportunity to present their objections.” *Mullane v. Cent. Hanover Bank & Trust Co.*, 339 U.S. 306, 319 (1950). Whether a trial court has provided adequate time for a party to prepare is reviewed for abuse of discretion. *Daley v. United States*, 739 A.2d 814, 817 (D.C. 1999).

Some jurisdictions have found that entities in DCHSI’s position lack a property interest protected by due process. *See, e.g., Plaza B.V. v. Stephens*, 913 S.W.2d 319, 321 (Ky. 1996) (holding that shareholders of insolvent insurer had no property rights in the company where assets were insufficient to satisfy policyholders and shareholders and they do not possess expectation of compensation so as to constitute a property interest). Because DCHSI has received more than sufficient process in this case, however, Chartered has chosen not to dispute whether DCHSI has a property right giving rise to constitutional protections. As described below, DCHSI received adequate notice, had a sufficient opportunity to present all of its evidence and arguments, did so, and fell short.

1. DCHSI had adequate notice and opportunity to be heard.

DCHSI knew on December 3, 2012 that the Rehabilitator was not submitting a bid on behalf of Chartered for a new Medicaid contract because the Rehabilitator issued a media release, which he also posted on the Insurance Department’s website, describing his plan to work with AmeriHealth. App. 16-17. The Rehabilitator also sent a copy of the release to DCHSI’s counsel just to make sure DCHSI was aware of it. App. 680, ¶ 29. A little over a month later, the Rehabilitator confirmed his intentions in his First

Status Report filed January 11, 2013. App. 12-20. DCHSI thus had notice of the proposed sale almost ninety days before the March 1 hearing, yet DCHSI claims not to have had adequate notice to prepare and took zero action to register its dissent from either the asset sale or the Reorganization Plan that the Rehabilitator continued to pursue in the meantime. App. 16-18. When the Rehabilitator filed his Second Status Report on February 22, 2013, which included the Rehabilitator's motion for approval of the AmeriHealth transaction and the definitive agreement, DCHSI still had eight days to do something before the scheduled March 1 hearing. App. 58-63.

The Second Status Report asked the trial court to approve both the sale and the Reorganization Plan, explaining that the AmeriHealth closing needed to occur before April 1, 2013, and therefore asking "the Court [to] hold an expedited status conference on this *Second Status Report and Petition* and issue the requested order on or before March 5, 2013." App. 55 (emphasis in original). The Second Status Report belies DCHSI's statement that "No one expected a merits hearing at the March 1 status conference," Br. I at 25. The Rehabilitator actually asked for a ruling on his motion at that hearing, or at least in the same time frame. App. 55. The deadlines were dictated by Health Finance's timetable for deciding which bidders would receive contracts. The AmeriHealth deal had to be approved by March 5 to allow for an anticipated April 1 closing so that AmeriHealth could provide uninterrupted coverage if Health Finance accepted its bid. App. 63-64. The Rehabilitator's Second Status Report and petition thus spelled out the need for speedy action on the sale and Reorganization Plan and put DCHSI on notice of

the need for prompt approval of the Plan. That DCHSI still did nothing and came to the March 1 hearing unprepared was surprising, but cannot be blamed on Chartered or the trial court.

DCHSI's argument focuses solely on its own financial interests, which it argues (contrary to the evidence) would have been better served had the Rehabilitator taken a different course. Other factors outweigh DCHSI's narrow interest. The Rehabilitator's Plan fostered continued contracts with providers and continuity of care for clients with those providers, provided \$5 million in cash and valuable transition services, and took care of most Chartered employees. Delay would have put the deal in jeopardy, affected AmeriHealth's participation in the bid process, and essentially eliminated the best chance to secure uninterrupted coverage for Chartered's clients. Implementing that Plan required expeditious action by the trial court.

Similarly, the trial court did not abuse its discretion in denying DCHSI's request for additional time. *See Daley, supra*, 739 A.2d at 817 (denial of request for continuance reviewed for abuse of discretion). "There are no mechanical tests for deciding when a denial of a continuance is so arbitrary as to violate due process. The answer must be found in the circumstances present in every case, particularly in the reasons presented to the trial judge at the time the request is denied." *Ungar v. Sarafite*, 376 U.S. 575, 589 (1964). "Relevant factors in determining whether there has been an abuse of discretion include the reasons for the request for a continuance, the prejudice resulting from its denial, the party's diligence in seeking relief, any lack of good faith, and prejudice to the

opposing party.” *Daley, supra*, 739 A.2d at 817. These factors align to show that the trial court acted correctly in granting the Rehabilitator’s motions without giving DCHSI additional time. DCHSI had plenty of notice, yet came to the hearing unprepared. App. 12-13, 55, 58-64; 253:10-13. Perhaps more importantly, granting DCHSI’s request to delay the proceedings for additional weeks would have squelched the best arrangement the Rehabilitator could get to assure uninterrupted Medicaid coverage for Chartered’s clients and a source of payment for health care providers who treated those clients. The trial court weighed these factors properly and decided that no further delay was warranted.

DCHSI’s contention that the status conference was supposed to consider only a briefing schedule on the Rehabilitator’s motions finds no support in the record. Br. I at 20. As quoted above, the Rehabilitator asked for a conference addressing his motions and emphasized the need to rule on them by March 5, 2013; the trial court’s docket notice setting the conference contained no limitation whatsoever on the topics to be considered. App. 55, 64, 232; 921; SA 14 (Trial Court Dkt., Status Hearing, Case No. 2012 CA 008227 2 (filed Feb. 27, 2013)). The suggestion that scheduling would be the conference’s topic came from DCHSI itself. DCHSI filed an opposition to the Rehabilitator’s request for a status conference on the same day the Rehabilitator filed the request. DCHSI asked the court to set a briefing schedule and hearing to occur several weeks later. The filing stated that “DCHSI is available for a conference ... to discuss scheduling this afternoon or the week of February 25, 2013.” App. 229. The trial court

never adopted the limitation that DCHSI sought, and the trial court's order set no limitation on the subject matter of the status conference. Given the Rehabilitator's request for urgent attention and the trial court's quick scheduling of an unlimited status conference – not to mention the fact that DCHSI had known for nearly three months that the Rehabilitator was working on an asset sale agreement – DCHSI could not reasonably rely on its own, last-minute attempt to limit the topics covered by the status conference and thereby delay a deal that needed to be addressed immediately.

DCHSI's only proffered alternative at the March 1 hearing was to assert that Chartered could obtain a delay in the bidding process or that the trial court could order that process to be stopped so that DCHSI could file briefs presenting its case against granting the motions. App. 269:13-20; 270:3-8. But Health Finance had already denied Chartered's request to delay the bid process. App. 676, ¶ 18. And the trial court rightly doubted its authority to stop the bidding process (a proposition for which DCHSI offered no on-point authority¹³) and said that it would not exercise such authority even if the court had it. App. 269:13-271:5, 275:7-10.

As an add-on to this point, DCHSI also argues that it should have been allowed to conduct discovery as an element of due process. But DCHSI admits it had no “absolute right” to discovery. More important, DCHSI did not propound any discovery in this

¹³ The one case DCHSI offered, *District of Columbia v. Group Insurance Administration*, 633 A.2d 2, 15 (D.C. 1993), addressed a different situation, in which bidding irregularities were alleged and the court stopped the process to allow the irregularities to be probed. Here, the only reason proffered for stopping the bidding process was to allow collateral litigation about one potential bidder to play out. App. 323-33 (containing DCHSI's arguments to stay bid process and for reversal of orders approving Reorganization Plan and sale).

portion of the litigation, so it asserted no right that was denied. Br. I at 22. DCHSI received sufficient notice and opportunity to be heard to satisfy the requirements of the Due Process Clause.

2. DCHSI availed itself of additional process by submitting extensive argument and evidence in connection with its motion for stay, which also was unsuccessful.

DCHSI not only had the opportunity to oppose the sale and Reorganization Plan in the weeks leading up to and at the March 1 hearing, it also had a second chance to protect its interests in the stay proceedings that followed and a third chance when it sought a stay from this court. If the stay had been granted, it would have provided all the relief DCHSI sought, namely an order precluding the sale to AmeriHealth. The proceedings surrounding the stay – including DCHSI’s 36-page memorandum, 16-page reply, and exhibits (which account for 479 pages in the 921-page appendix) in the trial court and 25 pages of further briefing on the stay in this court – provided DCHSI with more than adequate process. “Due process is flexible and calls for such procedural protections as the particular situation demands.” *In re Winstead*, 69 A.3d 390, 397 (D.C. 2013).

When there is a substantial interest in speedy process, the Due Process Clause allows flexibility, such as providing a hearing after the action complained of (similar to the role the stay proceedings played in this case). The key is whether the opportunity to be heard occurred ““at a meaningful time and in a meaningful manner.”” *Richard Milburn Pub. Charter Alternative High School v. Cafritz*, 798 A.2d 531, 541 (D.C. 2002) (quoting *Goldberg v. Kelly*, 397 U.S. 254, 267 (1970)). Courts in the District of

Columbia therefore have recognized that post-deprivation hearings may satisfy due process requirements. *See, e.g., Richard Milburn Pub. Charter Alternative High School, supra*, 798 A.2d at 541 n.9; *Wash. Teachers' Union Local No. 6 v. Bd. of Educ.*, 324 U.S. App. D.C. 1, 20, 109 F.3d 774, 781 (1997) (approving post-termination hearings for laid-off teachers); *James Madison Ltd. v. Ludwig*, 317 U.S. App. D.C. 281, 296-97, 82 F.3d 1085, 1100-01 (1996) (post-deprivation hearing provided sufficient process after Comptroller of Currency seized insolvent banks, relying in part on "Government's need to act swiftly"). "[W]here a State must act quickly, or where it would be impractical to provide predeprivation process, postdeprivation process satisfies the requirements of the Due Process Clause." *Gilbert v. Homar*, 520 U.S. 924, 930 (1997) (collecting cases).

Here, proceedings addressing the stay below and in this court were DCHSI's *second* and *third* bites at the apple – it also could have introduced evidence and argument in advance of or at the March 1 hearing on the Rehabilitator's requests but inexplicably chose not to do so. In its briefing on the stay, DCHSI spelled out all of its arguments that it has presented again to this court: that the Rehabilitator was effecting a *sub rosa* liquidation; that he had failed to provide DCHSI with requested information; that he was improperly usurping the role of Chartered's board; and that he improperly precluded Chartered from participating in the Health Finance bidding process. App. 323-33. DCHSI included hundreds of pages of affidavits, financial statements, documents from Health Finance, documents relating to DCHSI's bid protest, and other exhibits. App. 340-668. With these multiple opportunities to argue its case, DCHSI "had a meaningful

opportunity to challenge [the Rehabilitator's] . . . actions. Due process requires no more." *Jas. Madison Ltd., supra*, 317 U.S. App. at 297, 82 F.3d at 1101.

C. Chartered was in no financial condition to bid for the Medicaid contract.

DCHSI also implies that Chartered in fact had the financial strength to qualify for the Medicaid contract, but the record belies that. See Br. I at 25 & n.6; see also App. 703 § C.3.1.6 (stating standard to qualify to bid). At the time of the rehabilitation order, Chartered had almost no capital and surplus, and its Risk-Based Capital level was well below the 200 percent mandated by statute. App. 682. Chartered continued to lose money in 2012, and by the end of the year its capital and surplus was *negative* \$9.6 million – even after booking \$30 million to stand in for the uncollected claim against Health Finance. SSA 4. Its capital and surplus also included \$12 million in assets that were illiquid because they were pledged to Cardinal Bank as collateral for a loan the bank had made to DCHSI (and which Cardinal Bank liquidated after DCHSI defaulted, eliminating this asset from Chartered's books). App. 683; SSA 19-20. As of December 3, 2012, when bids for the Medicaid contract were due, Chartered was out of compliance with the Insurance Department's requirements for capitalization and reserves. App. 674. Thus, while Chartered could have submitted a bid in December 2012 for the Medicaid contract, its financial condition at the time (and thereafter) would have rendered its bid futile.

As well, even indulging DCHSI's hope that bidding on the Medicaid contract could have been reopened after December 2012, Chartered's continued financial decline

would have made a post-December bid equally pointless. By the end of the first quarter of 2013, Chartered's capital and surplus was negative \$28 million, and in the second quarter it sustained further losses and booked an \$8 million premium tax debt to the District. SSA 24, 31. In April 2013, the Rehabilitator had to suspend payments to providers because it had only \$8 million in cash on hand to pay an estimated \$60 million in providers' claims. SSA 7-8. Chartered has spent the entire \$18 million it received in the Health Finance settlement on payments to providers (and \$28 million of the other \$30 million of Health Finance settlement funds has similarly been paid to providers). SSA 47. As of January 2014, Chartered had \$9 million in cash on hand and at least \$14 million in remaining liabilities. SSA 47, 49. Therefore, because Chartered did not meet the minimum requirements under the Medicaid contract – in December 2012 and thereafter – it could not have been a successful bidder.

Notwithstanding the story told by its balance sheet, DCHSI argues that its claims against Health Finance would have cured its financial deficiency, ensuring a successful bid for the Medicaid contract. This is a fantasy built on two equally faulty premises. The first (explored in Part III, *infra*) is that Health Finance would pay Chartered 100 cents on the dollar to settle all of Chartered's claims. The second is that those future payments could be counted as cash on hand as of December 3, 2012, when bids were due for the new Medicaid contract. Neither premise is correct, and DCHSI simply cannot support its argument.

In support of its motion to stay, DCHSI proffered the affidavit of Gregory V. Serio, who offered a different view of how the rehabilitation should have been conducted. App. 744-762. Serio opined that “pursuit of the collectability of [Chartered’s claims against Health Finance] should have been ‘job one’ of the Rehabilitator.” App. 752. Serio argued that the Rehabilitator should first have secured payment from Health Finance on Chartered’s claims, then proceeded to turn around Chartered’s financial state so that it could have bid on the Medicaid contract. *Id.* DCHSI’s expert’s opinion demonstrates that a plan of rehabilitation can take many forms, based on the judgment and discretion of the individual rehabilitator and his advisors. But it does not follow that by pursuing a different plan, the Rehabilitator here abused his discretion. Indeed, Serio’s approach presumes that Chartered could have negotiated and closed a settlement with Health Finance in time (less than a month) for Chartered to compete for the Medicaid contract and that, ultimately, Chartered would have been awarded the contract. To say that those premises are speculative is charitable. And Serio’s approach is built on the backs of the District’s Medicaid health care providers, who would have had to wait many more months to receive the tens of millions of dollars Chartered owed them. A rehabilitator must weigh all competing interests and determine what is in the best interest of policyholders, creditors and the public as a whole. *See, e.g.*, D.C. Code §§ 31-1304, -1316 (2012 Repl.). The Rehabilitator’s judgment here reflects consideration of those diverse interests and therefore should not be set aside as an abuse of discretion.

D. The Reorganization Plan and asset sale were not a liquidation.

DCHSI also argues that the Rehabilitator carried out an unauthorized liquidation of Chartered. This assertion misapprehends the rehabilitation statute and disregards key facts. The Reorganization Plan (including the asset sale) did not liquidate Chartered. The Rehabilitator – acting with the swiftness required by exigent circumstances – assessed the situation; sought potential buyers and investors; culled that group; and reached a deal with AmeriHealth, the best candidate among the precious few interested parties. With assistance from Chartered’s personnel, AmeriHealth spearheaded preparation of an ultimately successful bid to succeed Chartered as a Medicaid contractor. This course of events protected Chartered’s approximately 100,000 clients and hundreds of providers as well as most Chartered employees. The Rehabilitator simultaneously presented a Reorganization Plan, which the trial court approved, that provided for marshaling assets and satisfying obligations as Chartered’s clients were resettled with AmeriHealth.

This course of events does not resemble a standard liquidation, in which a receiver immediately suspends policy obligations and all of the insurer’s assets are sold off. *E.g.*, D.C. Code § 31-1316 (2012 Repl.). That did not happen here. Chartered’s clients were able to obtain medical care at all times, and Chartered has paid nearly all of its obligations to providers, albeit on a delayed basis. This was not a fire sale that scattered the insurer’s enrollees and medical providers among various entities and left many obligations unpaid. Rather, the rehabilitation kept the business intact and service to

enrollees undisturbed. In time the Plan should make most providers – and perhaps other creditors – whole.

This was undoubtedly not the reorganization plan DCHSI wanted, but the Plan must be viewed in light of DCHSI's own business decisions – to make Chartered a company with only one source of revenue; to engage in questionable related-party transactions that triggered audit and regulatory concerns; to fail to resolve payment problems with Health Finance; to fail to file its consolidated income tax returns since 2010; and to fail utterly to resolve Chartered's financial problems in the months leading up to the rehabilitation order. It was DCHSI, not the Rehabilitator, whose actions made Chartered a poor candidate for sale or investment and prevented Chartered from being a qualified bidder for additional Health Finance business.

DCHSI's arguments focus solely on DCHSI's financial interests, whereas the Rehabilitator has obligations to all of Chartered's constituents. The Rehabilitator is not obliged to do the bidding of the shareholders, who were the ones in charge while the company's financial situation deteriorated. Rather, the Rehabilitator is obliged to use his discretion to reform or revitalize the company. D.C. Code § 31-1312 (c) (2012 Repl.). The Rehabilitator did exactly that, under circumstances that were challenging to say the least. DCHSI apparently believes that the Rehabilitator's job is merely to recapitalize the company, then hand it back to the prior owners. Br. I at 1, 8. But here, recapitalization was not possible and the Rehabilitator's entirely lawful plan protected Medicaid clients and providers before other interests.

The Rehabilitator is not required to ensure that the company in rehabilitation survives in any particular form, or at all. The respected treatise *Couch on Insurance* instructs that the rehabilitation plan “may result in the continuation of the business by the identical insurer, or by a new insurer to be formed to assume the assets of the old insurer” or by executing a trust allowing claims to be enforced against the insurer. Steven Plitt, et al., 1 *Couch on Insurance*, § 5:24 (3d ed. 1995) (internal numbering omitted). Here, the Rehabilitator helped to create a new insurer, using Chartered’s assets, customer and client relationships, and its employees, to carry on Chartered’s business without Chartered’s baggage. That act allowed uninterrupted service to more than 100,000 of the District’s Medicaid enrollees.

The Rehabilitator’s actions did not require a liquidation order. The District’s statutes require a liquidation order only when payment of policy obligations has been suspended for six months and the rehabilitator has not filed a rehabilitation plan – circumstances not present here. D.C. Code § 31-1314 (b) (2012 Repl.). Nor has DCHSI identified any benefit that would flow to it, to Chartered’s clients or providers, or to the public from a liquidation order. The Rehabilitator devised and executed what was the best plan possible in his business judgment under the circumstances, and DCHSI has not shown that he acted improperly in doing so. After determining that the Reorganization Plan was reasonable, lawful, and the product of the Rehabilitator’s good faith business judgment, the trial court approved it, and that is sufficient under the statute. D.C. Code § 31-1312 (e) (2012 Repl.).

E. There is no conflict between DCHSI, on the one hand, and the Special Deputy or the Rehabilitator's counsel, on the other.

DCHSI additionally posits that the Special Deputy and his counsel have conflicts of interest that should disqualify them from representing the interests of Chartered in the rehabilitation proceedings. Br. I at 3, 10. DCHSI is overreaching.

As to the Special Deputy, DCHSI argues that the conflict arises because Chartered's Chief Operating Officer from December 2007 to September 2011 is the Special Deputy's brother. *Id.* The statutory responsibilities for rehabilitation fall upon the Rehabilitator, not the Special Deputy, and the Rehabilitator performs them, himself and through others, under judicial supervision. DCHSI does not explain how the Special Deputy's family relationships *could* have influenced how the Rehabilitator managed his responsibilities, much less that it *did*. Contrary to one of DCHSI's earlier arguments on this point, there is no evidence in the record to show that the Special Deputy has investigated his brother as a former Chartered officer or that such an investigation was warranted or within his purview as Special Deputy. See App. 311. Moreover, DCHSI has not even indicated whether this sibling relationship is supposed to have rendered the Special Deputy more sympathetic or less sympathetic to DCHSI's, Chartered's, or any other stakeholder's interests.

As to the Rehabilitator's counsel, Faegre Baker Daniels LLP, DCHSI asserts vaguely that Faegre represented direct competitors of Chartered in the District of Columbia market, including a subsidiary of UnitedHealth Group, which is a client of Faegre, and AmeriHealth, for which Faegre is a registered lobbyist in Indiana. Br. I at 3,

10. As framed by DCHSI, the alleged conflict is that some of Faegre's clients would stand to benefit if Chartered went out of business. *Id.*

That is not the standard for disqualification under any applicable rule. DCHSI has not alleged – much less demonstrated – that Faegre's representation of the Rehabilitator in Chartered's rehabilitation proceeding is related in any way to its engagement by United or lobbying work for AmeriHealth. *See* D.C. Prof. Cond. R. 1.7; Ind. Prof. Conduct R. 1.7. The mere fact that Faegre represents a competitor of Chartered in unrelated matters does not constitute a conflict. The comments to both the District and Indiana Rules of Professional Conduct make clear that simultaneous representation of economic competitors in unrelated matters does not give rise to a conflict under Rule 1.7. *See* D.C. Prof. Cond. R. 1.7 cmt. 10 and Ind. Prof. Cond. R. 1.7 cmt. 1.6.¹⁴

¹⁴ In objecting to Faegre's retention, DCHSI relies on D.C. Code § 31-1405 (2012 Repl.), which mirrors Section 6 of the National Association of Insurance Commissioners' Model Law on Examinations, *Model Regulation Service October 1999, Model Law on Examinations* § 6 (NAIC 2012), and generally precludes the Insurance Commissioner from appointing an examiner who directly or indirectly has a conflict of interest. D.C. Code § 31-1405 (a) (2012 Repl.). Section 31-1405's purpose is to ensure a zealous and objective examination that will provide the Commissioner with an independent assessment of the relevant company's financial condition. Its purpose is not to disqualify simultaneous representation of economic competitors in unrelated matters. As explained by the National Association of Insurance Commissioners, *Financial Condition Examiners Handbook* § III.G.4 (2013 ed.): Conflicts of interest may occur if an examination of a company is performed by an independent contractor who has a significant relationship with the company, its affiliates, or their management (financial or non-financial) that may impair in fact, or appearance, the independent contractor's independence. Notably, the NAIC guidance warns of conflicts that could arise from an examiner's relationship with the company being examined. That is not the conflict suggested here because Faegre had no prior connection with Chartered.

F. The Rehabilitator acted in accord with his statutory powers.

DCHSI's final argument against the asset sale – that the Rehabilitator ignored Chartered's articles of incorporation and violated corporate law – is unpersuasive. District law and the Rehabilitation Order granted the Rehabilitator all the powers of Chartered's directors, officers and managers, gave him the authority to take possession and control of Chartered's assets and administer them under the court's supervision, and acknowledged the Rehabilitator's discretion to take such action as deemed necessary or appropriate to reform the company. *See* D.C. Code §§ 31-1311 (a), -1312 (c) (2012 Repl.); App. 9. The Rehabilitator exercised his powers appropriately, as the trial court concluded after closely reviewing all actions the Rehabilitator sought to take.

DCHSI's theory that the Rehabilitator should have sought the sole shareholder's (that is, DCHSI's) consent before taking any action is unsupported by the text of Chartered's corporate documents and contrary to the receivership statute. Chartered's articles of incorporation provide: "No action of the Board of Directors shall take effect unless it has been approved by the unanimous vote of the outstanding shares entitled to vote." App. 372. The Rehabilitator's action does not violate this provision. None of his actions are actions of Chartered's Board, and therefore they do not require the shareholder's approval. The rehabilitation statute puts the Rehabilitator in charge of the business and ousts the Board from its authority, negating the shareholder-consent provision. Additionally, DCHSI's position would allow the shareholder unilaterally to thwart the receivership statute by promoting its own interests ahead of all other stakeholders.

DCHSI's argument in support of the shareholder's supposed rights also ignores the statutorily recognized rights and interests of all others. With the exception of *Koken* (discussed below), the cases DCHSI cited discuss general common law principles and do not address the specific statutory regimes governing HMOs and rehabilitations. See Br. II at 34-35. The rehabilitation statute, in particular, recognizes the interests not just of shareholders, but also of policyholders, creditors, and others. See, e.g., D.C. Code §§ 31-1304, -1316 (2012 Repl.). For example, DCHSI cites D.C. Code § 31-1304 (2012 Repl.) for the proposition that the court may prevent any action that might lessen the value of the insurer's assets or prejudice shareholder rights. Br. II at 35. DCHSI's statement is true – but incomplete. Section 31-1304 (a) states that the receiver may apply to the court for any order deemed necessary and proper to prevent “(11) Any other threatened or contemplated action that might lessen the value of the insurer's assets or prejudice the rights of *policyholders, creditors, or shareholders . . .*” (emphasis added). The statute expressly recognizes the interests of policyholders and creditors and lists their interests before those of shareholders. *Id.*; see also D.C. Code § 31-1316 (b) (2012 Repl.) (acknowledging the rights of shareholders, but also those of the insurer, its creditors, policyholders, “and all other persons interested in its estate”). In sum, contrary to DCHSI's suggestions, nothing in the receivership statute suggests that the shareholder's rights should be elevated above all others. DCHSI may be the sole shareholder here, but it is not the sole stakeholder.¹⁵ DCHSI's argument on this point fails.

¹⁵ The shareholder's failure to acknowledge the rights of others, particularly policyholders, is also demonstrated by its selective citation of *Koken v. Legion Insurance Co.*, 831 A.2d 1196

III. The trial court properly approved settlement of Chartered's claims against Health Finance.

A. The trial court did not abuse its discretion by approving Chartered's settlement with Health Finance.

The trial court's decision to approve the \$48 million Health Finance settlement was correct and should not be disturbed, especially when viewed through the lens of the applicable abuse of discretion standard. *See In re Ambac Assurance Co.*, *supra*, 841 N.W.2d at 494; *see also Foster*, *supra*, 614 A.2d at 1092; *Kueckelhan*, *supra*, 444 P.2d at 667; *Minor v. Stephens*, 898 S.W.2d 71, 80 (Ky. 1995). Indeed, this court has acknowledged the "limited scope of [its] review of such orders," when considering a trial court's approval of a settlement. *Shepherd Park Citizens Ass'n v. Gen. Cinema Beverages of Washington, DC, Inc.*, 584 A.2d 20, 22 (D.C. 1990) (applying abuse of discretion standard to trial court's approval of settlement agreement under the District's *parens patriae* statute).

The Rehabilitator's recommendation to approve the settlement was a reasonable exercise of his judgment, and the trial court approved the settlement only after determining that it was fair, adequate, and reasonable. SA 316-17; *see Ball v. AMC Entm't, Inc.*, 315 F. Supp. 2d 120, 125 (D.D.C. 2004). The trial court's role is to approve

(Pa. Commw. Ct. 2003). DCHSI ignores *Koken's* repeated assertion that the "equitable purpose of rehabilitation and liquidation in insolvency statutes is to protect *first of all consumers* of insurance." *Koken*, *supra*, 831 A.2d at 1232 and 1247 (citation omitted, emphasis added). It is in that context – the concern for protecting the "interests of the creditors and policyholders in a decision to terminate a rehabilitation," *Koken*, *supra*, 831 A.2d at 1229, that the court determined that the rehabilitator had not used the correct means for liquidating the insurer. *Koken*, *supra*, 831 A.2d at 1229. Notably, the court ultimately concluded that the rehabilitator had demonstrated that liquidation was warranted. *Koken*, *supra*, 831 A.2d at 1246.

a settlement unless it represents an abuse of the rehabilitator's discretion: "the trial court in its supervisory and reviewing role may not substitute its judgment for that of the Commissioner, but may and should only intervene or restrain when it is made to appear that the Commissioner is manifestly abusing the authority and discretion vested in him and/or is embarking upon a capricious, untenable or unlawful course." *Kueckelhan, supra*, 444 P.2d at 674. The trial judge specifically acknowledged his role "to supervise the Rehabilitator and to review the actions for abus[e of] discretion and not to substitute the court's judgment or the judgment of the parent company [DCHSI] ... for that of the Rehabilitator." SA 317:15-18.

To determine whether a settlement is fair, adequate, and reasonable, a court assesses several factors, including:

- whether it is a result of arm's length bargaining. *Shepherd Park Citizens Ass'n, supra*, 584 A.2d 20, 25 n.9 (D.C. 2006);
- experienced counsels' opinions of the settlement's fairness, adequacy, and reasonableness. *Richardson v. L'Oreal USA, Inc.*, 951 F. Supp. 2d 104, 107-108 (D.D.C. 2013); and
- whether the settlement's terms are a fair match with the strength of the parties' claims. *Blackman v. District of Columbia*, 454 F. Supp. 2d 1, 8 (D.D.C. 2006) ("the most important factor" in evaluating a settlement is "comparison of the

terms of the proposed settlement with the likely recovery that plaintiffs would realize if they were successful at trial.”).

And it weighs the settlement in light of the principle that the justice system favors settlement. *Am. Sec. Vanlines, Inc. v. Gallagher*, 251 U.S. App. D.C. 198, 202, 782 F.2d 1056, 1060 (1986). After applying these principles to the evidence, the trial court correctly approved the settlement.

1. The settlement was a product of arm’s length bargaining.

The trial court received evidence from the Special Deputy and counsel that negotiations between Health Finance and the Rehabilitator were “vigorous, often contentious, and at all times at arm’s length.” SA 47. The Special Deputy specifically represented to the trial court that the settling parties had engaged in multiple telephone conferences, in-person meetings, and rigorous and adversarial efforts to draft a settlement agreement, producing a fair compromise of a difficult and complex set of disputes. *Id.* The Special Deputy further assured the trial court that negotiations involved no collusion. SA 51.

2. Opinions of experienced counsel supported the settlement’s terms.

The trial court also received and acknowledged evidence that each side was represented by experienced advocates throughout months of analysis and negotiation. SA 51. The court acknowledged that the Special Deputy had engaged a team of experts in connection with his analysis and recommended approval of the settlement. Specifically, at the August hearing on the settlement, the trial court noted that it had “reviewed the

numerous documents that ha[d] been presented and question[ed] the use of attorneys, accountants ... and others and ha[d] required additional information to be presented to it.” SA 317:24-318:5. Each party to the settlement was represented by experienced counsel, and the trial court took appropriate comfort that they had zealously represented their clients in hammering out a fair bargain.

3. The settlement was a fair match to the strengths of the parties’ claims and defenses.

The Rehabilitator also informed the trial court of the risks, costs, and benefits of settlement, permitting it to assess whether the settlement – which paid \$48 million on \$62 million in filed claims – was a reasonable resolution of the dispute between the Rehabilitator and Health Finance. SA 53. The Rehabilitator hired an actuarial firm to assist in evaluating its largest claim: the Pharmacy Claim for over \$51 million. SA 45. The settlement paid approximately eighty percent of Chartered’s filed claims and sixty percent of “Chartered’s outside estimate” of all potential damages. SA 49. That recovery is far better than one that DCHSI itself bargained for and agreed was satisfactory in a parallel context. Chartered – then under DCHSI’s direction – asserted a claim against Health Finance alleging that Health Finance was applying actuarially unsound rates and owed Chartered additional reimbursements, just as Chartered has done here. DCHSI accepted fifty cents on the dollar to settle that claim. SA 211-212.

The Rehabilitator’s settlement with Health Finance allowed Chartered to pay health care providers most of the amounts owed on their claims reasonably promptly.

SSA 26-27, 29-30; SSA 7; SA 341. The trial court expressly recognized the import of the settlement to the resolution of outstanding claims of providers. SA 318:9-11.

4. The parties considered alternatives to settlement.

Finally, the trial court received evidence concerning the alternative to settlement, which included costly and protracted litigation and an uncertain recovery. SA 49, 213. More important, in light of Chartered's financial condition, many of the costs of delay would have been borne by Chartered's health care providers, which could ill afford it. The expenses of litigation would have been significant, reducing the value of the rehabilitation estate. *E.g.*, SA 49.

Having considered the evidence and law, the trial court concluded at the August hearing that it was "satisfied that there is no abus[e of] discretion by the Rehabilitator or its team and, in fact, the court views the actions to be more than satisfactory." SA 318:3-5. The trial court's ruling was correct. The settlement was a reasonable resolution of Chartered's claims, which amounted to \$62 million of claims actually filed and an outside total of \$80 million taking into account all potential but speculative, unasserted claims. SA 44-45, 49.

B. DCHSI's argument that the only reasonable settlement is 100 percent of Chartered's claims is unsupported.

DCHSI maintains that the trial court should have rejected any settlement paying less than 100 percent of Chartered's claims. DCHSI asserts that "[t]here simply could be no credible defense to Chartered's retrospective rating claims given the District's prior determination that the Contract is retrospectively rated and the right to retrospective

payment was triggered.” SA 110. In other words, “[i]f the Rehabilitator were vigorously pursuing Chartered’s interests, he would demand that the District pay its debt in full.”

SA 98. DCHSI insisted that the only proper settlement was for Health Finance to pay every cent of the amount claimed. SA 108.

It is a rare claim that is subject to no uncertainty, and these claims were not in that category. As the Rehabilitator explained to the trial court, Chartered’s claims were solid but not impregnable. SA 209-10. Pursuing the administrative claims, and later judicial review, was a strategy with risks. Not only could long, drawn-out litigation lead to a bad outcome, further delays also could alienate the unpaid health care providers that Chartered’s clients counted on for health care.

DCHSI’s argument focused on the accounting opinion, the Rector Report, which concluded that for purposes of Chartered’s financial statements, its contract with Health Finance was retrospectively rated, meaning that its actuarial assumptions could be revisited after the fact to determine whether Chartered had received appropriate compensation. But it was an accounting opinion, not a legal opinion. It was prepared solely to determine whether Chartered’s claim against Health Finance could be included as an asset on Chartered’s financial statement. SA 300. The report did not establish the value of the asset in a way that bound third parties, least of all Health Finance, and it certainly did not require the Contract Appeals Board, the adjudicator of Chartered’s claims, to rule in Chartered’s favor. SA 209. Moreover, DCHSI omits to note that the Rector Report itself stated that whether the contract was retrospectively rated was a

“very close question.” SA 209, 301. It also noted that the Medicaid contract language did not “set out a stipulated formula that is to be used to determine retrospective and annual premium adjustments,” meaning that even if retrospective rating were applied, the amount produced would be uncertain. SA 307.

Under the applicable standard of review, the Rehabilitator’s actions were not an abuse of discretion. He avoided the costs and delays of litigation and obtained an appropriate settlement at a time when the rehabilitation estate needed funds to pay the providers who had waited months for payment and were continuing to provide care to the District’s Medicaid clients. *Shepard Park, supra*, 584 A.2d at 23-25 (risks and costs of litigation and relationship between settlement amount to possible recovery are relevant factors in evaluating settlement); *cf. Indian Motorcycle Co., Inc. v. Sterling Consulting Corp.*, 289 B.R. 269, 282-283 (B.A.P. 1st Cir. 2003) (“Compromises are generally approved if they meet the business judgment of the trustee. Bankruptcy courts should be no more willing to second guess competent, disinterested trustees and debtors-in-possession than other courts are willing to second guess competent, disinterested directors.”) (citation omitted).

C. There is no support in the record for DCHSI’s conspiracy theory.

DCHSI muses that “it was always the plan of the District to bring about the end of Chartered and to irreparably harm DCHSI.” Br. II at 39. There is nothing in the record to back up this conspiracy theory. Moreover, DCHSI’s histrionics ignore the statutory separation of duties between Health Finance, the Insurance Commissioner, and the

Rehabilitator. Health Finance and the Insurance Department are separate governmental agencies, with separate goals and agendas, and it is to be expected that they will not always act in harmony with one another. In this case, their purposes conflicted – sometimes acrimoniously – and the conflict was solved by compromise after hard bargaining. That DCHSI thinks the terms could have been better for Chartered’s equity owner is no basis to attack the integrity or motives of those who negotiated the settlement.

As a general matter, “[i]t shall be the duty of the Commissioner to see that all laws of the United States relating to insurance or insurance companies, benefit orders, associations, and others doing insurance business in the District are faithfully executed” D.C. Code § 31-202 (a) (2012 Repl.). As part of those duties, the Commissioner is authorized to institute actions to rehabilitate or liquidate insurance companies under D.C. Code Title 31, Chapter 13. The District’s rehabilitation statute itself recognizes a distinction between the Commissioner’s two separate roles as regulator and rehabilitator. *See, e.g.*, D.C. Code § 31-1311 (a) (2012 Repl.) (“An order to rehabilitate ... shall appoint the Commissioner and his or her successors in office the rehabilitator, and shall direct the rehabilitator forthwith to take possession of the assets of the insurer....”); D.C. Code § 31-1312 (a) (2012 Repl.) (“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”).

Other jurisdictions also recognize that the insurance commissioner or superintendent as regulator of insurance performs a distinct role from the rehabilitator or liquidator. “The plaintiff Superintendent of Insurance as Liquidator ... acts in a separate and distinct capacity from his role as regulator of the insurance industry.” *Corcoran v. Nat’l Union Fire Ins. Co.*, 143 A.D.2d 309, 310-311 (N.Y. App. Div. 1988)); *see also DiNallo v. DiNapoli*, 877 N.E.2d 643, 648 (N.Y. 2007) (insurance superintendent as liquidator occupies a status legally distinct from his position as a public official) .

Likewise, Health Finance is a separate, cabinet-level agency within the executive branch of the District’s government and subordinate to the Mayor. D.C. Code § 7-771.02 (2012 Repl. & 2013 Supp.). Health Finance’s mission includes maximizing the well-being and quality of life for eligible low-income individuals and other populations through the provision of health care benefits; developing a comprehensive, efficient and cost-effective health care system for the District’s uninsured, under-insured and low-income residents; and developing service delivery and reimbursement policies for the District’s health care financing programs. D.C. Code § 7-771.03 (2012 Repl.). Health Finance is headed by a director appointed by the Mayor with the advice and consent of the Council. D.C. Code § 7-771.04 (2012 Repl.). The director is charged with executing grants, contracts, or other agreements with governmental bodies, public and private agencies, and organizations on behalf of the Department. D.C. Code § 7-771.05 (2012

Repl.). Thus, Health Finance is separate from and has statutory obligations that are different from those of the Insurance Department and the Rehabilitator.

DCHSI has shown no conspiracy or collusion between or among any of these actors, and there was none. Indeed, there exists a strong presumption that public officials “discharge their duties correctly, lawfully, and in good faith.” *Beauregard v. Mabus*, 10-CV-1972 RLW, 2012 WL 4857788 at *3-4 (D.D.C. Oct. 15, 2012) (citation omitted). DCHSI tries unsuccessfully to rebut that presumption. For example, DCHSI asserts that the Insurance Department determined that Chartered’s contract with Health Finance was retrospectively rated and issued an Order adopting a limited scope financial examination report (the Rector Report) memorializing that determination. Br. II at 45. Yet DCHSI proffers no authority for the proposition that orders of the Insurance Department bind other District agencies, such as Health Finance. While DCHSI makes the conclusory assertion that “it was always the plan of the District to bring about the end of Chartered and to irreparably harm DCHSI,” there is nothing in the record to evidence any conspiracy toward that end. Br. II at 39.

D. DCHSI’s other objections to the settlement are groundless.

1. The trial court considered DCHSI’s opposition papers and found them unpersuasive.

DCHSI argues that the trial court failed to consider the evidence and arguments it presented. Br. II at 30. Specifically, DCHSI asserts that the trial court improperly did not consider the Towers Watson report or the evidence of its expert, Drew A. Joyce, and therefore made an unfair, less than fully informed decision. Br. II at 25.

The trial court's ruling, however, reflects appropriate consideration of the evidence. The Rehabilitator and DCHSI each fully briefed the merits of the settlement, and the trial court considered both DCHSI's opposition to the motion for expedited hearing on the settlement and its opposition to the settlement itself. SA 78-82, 96-198. DCHSI's opposition to the settlement comprised more than 100 pages and contained an extensive report by Joyce, the putative expert, attacking the Rehabilitator's claims valuation methodology and settlement position. SA 120-135. The trial court did not consider DCHSI's supplemental opposition to the settlement – filed at 5:00 p.m. the Friday before the hearing without delivering a courtesy copy to chambers – which included a draft of the Towers Watson report. SA 310:24-311:21; SA 311:22-312:11; 313:18-314:1. While the trial court did not receive DCHSI's supplemental submission containing the Towers Watson report before approving the settlement, the report simply explained the Rehabilitator's Pharmacy Claim valuation in more detail, a valuation DCHSI already had attacked in its opposition brief considered by the court. SA 312:1-313:6. Thus, the record contradicts DCHSI's contention that the trial court's decision approving the settlement was unfair. Moreover, as discussed above, DCHSI was not a party to the rehabilitation litigation in any event, and therefore any materials the trial court accepted from DCHSI were received in the interest of fairness and not because the trial court was obligated to accept them.

At the hearing on approval of the settlement, the trial court told counsel for DCHSI: "I've considered all the things that you would have raised, had you been granted

standing.” SA 329:16-17. Indeed, the trial court specifically referred to DCHSI’s opposition pleadings:

I have reviewed your opposition [papers]. I do not find them to be persuasive. The court finds additional discovery would be useless and only increase litigation costs. There can be criticism of any settlement and the evaluation of every claim can always lead one to say that you could have gotten more, but in every case ... there’s compromise and it has to be weighed and I find the Rehabilitator has done that in this case.

SA 318:12-19. The trial court heard and rejected DCHSI’s arguments in opposition to the settlement, including the merits of the claim analyzed by Towers Watson. That the trial court did not admit the Towers Watson report as evidence before ruling is of no moment. DCHSI’s expert had attacked the claim valuation methodology, and the Rehabilitator had defended it.

The best possible recovery in contested litigation is not the standard for judging a settlement in any context cited by DCSHI, much less in a rehabilitation proceeding. Courts generally analyze a settlement in terms of a range of reasonableness and should generally refuse to substitute their business judgment for that of the settlement’s proponents. And, while shareholders and creditors may have differing views of a rehabilitation plan based on their own self-interest, a rehabilitator is unencumbered by self-interest and can balance the competing interests of all claimants in a fair and equitable manner. *See Minor, supra*, 898 S.W.2d at 76 (noting that the rehabilitator “is the best qualified to perform the rehabilitation ... process as he has no special interest in

the outcome except to administer the matter for the maximum benefit of all interested parties”) (citation omitted).

2. DCHSI has not established that the Rehabilitator’s settlement of potential claims against Health Finance was an abuse of discretion.

DCHSI also contends that it was an abuse of discretion for the Rehabilitator (and trial court) to “allow[] the settlement of an unknown amount of claims for a deep discount of only the known claims.” Br. II at 45. DCHSI maintains that “the District’s final debt to Chartered could not be determined until Chartered’s obligations to plan providers were determined after the August 31, 2013 bar date,” which fell after the settlement approval hearing. Br. II at 44.

DCHSI’s contention is incorrect both as a matter of law and a matter of fact. It is incorrect as a matter of law because it rests on a misunderstanding on the nature of the claim: DCHSI assumes that Chartered’s contract with Health Finance was retrospectively rated – a position that Health Finance vigorously disputed. See *supra* Part III.B.1. It is incorrect as a matter of fact because the Rehabilitator had closely monitored provider claims and (correctly, it turned out) did not anticipate any material changes in the total. SA 210.

DCHSI ignores that the Rehabilitator had undertaken efforts to substantially increase and bolster Chartered’s claims against Health Finance, efforts that DCHSI itself had failed to undertake. The Rehabilitator engaged Towers Watson, independent actuarial experts, to analyze and value Chartered’s claims against Health Finance. SA 45.

The Rehabilitator nearly doubled Chartered's one filed claim against Health Finance, from \$25.8 million to \$51 million, and filed two additional claims for underpayments in other programs totaling \$11 million, for an aggregate claim of \$62 million. SA 44-45. DCHSI has not shown that the Rehabilitator's approach was unreasonable or that the settlement he accepted did not advance the purposes of the rehabilitation.

3. DCHSI undervalued the settlement by improperly inflating the value of Chartered's claims.

Even assuming DCHSI's valuation process had been correct, its arithmetic was wrong. To get to the \$98 million that DCHSI claims Health Finance owed Chartered, DCHSI included more than \$30 million in disputed claims that health care provider MedStar hospitals had against Chartered, which Chartered in turn would seek to recover from Health Finance. SA 210. But the MedStar dispute settled for \$8 million, lopping \$22 million off of DCHSI's \$98 million total. SSA 36, ¶ 1(a)(iv); Order Approving MedStar Settlement, Case No. 2012 CA 008227 2 (filed Oct. 17, 2013) [Trial Court Dkt. Sheet]. So even assuming DCHSI's methodology were correct, its total potential damages would be \$76 million, not \$98 million. Using DCHSI's own methodology, the Rehabilitator still recovered sixty three percent of the total damages DCHSI claimed might be due.

The trial court was not charged with determining "whether a better settlement [was] conceivable." *Ball, supra*, 315 F. Supp. 2d at 129 (internal quotation omitted). Rather, the trial court was tasked with considering whether the Rehabilitator abused his discretion in deciding to settle when and for the amount he did. Given that the

Rehabilitator secured a settlement from Health Finance that was appreciably better than then-DCHSI-controlled Chartered had accepted on a prior, similar claim, and did so at a time when health care providers were clamoring for payment of over \$60 million in claims that Chartered had for months been unable to pay, there was no abuse of discretion.

4. DCHSI was not entitled to discovery in connection with the settlement.

DCHSI also claims that the case law contemplates that court approval of settlements may occur only “after meaningful discovery.” That is not correct. As an initial matter, again, DCHSI is not a party to the rehabilitation proceeding and therefore has no right to discovery. *See In re Ambac Assurance Co.*, *supra*, 841 N.W.2d at 514 (affirming trial court ruling that non-parties to rehabilitation proceeding were not entitled to discovery); see also *supra* Part I.

As for the cases DCHSI cites in support, they are not decided in the context of the special statutory proceeding governing insurer rehabilitations. Rather, they are decided in the context of class actions and consent decrees, which are substantively and procedurally distinct. *Wal-Mart Stores, Inc. v. Visa U.S.A. Inc.* 396 F.3d 96 (2d Cir. 2005), concerns the settlement of a class action by retailers alleging antitrust violations; *United States v. North Carolina*, 180 F.3d 574 (4th Cir. 1999), concerns a consent decree resolving gender discrimination in hiring; and *Williams v. Vukovich*, 720 F.2d 909 (6th Cir. 1983), concerns a class action settlement of race discrimination suit. None addresses the court’s role in approving a settlement recommended by a rehabilitator in a special

statutory proceeding. Notably, the trial court serves a different role in approving a class action settlement or consent decree than it does in a rehabilitation proceeding. *Cf. Walsh v. Great Atl. & Pac. Tea Co.*, 726 F.2d 956, 965 (3d Cir.1983) (noting it is well-settled that the approval of a proposed class action settlement is committed to the sound discretion of the district court). And, while the factors courts consider in approving class settlements are generally instructive in court approvals of settlements in other contexts, class actions present the unique risk that “the parties and counsel will bargain away the interests of unnamed class members in order to maximize their own.” *In re Dry Max Pampers Litig.*, 724 F.3d 713, 715 (6th Cir. 2013). *See also* Joseph M. McGlaughlin, 2 *McLaughlin on Class Actions* § 6:4 (10th ed. 2009) (“[C]lass counsel may be tempted by the prospect of a substantial fee to accept a settlement proposal that provides the class with less relief than could have been obtained through more vigorous negotiation.”). A rehabilitator lacks any similar incentive and instead acts as a fiduciary of the insurer. *See In re Mills, supra*, 818 N.Y.S.2d at 334.

Furthermore, the cases DCHSI cites do not mandate discovery before the court’s approval of a settlement, even in the context of class action settlements or consent decrees. Indeed, formal discovery is not required for preliminary approval of a proposed class action settlement, and is not necessarily required even for final approval of a settlement. *See Trombley v. Nat’l City Bank*, 759 F. Supp. 2d 20, 26 (D.D.C. 2011) (granting preliminary approval of proposed class action settlement and noting that formal discovery is not required for preliminary or final approval of a proposed settlement); *see*

also Pigford v. Glickman, 185 F.R.D. 82, 103 (D.D.C. 1999) (recognizing that discretion of the court to reject a settlement is restrained by the “principle of preference” that encourages settlements and that, in the context of a proposed class action settlement, the court must look at the settlement as a whole and should not reject it merely because individual class members claim that they would have received more at trial).

5. It was reasonable for the trial court to reject DCHSI’s requests for delay.

Finally, DCHSI challenges the trial court’s decision not to delay the hearing on the court approval of the settlement. Br. II at 6-7; SA 80. The Rehabilitator had asked for expedited approval of the settlement, so that the settlement could be paid from already appropriated 2013 funds and providers could be paid quickly. SA 90-91. The Rehabilitator argued that time was of the essence because Chartered’s providers had been waiting months for payment. SA 90-91. By mid-2013, Chartered had processed \$48 million in providers’ claims, but had suspended payment on those claims as of April 19, 2013. SSA 26-27, ¶ 2 (c), SSA 29-30, SSA 7, ¶ 3. DCHSI argued that the court should instead permit discovery and reconvene four months later to discuss a schedule for addressing the settlement, with the parties presumably continuing to litigate the reimbursement-rate issues in the meantime. SA 81. The trial court reasonably concluded that DCHSI’s requests for delay did not work for the ultimate good of the estate and therefore approved the Health Finance settlement on an expedited basis.

* * *

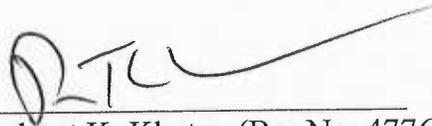
In sum, none of DCHSI's objections has merit. DCHSI has failed to show that the trial court abused its discretion in approving the Health Finance settlement. DCHSI cannot overcome the high burden to show that the Rehabilitator erred because the Rehabilitator has broad discretion to manage the affairs of an imperiled insurer, and the courts generally tend to defer to a receiver's business judgment. *See, e.g., In re Callon Petroleum Co.*, 863 N.Y.S.2d 92 (App. Div. 2008) (recognizing that a party contesting the receiver's actions normally bears the burden of demonstrating arbitrary or capricious conduct or an abuse of discretion by the rehabilitator); *Foster, supra*, 614 A.2d at 1091 (“[I]t is not the function of the courts to reassess the determinations of fact and public policy made by the Rehabilitator. Rather, the involvement of the judicial process is limited to the safeguarding of the plan from any potential abuse of the Rehabilitator's discretion.”). Under this highly deferential standard, the trial court's decision to approve the settlement must be affirmed.

CONCLUSION

This court should dismiss this appeal on standing and mootness grounds. In the alternative, this court should affirm the trial court's orders.

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CERTIFICATE OF SERVICE

I certify that on March 7, 2014, Brief for Appellee D.C. Chartered Health Plan, Inc. with Addendum was served by first-class mail, postage prepaid, and by email to:

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ADDENDUM
RELEVANT PARTS OF STATUTES
RELIED UPON BY APPELLEE

D.C. Code § 7-771.02. Establishment of the Department of Health Care Finance.

Pursuant to § 1-204.04(b), there is established a Department of Health Care Finance as a separate, cabinet-level agency, subordinate to the Mayor, within the executive branch of the government of the District of Columbia.

D.C. Code § 7-771.03. Purpose of the Department.

The Department shall:

- (1) Maximize the well-being and quality of life for eligible low-income individuals and other populations through the provision of leadership and direction in administering responsive, effective, and efficient health-care benefits;
- (2) Develop a comprehensive, efficient, and cost-effective health-care system for the District's uninsured, under-insured, and low-income residents;
- (3) Develop eligibility, service coverage, and service delivery and reimbursement policies for the District's health-care-financing programs that ensure improved access and efficient delivery of service;
- (4) Ensure that District health-care programs maximize available federal financial assistance; and
- (5) Support the health-care policy, delivery, and access initiatives of the Department of Health and other District agencies through sound health-care financing.

D.C. Code § 7-771.04. Appointment of Director.

The Department shall be headed by a Director, who shall:

- (1) Be appointed by the Mayor with the advice and consent of the Council, pursuant to § 1-523.01(a);

(2) Be qualified by experience and training to carry out the purposes of the Department as set forth in § 7-771.03; and

(3) Serve at the pleasure of the Mayor.

D.C. Code § 7-771.05. Duties of Director.

In addition to other duties as may be lawfully imposed, the Director shall:

...

(4) Execute grants, contracts, memoranda of agreement and understanding, or other agreements with governmental bodies, public and private agencies, institutions, and organizations on behalf of the Department;

...

D.C. Code § 11-721. Orders and judgments of the Superior Court.

(a) The District of Columbia Court of Appeals has jurisdiction of appeals from --

(1) all final orders and judgments of the Superior Court of the District of Columbia;

(2) interlocutory orders of the Superior Court of the District of Columbia --

(A) granting, continuing, modifying, refusing, or dissolving or refusing to dissolve or modify injunctions;

(B) appointing receivers, guardians, or conservators or refusing to wind up receiverships, guardianships, or the administration of conservators or to take steps to accomplish the purpose thereof; or

(C) changing or affecting the possession of property; and

(3) orders or rulings of the Superior Court of the District of Columbia appealed by the United States or the District of Columbia pursuant to section 23-104 or 23-111(d)(2).

(b) Except as provided in subsection (c) of this section, a party aggrieved by an order or judgment specified in subsection (a) of this section, may appeal therefrom as of right to the District of Columbia Court of Appeals.

(c) Review of judgments of the Small Claims and Conciliation Branch of the Superior Court of the District of Columbia and of judgments in the Criminal Division of that court where the penalty imposed is a fine of less than \$50 for an offense punishable by imprisonment of one year or less, or by fine of not more than \$1,000, or both, shall be by application for the allowance of an appeal, filed in the District of Columbia Court of Appeals.

...

D.C. Code § 31-202. General duties of Commissioner; companies or associations to file certain information; service of legal process; rules and regulations.

(a) It shall be the duty of the Commissioner to see that all laws of the United States relating to insurance or insurance companies, benefit orders, associations, and others doing insurance business in the District are faithfully executed, to keep on file in the Insurance Administration office copies of the charters, declarations of organizations, or articles of incorporation of every company, association, or order doing business in the District.

...

D.C. Code § 31-208. Capital requirements of companies or associations.

It shall be the duty of the said Commissioner of Insurance and Securities to ascertain whether the capital required by law or the charter of each insurance company or association organized under the laws of the District of Columbia has been actually paid up in cash and is held by its board of directors subject to their control, according to the provisions of their charter, or has been invested

in property worth not less than the full amount of the capital stock required by its charter; or, if a mutual company, that it has received and is in actual possession of securities, as the case may be, to the full extent of the value required by its charter; and the president and secretary of such company or association shall make a declaration under oath to said Commissioner, who is hereby empowered to administer oaths when hereby required, that the tangible assets exhibited to him represent bona fide the property of the company or association, which sworn declaration shall be filed and preserved in the office of said Commissioner; and any such officer swearing falsely in regard to any of the provisions hereof shall be deemed guilty of perjury and shall be subject to all the penalties prescribed by law in the District of Columbia for that crime.

D.C. Code § 31-1301. Definitions.

For the purposes of this chapter, the term:

(1) “Ancillary state” means any state other than a domiciliary state.

(1A) “Commissioner” means the Commissioner of the Department of Insurance, Securities, and Banking.

(2) “Creditor” is a person having any claim, whether matured or unmatured, liquidated or unliquidated, secured or unsecured, absolute, fixed, or contingent.

(3) “Delinquency proceeding” means any proceeding instituted against an insurer for the purpose of liquidating, rehabilitating, reorganizing, or conserving the insurer, and any summary proceeding under § 31-1308.

(4) “District” means the District of Columbia.

(5) “Doing business” includes any of the following acts, whether effected by mail or otherwise:

(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.

(6) "Domiciliary state" means the state in which an insurer is incorporated or organized, or, in the case of an alien insurer, its state of entry.

(7) "Fair consideration" is given for property or obligation:

(A) When, in exchange for the property or obligation, as a fair equivalent therefor and in good faith, property is conveyed, services are rendered, an obligation is incurred, or an antecedent debt is satisfied; or

(B) When the property or obligation is received in good faith to secure a present advance or antecedent debt in an amount not disproportionately small as compared to the value of the property or obligation obtained.

(8) "Foreign country" means any other jurisdiction not in any state.

(9) "Formal delinquency proceeding" means any liquidation or rehabilitation proceeding.

(10) "General assets" means all property, real, personal, or otherwise, not specifically mortgaged, pledged, deposited, or otherwise encumbered for the security or benefit of specified persons or classes of persons. As to specifically encumbered property, the term "general assets" includes all the property or its proceeds in excess of the amount necessary to discharge the sum or sums secured thereby. Assets held in trust and on deposit for the security or benefit of all policyholders or all policyholders and creditors, in more than a single state, shall be treated as

general assets.

(11) "Guaranty association" means the District of Columbia Property and Casualty Insurance Guaranty Association, and any other similar entity now or hereafter created by the Council of the District of Columbia for the payment of claims of insolvent insurers. The term "foreign guaranty association" means any similar entities now in existence in or hereafter created by the legislature of any other state.

(12) "Insolvency" or "insolvent" means:

(A) For an insurer issuing only assessable fire insurance policies:

(i) The inability to pay any obligation within 30 days after it becomes payable; or

(ii) If an assessment be made within 30 days after the date, the inability to pay the obligation 30 days following the date specified in the first assessment notice issued after the date of loss;

(B) For any other insurer, that it is unable to pay its obligations when they are due, or when its admitted assets do not exceed its liabilities plus the greater of:

(i) Any capital and surplus required by law for its organization; or

(ii) The total par or stated value of its authorized and issue capital stock;

(C) As to any insurer licensed to do business in the District as of October 15, 1993, which does not meet the standard established under subparagraph (B) of this paragraph for a period not to exceed 3 years from October 15, 1993, that it is unable to pay its obligations when they are due or that its admitted assets do not exceed its liabilities plus any required capital contribution ordered by the Commissioner under provisions of the insurance law; and

(D) For purposes of this paragraph, the term "liabilities" shall include, but not be limited to, capital, surplus, or other reserves required by statute or by insurance administration

general regulations, or specific requirements imposed by the Commissioner upon a subject company at the time of admission or subsequent thereto.

(13) "Insurer" means any person who has done, purports to do, is doing, or is licensed to do an insurance business, and is or has been subject to the authority of, or to liquidation, rehabilitation, reorganization, supervision, or conservation by, any insurance superintendent or commissioner.

(14) "Person" means corporations, partnerships, associations, trusts, and individual natural persons.

(15) "Preferred claim" means any claim with respect to which the terms of this chapter accord priority of payment from the general assets of the insurer.

(16) "Receiver" means receiver, liquidator, rehabilitator, or conservator as the context requires.

(17) "Reciprocal state" means any state other than the District in which in substance and effect §§ 31-1316(a), 31-1350, 31-1351, and 31-1353 through 31-1355 are in force, and in which provisions are in force requiring that the Commissioner or equivalent official be the receiver of a delinquent insurer, and in which fraudulent conveyances and preferential transfers by a delinquent insurer may be avoided.

(18) "Secured claim" means any claim secured by mortgage, trust deed, pledge, deposit as security, escrow, or otherwise, but not including special deposit claims or claims against general assets. The term "secured claim" also includes claims which have become liens upon specific assets by reason of judicial process.

(19) "Special deposit claim" means any claim secured by a deposit made pursuant to statute for the security or benefit of a limited class or classes of persons, but not including any claim secured by general assets.

(20) "State" means any state, district, or territory of the United States and the Panama Canal Zone.

(21) Repealed.

(22) "Transfer" shall include the sale and every other and different mode, direct or indirect, of disposing of or parting with property or with an interest therein, or with the possession thereof or of fixing a lien upon property or upon an interest therein, absolutely or conditionally, voluntarily, by or without judicial proceedings. The retention of a security title to property delivered to a debtor shall be deemed a transfer suffered by the debtor.

D.C. Code § 31-1302. Applicability.

The proceedings authorized by this chapter may be applied to:

(1) All insurers who are doing, or have done, an insurance business in the District, and against whom claims arising from that business may exist now or in the future;

...

D.C. Code § 31-1304. Injunctions and orders.

(a) Any receiver appointed in a proceeding under this chapter may at any time apply for, and any court of general jurisdiction may grant, restraining orders, preliminary and permanent injunctions, and other orders deemed necessary and proper to prevent:

- (1) The transaction of further business;
- (2) The transfer of property;
- (3) Interference with the receiver or with a proceeding under this chapter;
- (4) Waste of the insurer's assets;
- (5) Dissipation and transfer of bank accounts;

- (6) The institution or further prosecution of any actions or proceedings;
- (7) The obtaining of preferences, judgments, attachments, garnishments, or liens against the insurer, its assets or its policyholders;
- (8) The levying of execution against the insurer, its assets, or its policyholders;
- (9) The making of any sale or deed for nonpayment of taxes or assessments that would lessen the value of the assets of the insurer;
- (10) The withholding from the receiver of books, accounts, documents, or other records relating to the business of the insurer; or
- (11) Any other threatened or contemplated action that might lessen the value of the insurer's assets or prejudice the rights of policyholders, creditors, or shareholders, or the administration of any proceeding under this chapter.

(b) The receiver may apply to any court outside of the jurisdiction for the relief described in subsection (a) of this section.

D.C. Code § 31-1310. Grounds for rehabilitation.

The Commissioner may apply by petition to the Superior Court of the District of Columbia for an order authorizing him or her to rehabilitate a domestic insurer or an alien insurer domiciled in the District based on any one or more of the following grounds:

- (1) The insurer is in such a condition that the further transaction of business would be hazardous financially to its policyholders, creditors, or the public.
- (2) There is reasonable cause to believe that there has been embezzlement from the insurer, wrongful sequestration or diversion of the insurer's assets, forgery or fraud affecting the insurer, or other illegal conduct in, by, or with respect to the insurer that if established would endanger assets in an amount threatening the solvency of the insurer.

(3) The insurer has failed to remove any person who in fact has executive authority in the insurer, whether an officer, manager, general agent, employee, or other person, if the person has been found after notice and hearing by the Commissioner to be dishonest or untrustworthy in a way affecting the insurer's business.

(4) Control of the insurer, whether by stock ownership or otherwise, and whether direct or indirect, is in a person or persons found after notice and hearing to be untrustworthy in any way that affects the insurer's business.

(5) Any person who in fact has executive authority in the insurer, whether an officer, manager, general agent, director or trustee, employee, or other person, has refused to be examined under oath by the Commissioner concerning its affairs, whether in the District or elsewhere, and after reasonable notice of the fact, the insurer has failed promptly and effectively to terminate its relationship with that person, or to prevent that person from influencing the insurer's management.

(6) After demand by the Commissioner under this chapter, or any law authorizing the Commissioner to examine the operations of an insurer, the insurer has failed to promptly make available for examination any of its own property, books, accounts, documents, or other records, or those of any subsidiary or related company within the control of the insurer, or those of any person having executive authority in the insurer so far as they pertain to the insurer.

(7) Without first obtaining the written consent of the Commissioner, the insurer has transferred, or attempted to transfer, in a manner contrary to Chapter 7 of this title, substantially its entire property or business, or has entered into any transaction the effect of which is to merge, consolidate, or reinsure substantially its entire property or business in or with the property or business of any other person.

(8) The insurer or its property has been or is the subject of an application for the appointment of a receiver, trustee, custodian, conservator, or sequestrator or similar fiduciary of the insurer or its property other than as authorized under the insurance laws of the District, and the appointment has been made or is imminent, and the appointment would deprive the courts of the District of Columbia of jurisdiction or might prejudice the orderly delinquency proceedings under this

chapter.

(9) The insurer, within the previous 4 years, willfully violated its charter or articles of incorporation, its bylaws, any insurance law of the District, or any valid order of the Commissioner.

(10) The insurer has failed to pay, within 60 days after due date, any obligation to any state or any subdivision or any judgment entered in any state, if the court in which the judgment was entered had jurisdiction over the subject matter, except that the nonpayment shall not be a ground until 60 days after any good faith effort by the insurer to contest the obligation has been terminated, whether it is before the Commissioner or in court, or the insurer has systematically attempted to compromise or renegotiate previously agreed settlements with its creditors on the ground that it is financially unable to pay its obligations in full.

(11) The insurer has failed to file its annual report or other financial report required by statute within the time allowed by law, and, after written demand by the Commissioner, has failed to give an adequate explanation immediately.

(12) The board of directors or the holders of a majority of the shares entitled to vote, or a majority of those individuals entitled to the control of those entities specified in the insurance laws of the District, request or consent to rehabilitation under this chapter.

D.C. Code § 31-1311. Rehabilitation orders.

(a) An order to rehabilitate the business of a domestic insurer, or an alien insurer domiciled in the District, shall appoint the Commissioner and his or her successors in office the rehabilitator, and shall direct the rehabilitator forthwith to take possession of the assets of the insurer, and to administer them under the general supervision of the court. The filing or recording of the order with the clerk of the Superior Court of the District of Columbia shall impart the same notice as a deed, bill of sale, or other evidence of title duly filed or recorded with the recorder of deeds would have imparted. The order to rehabilitate the insurer shall by operation of law vest title to all assets of the insurer in the rehabilitator.

(b) Any order issued under this section shall require accountings to the court by the rehabilitator. Accountings shall be at intervals the court specifies in its order, but no less frequently than

semiannually. Each accounting shall include a report concerning the rehabilitator's opinion as to the likelihood that a plan under § 31-1312(e) will be prepared by the rehabilitator and the timetable for doing so.

(c) Entry of an order of rehabilitation shall not constitute an anticipatory breach of any contracts of the insurer nor shall it be grounds for retroactive revocation or retroactive cancellation of any contracts of the insurer, unless the revocation or cancellation is done by the rehabilitator pursuant to § 31-1312.

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 § 31-1313. Actions by and against the rehabilitator.

(a) Any court in the District before which any action or proceeding in which the insurer is a party, or is obligated to defend a party, is pending when a rehabilitation order against the insurer is entered shall stay the action or proceeding for 90 days and any additional time necessary for the rehabilitator to obtain proper representation and prepare for further proceedings. The rehabilitator shall take any action respecting the pending litigation deemed necessary in the interests of, justice and for the protection of creditors, policyholders, and the public. The rehabilitator shall immediately consider all litigation pending outside the District and shall

petition the court having jurisdiction over that litigation for a stay whenever necessary to protect the estate of the insurer.

...

(c) Any guaranty association or foreign guaranty association covering life or health insurance or annuities shall have standing to appear in any court proceeding concerning the rehabilitation of a life or health insurer if the association is or may become liable to act as a result of the rehabilitation.

D.C. Code § 31-1314. Termination of rehabilitation.

...

(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.

...

D.C. Code § 31-1315. Grounds for liquidation.

The Commissioner may petition the Superior Court of the District of Columbia for an order directing him or her to liquidate a domestic insurer or an alien insurer domiciled in the District on the basis:

(1) Of any ground for an order of rehabilitation as specified in § 31-1310, whether or not there has been a prior order directing the rehabilitation of the insurer;

(2) That the insurer is insolvent; or

(3) That the insurer is in such a condition that the further transaction of business would be hazardous, financially or otherwise, to its policyholders, its creditors, or the public.

D.C. Code § 31-1316. Liquidation orders.

(a) An order to liquidate the business of a domestic insurer shall appoint the Commissioner and his or her successors in office liquidator and shall direct the liquidator to take possession of the assets of the insurer and to administer them under the general supervision of the court. The liquidator shall be vested by operation of law with the title to all of the property, contracts, and rights of action, and all of the books and records of the insurer ordered liquidated, wherever located, as of the entry of the final order of liquidation. The filing or recording of the order with the Clerk of the Superior Court of the District of Columbia, or, in the case of real estate, with the recorder of deeds of the county where the property is located, shall impart the same notice as a deed, bill of sale, or other evidence of title duly filed or recorded with that recorder of deeds would have imparted.

(b) Upon issuance of the order, the rights and liabilities of any insurer and of its creditors, policyholders, shareholders, members, and all other persons interested in its estate shall become fixed as of the date of entry of the order of liquidation, except as provided in §§ 31-1317 and 31-1335.

...

D.C. Code § 31-1405. Conflict of interest.

(a) No examiner may be appointed by the Mayor if the examiner, either directly or indirectly, has a conflict of interest or is affiliated with the management of or owns a pecuniary interest in any person subject to examination under this chapter. This section shall not be construed to automatically preclude an examiner from being:

(1) A policyholder or claimant under an insurance policy;

- (2) A grantor of a mortgage or similar instrument on the examiner's residence to a regulated entity if done under customary terms and in the ordinary course of business;
- (3) An investment owner in shares of regulated diversified investment companies; or
- (4) A settlor or beneficiary of a blind trust into which any otherwise impermissible holdings have been placed.

(b) Notwithstanding the requirements of this section, the Mayor may retain from time to time, on an individual basis, qualified actuaries, certified public accountants, or other similar individuals who are independently practicing their professions, even though these persons may from time to time be similarly employed or retained by persons subject to examination under this chapter.

D.C. Code § 31-3851.01. Definitions.

For the purposes of this chapter, the term:

...

(15) "RBC instructions" means the instructions for the RBC report, including risk-based capital instructions adopted by the NAIC, as these RBC instructions may be amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC.

...

D.C. Code § 31-3851.06. Mandatory Control Level Event.

(a) If a Mandatory Control Level Event occurs, the Commissioner shall take such action as is necessary to place the health organization under regulatory control under Chapter 34 of this title or Chapter 13 of this title. In such event, the Mandatory Control Level Event shall be sufficient reason for the Commissioner to take action under Chapter 34 of this title or Chapter 13 of this title. In such event, the Commissioner shall have the rights, powers, and duties with respect to the health organization as are set forth in Chapter 34 of this title and Chapter 13 of this title.

(b) If the Commissioner takes action under subsection (a) of this section pursuant to an adjusted RBC report, the health organization shall be entitled to the protections of Chapter 34 of this title and Chapter 13 of this title pertaining to summary proceedings.

(c) Notwithstanding the provisions of subsections (a) or (b) of this section, the Commissioner may forego action for up to 90 days after the Mandatory Control Level Event if the Commissioner finds there is a reasonable expectation that the Mandatory Control Level Event may be eliminated within the 90-day period.

ADDENDUM
UNPUBLISHED CASES

C

Only the Westlaw citation is currently available.

United States District Court,
District of Columbia.
Alan BEAUREGARD, Plaintiff,
v.
Honorable Ray MABUS, Defendant.

Civil Action No. 10-cv-1972 (RLW).
Oct. 15, 2012.

David Patrick Sheldon, Law Office of David P. Sheldon, Washington, DC, for Plaintiff.

Carl Ezekiel Ross, U.S. Attorney's Office, Washington, DC, for Defendant.

MEMORANDUM OPINION^{FN1}

ROBERT L. WILKINS, District Judge.

*1 Plaintiff Alan P. Beauregard, (“Beauregard”), father and personal representative of the late First Lieutenant James J. Beauregard (“Lt. Beauregard”), brings this action against Secretary of the Navy, Honorable Ray Mabus, seeking judicial review of the March 15, 2006 decision of the Board for Correction of Naval Records (“the Board”) under the Administrative Procedure Act (“APA”). 5 U.S.C. § 701 *et seq.* (2000). Beauregard challenges the Board's decision regarding the delay and denial of the promotion of Lt. Beauregard, the characterization of Lt. Beauregard's discharge, and the correction of Lt. Beauregard's military records. (*See generally* Compl.). Beauregard alleges that the Board's actions in denying Beauregard's application for relief were arbitrary and capricious.

Defendant has moved for summary judgment pursuant to Fed.R.Civ.P. 56, arguing that the Board used an adequate decision making process as to all issues relating to Lt. Beauregard's promotion and discharge. (Dkt. No. 9 at 11–12). Plaintiff has cross-moved for summary judgment, arguing that summary judgment should be granted in Plaintiff's favor because the Board's decision was arbitrary, capricious and an abuse of discretion. (Dkt. No. 14 at 17). Upon a complete review of the administrative record (“AR”), and for the reasons set forth below, the Court concludes that the administrative record supports the Board's determination. Accordingly, Defendant's Motion for Summary Judgment is granted, and Plaintiff's Cross-Motion for Summary Judgment is denied.

BACKGROUND

Lt. Beauregard entered active duty as an officer candidate in the United States Marine Corps on May 10, 1996. (AR at 4). In March 2001, Lt. Beauregard became the subject of a criminal investigation by both civilian and military authorities regarding allegations of larceny and several other related offenses. (Compl. at ¶ 28–29). While this investigation was pending, Lt. Beauregard was selected for promotion from First Lieutenant to Captain and his name was added to the promotion list on June 1, 2001. (Compl. at ¶ 27; AR at 5, 40). On June 8, 2001, Lt. Beauregard's Commanding Officer recommended that his promotion be delayed and that his name be possibly removed from the promotion list due to the ongoing investigation. (Compl. at ¶ 49; Dkt. No. 9 at ¶ 8; AR at 182). On June 25, 2001, Lt. Beauregard acknowledged the promotion delay by submitting a written response to his Commanding Officer regarding the decision to withhold his promotion. (Compl. at ¶ 50; Dkt. No. 9 at ¶ 9; AR 42). On June 28, 2001, the official “Notification of

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Promotion Delay and Possible Removal from Fiscal Year 2002 Promotion List” notice was issued recommending to the Commandant of the Marine Corps that due to the “serious nature of the pending charges” the Commander of the First Marine Division “strongly recommend[ed] that [Lt. Beaugard's] promotion be delayed until his case is resolved.” (Dkt. No. 9 at ¶ 11; AR at 44, 183). On July 11, 2001, the Staff Judge Advocate to the Commandant of the Marine Corps ordered that Lt. Beaugard not be separated, promoted, or transferred without coordination with the Judge because of the pending charges. (Dkt. No. 9 at ¶ 15; AR at 5, 49–51).

*2 Based on Lt. Beaugard's position on the promotion list, he was set for promotion on August 1, 2001; however, on August 16, 2001, the Commandant of the Marine Corps approved the recommendation that Lt. Beaugard's promotion be delayed due to “the potentially adverse allegations of larceny and fraud.” (Compl. ¶ 37; Dkt. No. 9 at ¶ 16; AR at 5, 52–53). On August 12, 2001, Lt. Beaugard was arrested and charged with driving under the influence of alcohol (“DUI”). (Compl. ¶ 37; Dkt. No. 9 at ¶ 18; AR at 5, 56–57). Investigative hearings on the criminal charges were held on September 5, 2001 and October 4, 2001. (Compl. ¶ 33). During the September 5, 2001 hearing, Lt. Beaugard testified to being charged with a DUI. (Compl. ¶ 41). Lt. Beaugard admitted his guilt to the DUI offense to civilian authorities on September 17, 2001. (Compl. at ¶ 42; Dkt. No. 9 at ¶ 20; AR at 5–6, 67).

On May 22, 2002, the Commanding General withdrew and dismissed all charges against Lt. Beaugard regarding his larceny and other related offenses. (Compl. ¶¶ 35–36; Dkt. No. 9 at 23; AR at 6). Lt. Beaugard's Commanding Officer initiated separation actions on June 28, 2002. (Compl. at ¶ 60; Dkt. No. 9 at ¶ 24; AR at 6, 70–71). Lt. Beaugard was notified of the separation proceedings on July 3, 2002, at which time Lt. Beaugard was informed of

his procedural rights, including his right to a Board of Inquiry hearing and his right to render his resignation in lieu of separation processing. (Dkt. No. 9 at 25–26; AR at 72–73). On July 9, 2002, Lt. Beaugard submitted a resignation request in lieu of separation processing and waived his right to a Board of Inquiry hearing. (Compl. ¶ 72; Dkt. No. 9 at ¶ 27–28; AR at 6, 74–75, 197). The First Endorsement of Lt. Beaugard's separation was issued July 12, 2002, the Second Endorsement was issued on July 25, 2002, and the Third Endorsement was issued October 9, 2002. (Compl. at ¶¶ 63, 69, 74; Dkt. No. 9 at ¶¶ 30, 31, 33; AR at 6, 77–83). Lt. Beaugard's resignation request was ultimately denied on October 2, 2002. (Dkt. No. 9 at ¶ 32; AR at 7, 80).

Lt. Beaugard was separated from the United States Marine Corps on October 15, 2002, at which time he was issued a Certificate of Release or Discharge from Active Duty (“DD Form 214”) indicating a discharge characterization of “Honorable” by reason of completion of his required active service. (Compl. at ¶ 10; Dkt. No. 9 at ¶¶ 34–35; AR at 7, 84). On October 24, 2002, the Assistant Secretary of the Navy for Manpower for Reserve Affairs directed that Lt. Beaugard receive a “General” discharge by reason of unacceptable conduct. (Compl. at ¶ 75; Dkt. No. 9 at ¶ 36; AR at 7). Consequently, on February 6, 2003, Lt. Beaugard's DD Form 214 was corrected by issuance of a DD Form 215 designating a “General” discharge by reason of unacceptable conduct. (Compl. at ¶ 77; Dkt. No. 9 at ¶ 37; AR at 7, 85–86).

*3 Following Lt. Beaugard's death on August 6, 2004, his father and personal representative completed the application process for the correction of records on behalf of his son pursuant to 32 C.F.R. § 723.3(a)(3). (Compl. at ¶ 7, 11–12, 80; Dkt. No. 9 at ¶ 38; AR at 87). In his application, Beaugard requested that the Board: 1) void the existing DD–215 Form with its “General” characterization; 2) reinstate the original DD–214 Form with its

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“Honorable” characterization; 3) direct that Lt. Beaugard be posthumously promoted to Captain; 4) award Lt. Beaugard's back pay; 5) direct the removal from Lt. Beaugard's official military personnel file of all documents referencing the withdrawn and dismissed criminal charges. (Compl. at ¶ 81; Dkt. No. 9 at ¶ 39; AR 88–111). On March 15, 2006, after the issuance of an Advisory Opinion from the Military Law Branch of the Judge Advocate Division (“JAM”) that recommended the denial of the application for relief, the Board issued its decision concluding that, despite procedural deficiencies, the Department had substantially complied with all relevant procedures. (Compl. at ¶ 13, 15; Dkt. No. 9 at ¶ 40–48; AR at 3–12, 18). The Board denied Beaugard's application on all counts finding that Beaugard's requests were without merit. (AR at 11). Beaugard timely filed his Complaint in this Court seeking review of the Board's decision on November 17, 2010. *See* 28 U.S.C. § 2401(a).

STANDARD OF REVIEW

The Secretary of a military department, acting through a civilian board of the executive part of that military department, “may correct any military record of the Secretary's department when the Secretary considers it necessary to correct an error or remove an injustice.” 10 U.S.C. § 1552(a)(1). Once a civilian board makes a final decision, that decision is “subject to review under § 706 of the Administrative Procedure Act.” *Pettiford v. Sec'y of the Navy*, 774 F.Supp.2d 173, 181 (D.D.C.2011). Under the APA, a reviewing court may hold unlawful or set aside an agency action that the court determines to be “arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with the law.” 5 U.S.C. § 706(2)(A).

When reviewing an agency's action under the APA, it is not the role of the court to resolve factual issues, rather the court need only “determine whether or not as a matter of law the evidence in the

administrative record permitted the agency to make the decision it did.” *Fuller v. Winter*, 538 F.Supp.2d 179, 185 (D.D.C.2008) (quoting *Occidental Eng'g Co. v. INS*, 753 F.2d 766, 769–70 (9th Cir.1985)).

Given the language of 10 U.S.C. § 1552(a), which grants the Secretary broad discretion to correct an error or injustice, federal courts review the decisions of military correction boards with “an unusually deferential application of the ‘arbitrary and capricious’ standard.” *Kreis v. Secretary of the Air Force*, 866 F.2d 1508, 1514 (D.C.Cir.1989); *see also Orloff v. Willoughby*, 345 U.S. 83, 93, 73 S.Ct. 534, 97 L.Ed. 842 (1953) (“[G]iven the special circumstances in which the military must operate, the courts are ill-equipped to resolve controversies arising from the use of discretionary powers specifically designed to provide military authorities with the freedom and flexibility needed to establish and maintain a well-trained and well-disciplined armed force.”). “This deferential standard is calculated to ensure that the courts do not become a forum for appeals by every soldier dissatisfied with his or her ratings, a result that would destabilize military command and take the judiciary far afield of its area of competence.” *Cone v. Caldera*, 223 F.3d 789, 793 (D.C.Cir.2000). Moreover, there exists a “strong but rebuttable presumption that administrators of the military, like other public officials, discharge their duties correctly, lawfully, and in good faith.” *Frizelle v. Slater*, 111 F.3d 172, 177 (D.C.Cir.1997) (quoting *Collins v. United States*, 24 Cl.Ct. 32, 38 (1991), *aff'd*, 975 F.2d 869 (Fed.Cir.1992)).

*4 Generally, summary judgment is appropriate “if the movant shows [through facts supported in the record] that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law.” Fed.R.Civ.P. 56(a); *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248, 106 S.Ct. 2505, 91 L.Ed.2d 202 (1986). However, when parties seek “review of a final agency action under the

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Administrative Procedure Act, ... the standard set forth in [Rule 56(a)] does not apply because of the limited role of a court in reviewing the administrative record.” *Calloway v. Harvey*, 590 F.Supp.2d 29, 35–36 (D.D.C.2008). Thus, “summary judgment [is] the mechanism for deciding, as a matter of law, whether agency action is supported by the administrative record and otherwise consistent with the APA standard of review.” *Fuller*, 538 F.Supp.2d at 185 (citing *Richard v. INS*, 554 F.2d 1173, 1177 & n. 28 (D.C.Cir.1977)).

The Court is permitted to “determine only whether the Secretary's decision making process was deficient, not whether his decision was correct.” *Kreis*, 866 F.2d at 1508. Accordingly, the Court must defer to the Board's decision unless the Secretary's action in this area was “arbitrary, capricious, or contrary to the statutes and regulations governing that agency,” which resulted in an error in its own decision making process. *Id.* at 1512 (quoting *Dilley v. Alexander*, 603 F.2d 914, 920 (D.C.Cir.1979)); *Frizelle*, 111 F.3d at 176. The court “will not disturb the decision so long as the deciding body examine[d] the relevant data and articulate[d] a satisfactory explanation for its action, including a rational connection between the facts found and the choice made.” *Poole v. Harvey*, 571 F.Supp.2d 120, 124 (D.D.C.2008) (citing *Kreis*, 406 F.3d at 686).

ANALYSIS

A. Parties' Arguments

Beauregard brings three counts under the APA alleging that the Board ignored significant regulatory violations in its decision making process resulting in an arbitrary and capricious decision. (Compl. at ¶¶ 25–38). In Counts One and Two, Beauregard challenges the Board's conclusions that the alleged procedural defects related to Lt. Beauregard's promotion and discharge characterization of service were harmless error because, according to Beauregard, these conclusions were contrary to applicable law and regulations. (Compl. at ¶¶ 25–32).

In Count Three, Beauregard seeks a determination that the Board's ultimate decision in denying the full and complete relief requested by Beauregard—promotion, re-characterization of discharge, awarding of back pay, and removing all mention of the withdrawn and dropped charges brought against Lt. Beauregard—was arbitrary and capricious. (Compl. at ¶¶ 32–38).

Defendant contends that summary judgment is appropriate because there is no genuine issue of material fact and it is entitled to judgment as a matter of law. (Dkt. No. 9 at 12). Moreover, because military correction boards are reviewed under “an unusually deferential application of the ‘arbitrary and capricious’ standard,” Defendant contends the Court is only asked to determine whether the decision making process was deficient, not whether the decision itself was correct. *Kreis*, 866 F.2d at 1515; *Dickson v. Secretary of Defense*, 68 F.3d 1396, 1405–06 (D.C.Cir.1995). For this reason, Defendant argues the Court should rule in its favor by finding the Board's decision making process was not conducted in an arbitrary manner. (Dkt. No. 9 at 13–15). Finally, Defendant submits that Plaintiff bears the burden to overcome the strong but rebuttable presumption that the military administrators discharged their duties correctly, lawfully and in good faith and that Beauregard failed to meet this burden. (Dkt. No. 9 at 13); *Frizelle*, 111 F.3d at 177.

B. Delay and Failure to Promote

*5 Beauregard argues that the Board provided no legal basis for its conclusion that Lt. Beauregard was not entitled to a promotion. With respect to the delay of Lt. Beauregard's promotion, Plaintiff contends that Lt. Beauregard was not provided with the requisite notice pursuant to 10 U.S.C. § 624(d), and Department regulations Secretary of the Navy Instruction (“SECNAVINST”) 1420.1A. Section 624(d)(3) provides that:

The appointment of an officer may not be delayed

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under this subsection unless the officer has been given written notice of the grounds for the delay, unless it is impracticable to give such written notice before the effective date of the appointment, in which case such written notice shall be given as soon as practicable. An officer whose promotion has been delayed under this subsection shall be afforded an opportunity to make a written statement to the Secretary concerned in response to the action taken. Any such statement shall be given careful consideration by the Secretary.

10 U.S.C. § 624(d)(3). Plaintiff maintains that Lt. Beauregard was not properly notified of the initial six-month promotion delay pursuant to Section 624(d)(3) because he was not notified of the delay until August 16, 2001, two weeks after his scheduled promotion date. Beauregard also contends that the original six-month promotion delay was never formally extended, in violation of Section 624(d)(4), which provides that an officer's promotion may not be delayed six months beyond the date he would have been otherwise appointed unless the Secretary specifies a further period of delay. 10 U.S.C. § 624(d)(4). Further, under Section 624(d)(4), “[a]n officer's appointment may not be delayed more than 90 days after final action has been taken in any criminal case ... or more than eighteen months after the date on which such officer would otherwise have been appointed, whichever is later.” *Id.*

The Board acknowledged that there were procedural deficiencies with regard to the delay of Lt. Beauregard's promotion. Specifically, the Board noted that “the delay itself was not directed until about two weeks after [Lt. Beauregard] was due to be promoted, and the initial period of delay was never formally extended.” (AR at 11). However, with respect to the initial delay, the Board noted that: (1) Lt. Beauregard had been informed of the intent to delay his promotion on June 8, 2001; (2) he replied to the June 8, 2001 notice on June 25, 2001, and his statement was forwarded to the decision-maker; (3)

he was again notified of the delay on August 16, 2001, and given another opportunity to respond. *Id.* With respect to Plaintiff's contention that the period of delay was never formally extended, the Board concluded that “although the initial delay was never extended, the total period of delay did not exceed the maximum allowable period of 18 months, and the Secretary essentially ratified further delay when [Lt. Beauregard's] separation was directed. (AR at 11–12). The Board also concluded that Lt. Beauregard's DUI provided additional grounds to delay Lt. Beauregard's promotion even though the criminal larceny and forgery charges had been dropped. (AR at 11–12). Although the Board conceded that the initial delay was never extended, the Board provided a reasoned explanation for its conclusion that the procedural deficiencies were harmless error.

*6 Moreover, the Board concluded that these failures to comply with the procedural requirements for delay do not compel promotion. It is well established that military officers do not have a property or liberty interest in a promotion *per se* and, therefore, are not entitled to a promotion as a matter of law. *Blevins v. Orr*, 721 F.2d 1419, 1422 (D.C.Cir.1983); *see also Dysart v. United States*, 369 F.3d 1303, 1314 (Fed.Cir.2004); *Pauls v. Secretary of the Air Force*, 457 F.2d 294, 297 (1st Cir.1972). Additionally, although the language of Section 624(a)(1) indicates that officers on a promotion list *shall* be promoted to the next higher grade, the President of the United States is afforded complete discretion to choose whether or not to appoint an officer and the “statute does not [] alter that process by providing for automatic appointment.” ^{FN2} *Dysart*, 369 F.3d at 1311. Thus, after considering the evidence in the record, as well as Plaintiff's arguments regarding the procedural deficiencies in the delay action, the Board rationally determined that the delay in receiving notice was harmless error and did not justify Plaintiff's requested remedy of promotion.

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Consequently, the Board is “free to draw [its] own reasonable inferences and conclusions from the evidence before [it].” *Mudd v. Caldera*, 134 F.Supp.2d 138, 143 (D.D.C.2001) (citing *Mail Order Ass'n of America v. United States Postal Serv.*, 2 F.3d 408, 421 (D.C.Cir.1993)). Furthermore, an agency's decision need not be a model of analytic precision to survive, but rather the agency needs only to have used its discretion in a reasoned manner. *Frizelle*, 111 F.3d at 176; *Kreis*, 866 F.2d at 1512. As the Court must employ an “unusually deferential application of the arbitrary and capricious standard,” the Court concludes that the Board provided a sufficient rational explanation for its conclusion that the procedural deficiencies in the delay of Lt. Beaugard's promotion amount to harmless error and, therefore, does not compel the promotion requested by Plaintiff here. *Kreis*, 866 F.2d at 1514.

C. Separation and Characterization of Service

Plaintiff argues that the Board's decision upholding Lt. Beaugard's General discharge characterization was arbitrary, capricious or contrary to law because the Marine Corps impermissibly considered the withdrawn and dismissed larceny charges. Additionally, Plaintiff contends that the Marine Corps did not adequately consider the meritorious aspects to Lt. Beaugard's record. Further, Plaintiff argues that the conduct that purportedly gave rise to separation action—Lt. Beaugard's DUI—does not provide an adequate basis for a less than “honorable” service characterization. The Board's decision addresses each of these arguments and provides a rational basis for its ultimate conclusion. Essentially, the Board's decision indicates that Plaintiff's arguments were not sufficient to “overcome the strong but rebuttable presumption that administrators of the military, like other public officers, discharge their duties correctly, lawfully, and in good faith.” *Frizelle*, 111 F.3d at 177. The Court defers to the Board's conclusion and reasoning that Lt. Beaugard could be processed for separation under the notification procedure because

the separation procedure was initiated before Lt. Beaugard had attained five years of service. The Board's determination is consistent with the binding guidance which provides that an officer with less than five years of service may be processed for separation with the notification procedure as long as he is notified of the separation and given the opportunity to submit a statement. (AR at 8, 470–567) (SECNAVINST 1920.6B, “Administrative Separation of Officers” (Dec. 13, 1999)). Furthermore, under the same guidance, an officer need only be afforded the right to a Board of Inquiry if he or she is to be discharged under an “other than honorable” service characterization, but need not be provided this right if he or she is being discharged under a “general” or “honorable” service characterization. (*Id.*) The Court also defers to the Board's conclusion that Lt. Beaugard's DUI conviction was sufficient basis for his separation by reason of misconduct. The directive which provides guidance on the administrative separation of officers in the Navy and Marine Corps explains that an officer may be released from active duty for cause on the basis of misconduct if the officer has committed a military or civilian offense that could be punished by confinement of six months or more. (*Id.*) Therefore, Lt. Beaugard's DUI provided a sufficient basis for administrative separation. Finally, the Court defers to the Board's ultimate determination that the “general” discharge characterization given to Lt. Beaugard was appropriate. In making this determination, the Board explicitly stated that it considered “not only the overall quality of [Lt. Beaugard's] service, as reflected in his fitness reports, but also that the officers in his chain-of-command recommended an honorable discharge.” (AR 12). Nonetheless, the Board concluded that the general discharge was appropriate, even though the Board noted that a general discharge is “rarely appropriate when an officer is separated for misconduct” and that officer misconduct normally warrants discharge under an “other than honorable” service characterization. *Id.* Therefore, the Court defers to the Board's conclusion

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that Lt. Beauregard's DUI conviction, even when balanced against his meritorious record, provided sufficient basis for Lt. Beauregard's general characterization of service.

*7 Plaintiff contends that the Board failed to address two additional arguments which Plaintiff raised in his Response to the JAM Advisory Opinion. First, Plaintiff takes issue with the assertion in the JAM Advisory Opinion that the July 16, 2002 DD Form 214 should not have issued due to the JAM's July 11, 2001 request that no action to promote or separate Lt. Beauregard be taken without prior coordination with the Judge Advocate Division. Plaintiff argued in his response to the Advisory Opinion that this request was no longer relevant in July 2002 because the underlying criminal charges that were the basis for the request were withdrawn and dismissed on May 22, 2002. Plaintiff now contends that the Board did not address this argument and merely adopted the conclusion of the Advisory Opinion. The Court disagrees. While it is true that the Board agreed with the JAM's conclusion that the July 16, 2002 DD Form 214 should never have been issued, the Board reached that conclusion for a different reason. The Board explained that the July 16, 2002 DD Form 214—which released Lt. Beauregard from active duty on October 15, 2002 with an honorable service characterization—should have never been issued because administrative separation proceedings had already been initiated on July 3, 2002. (AR at 12). The Board noted that Lt. Beauregard “never should have been released from active duty on 15 October 2002, prior to Secretarial action on the pending administrative separation *and relies on the provision of the applicable regulation to the effect that a release should not occur if separation for cause, clearly the situation here.*” (*Id.*) (emphasis added). Thus, the Board relied on the directive set forth in SECNAVINST 1920.6B, “Administrative Separation of Officers,” which provides that an officer may be released from active duty unless separation processing for cause is

warranted. Consistent with this directive, the Board concluded that Lt. Beauregard should not have been released from active duty on October 15, 2002 for completion of his service term because administrative separation for cause had already been initiated. Therefore, the Board did not rely on the July 11, 2001 order as a basis for its conclusions. Although the Board did not squarely address Plaintiff's argument concerning the July 11, 2001 request, the Board has, however, given “a reason that a court can measure” for its decision. *Kreis*, 866 F.2d at 1514.

Second, Plaintiff challenges the assertion in the Advisory Opinion that no DD Form 214 should have been issued until after the Secretary's order of October 24, 2002 directing that Lt. Beauregard receive a general service characterization. Plaintiff argues that the Secretary's order should be considered invalid because it was issued after Lt. Beauregard's final End of Service Date, October 15, 2002. Essentially, Plaintiff contends that because Lt. Beauregard was released from active duty for “Completion of Required Active Service” on October 15, 2002, the Secretary's later order discharging Lt. Beauregard for cause should be invalid or ineffective. Plaintiff cites to no authority for this proposition. Moreover, as previously discussed, the Board explained that Lt. Beauregard's October 15, 2002 release should not have occurred because separation for cause had already been initiated. Accordingly, the Board directed that the record should be corrected to reflect that Lt. Beauregard was not released from active duty, but instead was retained on active duty until October 25, 2002, when he was issued a general discharge by reason of misconduct/unacceptable conduct. Therefore, the Court concludes that the Board's decision addresses all of Plaintiff's arguments and gives reasons, sufficiently supported by the administrative record, for the Board's ultimate decision.

CONCLUSION

*8 For the reasons set forth above, summary

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judgment will be entered in favor of the defendant.
An Order accompanies this Memorandum.

FN1. This unpublished memorandum opinion is intended solely to inform the parties and any reviewing court of the basis for the instant ruling, or alternatively, to assist in any potential future analysis of the *res judicata*, law of the case, or preclusive effect of the ruling. The Court has designated this opinion as “not intended for publication,” but this Court cannot prevent or prohibit the publication of this opinion in the various and sundry electronic and legal databases (as it is a public document), and this Court cannot prevent or prohibit the citation of this opinion by counsel. *Cf.* Fed. R.App. P. 32.1. Nonetheless, as stated in the operational handbook adopted by our Court of Appeals, “counsel are reminded that the Court’s decision to issue an unpublished disposition means that the Court sees no precedential value in that disposition.” D.C. Circuit Handbook of Practice and Internal Procedures 43 (2011).

FN2. The President may, however, delegate this appointment power to another; in this case, the power was vested in the Secretary of the Navy.

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