Nos. 10-AA-1475, 10-AA-1492 & 11-AA-633

DISTRICT OF COLUMBIA COURT OF APPEALS

DC CHARTERED HEALTH PLAN,

Petitioner,

and

DC DEP'T OF HEALTH CARE FINANCE,

Petitioner,

v.

YVONNE SETTLES,

Respondent.

On Petition for Review from
the Office of Administrative Hearings

BRIEF OF RESPONDENT

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1. Because Chartered agreed in its contract establishing a process for reviewing denials of coverage that it would comply with a decision by the Office of Administrative Hearings (OAH) in favored of an insured and waived its right to appeal such a decision,

(a) must this Court grant Ms. Settles' pending motion to dismiss Chartered's appeal; and

(b) must this Court also dismiss the Department of Health Care Finance appeal with regard to OAH's ruling against Chartered?

2. Does substantial evidence support OAH's finding that Chartered promised coverage in its Member Handbook (given to its insureds) to a member who obtained emergency medical care from the nearest emergency room in these circumstances?

3. Does substantial evidence support the ALJ, in her express consideration and rejection of the contract defense by Chartered and DHCF based on their contract not given to insureds?

4. In this Court, as a matter of law, must the contract defense be rejected on the additional grounds

(a) that petitioners' tactical failure to provide to OAH the entire contract on which their contract defense is based requires affirmance for failure of proof on their contract defense?

(b) that the OAH covered-service determination, also in the contract, is not and cannot be, by definition, a non-covered emergency service because OAH determines the covered services and its decision is final under the contract?

5. Alternatively, does the Access to Emergency Medical Services Act, D.C. Code § 31-2802, independently require reimbursement of Ms. Settles' emergency medical expenses?

STATEMENT OF FACTS

This case concerns liability for the cost of emergency medical care rendered to a District of Columbia resident enrolled in the D.C. Alliance health insurance program at a hospital chosen by D.C. Emergency Medical Services personnel in response to her medical condition.

A. The D.C. Healthcare Alliance Program

Due to her low income and assets and lack of access to other insurance, Yvonne Settles, a fifty-eight year-old resident of the District of Columbia, qualified for and was an enrollee in the Alliance program. The Alliance program provides "comprehensive community-centered health care and medical services" for low-income residents of the District who are not eligible for Medicaid or Medicare. D.C. Code § 7-1405(d). The program serves residents whose income is at or below 200 percent of the Federal Poverty Level and provides—by contract with independent insurance companies, of which Chartered is one—access to a network of providers for the "comprehensive" medical care required by the D.C. Code.

The District's Department of Health Care Finance (DHCF) administers this locally funded government health insurance program whose benefits are delivered through contracted private managed care organizations, including Chartered. Every Alliance enrollee whose care is provided through the Chartered managed care organization receives a HealthCare Alliance Chartered Health Plan Member Handbook. (App. 3.)

B. Ms. Settles' Medical Emergency

The morning of April 13, 2010, Yvonne Settles had an immediate medical emergency.[1] Her face was swollen, her breathing was irregular, and her tongue had swollen to the point that she could no longer speak. (App. 2, OAH Amended Final Order, April 28, 2011 ("Order") at 2.)

[1] In her OAH testimony (Tr. at 49), Ms. Settles stated that the incident occurred on April 12, 2010, but all records indicate that the correct date is April 13.

Ms. Settles' brother, Gary Gafford, was visiting and asked what was wrong, but Ms. Settles could only gesture toward her mouth. (Tr. at 45-46.) Mr. Gafford dialed 9-1-1, (*id.* at 46), and a District of Columbia Emergency Medical Service (EMS) ambulance was dispatched.

Minutes later, the D.C. EMS arrived at Ms. Settles' home in the 300 block of 36th Street, NE. (Ex. 100, DC Fire & EMS Conversion Record at 1.) The EMS paramedics carried Ms. Settles to the ambulance and asked her a series of questions. (Tr. at 46.) But she could not speak. (*Id.*) Mr. Gafford gave the paramedics Ms. Settles' identification card and her D.C. Health Care Alliance Chartered Member I.D. Card. (App. 2, Order at 3.) The EMS then transported Ms. Settles outside the District to Prince George's (PG) Hospital Center.

PG Hospital Center is the emergency room nearest to Ms. Settles' home. It is a 3.7-mile, 7-minute drive from Ms. Settles' house.

Ms. Settles' regular hospital – the closest Alliance in-network emergency room, Washington Hospital Center – is nearly twice as far away. (Tr. at 54.) It is a 15-minute, 5.0-mile drive.[2] Ms. Settles was aware that her Alliance membership was for in-network care within

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[2] This Court has recognized driving distance as a judicially-noticeable fact. *See Bruno v. W. Union Fin. Servs.* 973 A.2d 713, 715 n.3 (D.C. 2009) (holding that "[b]ased upon reference to various maps and the court's familiarity with the area," the driving distance was ascertainable and judicially noticed). The driving times and distances were calculated using Google Maps (www.maps.google.com) based on non-emergency vehicles traveling in minimal traffic. This information is not in the record, but the Court can take judicial notice of it, as the information is "can be accurately and readily determined from sources whose accuracy cannot reasonably be questioned." Fed. R. Evid. 201(b). "Judicial notice may be taken at any time, including on appeal." *Robert Siegel, Inc. v. District of Columbia*, 892 A.2d 387, 395 n.11 (D.C. 2006) (internal quotation marks and citation omitted).

"Courts commonly use internet mapping tools to take judicial notice of distance and geography." *Rindfleisch v. Gentiva Health Sys., Inc.*, 752 F. Supp. 2d 246, 259 n.13 (E.D.N.Y. 2010); *see also Briscoe v. Ercole*, 565 F.3d 80, 83 n.2 (2d Cir. 2009) (Yahoo! Local Maps (www.maps.yahoo.com)); *Raygoza v. Hulick*, 474 F.3d 958, 960 (7th Cir. 2007) (MapQuest (www.mapquest.com)). In particular, courts use Google Maps to determine distances and travel times. *See, e.g., Citizens for Peace in Space v. City of Colo. Springs*, 477 F.3d 1212, 1219 n.2 (10th Cir. 2007); *Warwick v. Univ. of the Pac.*, No. C 08-03904 CW, 2010 WL 2680817, at *3

the District of Columbia (*Id.* at 57), but she could not communicate with the EMS personnel and did not know to which emergency room they would drive her. "[W]e just took off to the hospital," testified Ms. Settles before the Office of Administrative Hearings (OAH). "I had no idea where I was going." (*Id.* at 47.) There is no evidence that Ms. Settles had any say about which hospital the ambulance took her to. The only plausible inference from the record is that the EMS ambulance took her to the nearest hospital, even though it was not a participant in the Alliance program and was located just across the District line, because Ms. Settles needed treatment immediately.

Administrative Law Judge (ALJ) Claudia Barber found it undisputed that Ms. Settles "was transported without her knowledge or consent to Prince George's Hospital Center in Prince George's County, Maryland." (App. 2, Order at 3.) At the hospital, she was "physically unable" to sign the ambulance report. (Ex. 100, DC Fire & EMS Conversion Record at 2.) The emergency room personnel at PG Hospital Center determined that Ms. Settles was experiencing a severe allergic reaction to some food she had consumed, and that she needed to be admitted. She "remained in critical care from on or about April 13 through April 21, 2010." (App. 2, Order at 3.) She was initially unable to contact Chartered due to her emergency condition. OAH found as a fact, and it is undisputed, that "Alliance did not provide any evidence that Prince George's Hospital Center notified Alliance of Petitioner's admission, or if Alliance gave any consideration to relocating [Ms. Settles] to an in-network provider after it became aware of [Ms. Settles'] emergency admission." (App. 2, Order at 4.)

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n.8 (N.D. Cal. July 6, 2010); *Rindfleisch*, 752 F. Supp. 2d at n.13; *Dynka v. Norfolk S. Ry. Corp.*, No. 09-cv-4854, 2010 U.S. Dist. LEXIS 59664, at *1 n.2 (E.D. Pa. June 15, 2010); *United States v. Stewart*, No. 3:07-cr-51 (REP), 2007 U.S. Dist. LEXIS 61715, at *1 n.2 (E.D. Va. Aug. 22, 2007); *State v. Rush*, 219 W. Va. 717, 720 n.6, 639 S.E.2d 809, 812 n.6 (2006).

C. Chartered's Refusal to Pay for Emergency Care

After she was released, Ms. Settles received four medical bills that she could not afford to pay and that she submitted to her medical insurer Chartered for payment: $534.30 from D.C. EMS; $27,149.78 from PG Hospital Center; $1,200 for anesthesia; and $316 for radiology treatment. Except for the EMS bill, Chartered refused to pay the other three bills. (App. 2, Order at 3.) Chartered told Ms. Settles that, under its contract with the District of Columbia, it would not cover services by this out-of-network hospital to which District EMS had transported her for emergency treatment, leaving Ms. Settles with $28,665.78 in unpaid and unpayable medical bills.

D. The Chartered Member Handbook

Page 5 of the Member Handbook received by Ms. Settles from her insurer defines emergency care as "a serious, sudden, sometimes life-threatening injury or illness. Some examples of when you need to go to the Emergency Room are: . . . Suddenly not able to see, move or speak." (App. 3, Handbook at 5.) It identifies three steps that an insured must take to obtain emergency care coverage:

> WHAT TO DO IF YOU HAVE AN EMERGENCY:
> 1. Call 9-1-1 or go to your nearest emergency room.
> 2. Show the Emergency Room (ER) your Chartered Member I.D. Card.
> 3. As soon as you can, call your PCP.

(*Id.*) Ms. Settles followed these three steps and indeed complied with *both* alternative instructions in the first step. It is undisputed that her Chartered card was shown to both District EMS personnel in the ambulance (App. 2, Order at 3) and the emergency admitting room at the hospital. It is undisputed that Ms. Settles notified Chartered when she could from the hospital. (App. 2, Order at 4) ("[Chartered] became aware of [Ms. Settles'] emergency admission.") Thus, all three Handbook steps were satisfied.

Chartered nevertheless denied coverage on the basis of a different section on a different page. Page 6 states:

> CHARTERED PROVIDERS AND PROVIDERS WHO ARE NOT PART OF CHARTERED
> . . . *You don't need prior authorization when you have an emergency however you must get care from an In-Network hospital.*

(*Id.* at 6, emphasis in original). Later on page 14, the Handbook states:

> Exclusions are benefits and/or services that are not paid for by Chartered. They include the following:
> Screening and stabilization services for Emergency Medical Care provided outside the District *or by an Out-of-Network facility*. . . .
> Any covered services furnished by Out-of-Network providers.

(*Id.* at 14, emphasis in original.)

Page 16 of the Handbook also has a captioned section "PAYING FOR NON-COVERED SERVICES." (App. 3, Handbook at 16.) It states: "*If you decide* you want a service that we do not pay for and you do not have written permission from Chartered, you will have to pay for the services yourself." (*Id.* (emphasis added).) Similarly, the second bullet point states: "*If you decide* to get a service that we do not pay for, you must sign a statement that you agree to pay for the service yourself." (*Id.* (emphasis added).) Ms. Settles, however, did not "decide" anything about which possible emergency room. She could not speak; the D.C. EMS "decide[d]" where to take her.

E. Proceedings before OAH

Ms. Settles appealed Chartered's denial of her medical claim to OAH. Administrative Law Judge Claudia Barber held that Chartered's Handbook formed a contract with Ms. Settles and that Ms. Settles "met all requirements for emergency care set forth on Page 5 of her member handbook." (*Id.* at 5.) The ALJ further found based on the undisputed evidence "[t]he fact that the ambulance driver took [Ms. Settles] to a medical facility, unbeknownst to her that was out of

network is not her fault." The ALJ had substantial evidence to conclude that "[s]he did not breach, nor could she have breached, the contract under these circumstances." (*Id.*) The ALJ further found that contrary language from other handbook pages – regarding exclusion of non-network providers –at most creates an ambiguity that as a matter of law must be construed against Chartered as the drafter. (*Id.* at 6 (citing *Meade v. Prudential Ins. Co. of Am.*, 477 A.2d 726, 727 (D.C. 1984); *Vaulx v. Cumis Ins. Soc., Inc.*, 407 A.2d 262, 264 (D.C. 1979)).) Finally, the ALJ held that, "[e]ven if we assume Alliance denied coverage of Petitioner's medical bills because Petitioner did not properly obtain preauthorization, Alliance's argument fails under D.C. Code § 31-2802, which states that "[a]ll health insurers . . . shall reimburse for emergency services that are due to a medical emergency." (*Id.* at 7.) OAH ordered "that D.C. Health Care Alliance Chartered Health Plan pay all bills associated with [Ms. Settles'] emergency admission to Prince George's Hospital Center on April 13, 2010 through April 21, 2010."[3] (*Id.* at 1.) Chartered and DHCF requested, and OAH granted, a stay, pending this appeal.

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[3] DHCF's second basis for appeal erroneously argues that the ALJ abused its discretion in ordering DHCF to reimburse Ms. Settles. DHCF Motion (hereafter "DHCF Br.") at 4.) The words of the ALJ's order did no such thing and Chartered has not contended otherwise. Rather, Chartered through the Alliance program must reimburse Ms. Settles. The ALJ says Chartered must pay expressly on the first page of the Order (*see* App. 2, at 1). The ALJ says so again at the end of the Order using different words that DHCF quotes only in part, but the meaning of the full sentence is unequivocal. The language quoted by DHCF has the important omitted modifier in italics "DHCF shall pay . . . *under the DC HealthCare Alliance program.*" (*Id.* at 8, emphasis added.) "Under" that program, Chartered pays the claim. DHCF also omits the context for this sentence's mention of DHCF. In the immediately preceding sentence, the ALJ orders that DCHF's "June 9, 2010 notice letter" denying Ms. Settles claim is "REVERSED". (*Id.*) In short, DHCF sent the formal denial letter of Ms. Settles claim against Chartered; that letter is reversed, meaning that Chartered must pay the bill. In any event, as to whether the money for the payments ultimately comes from Chartered or DHCF, Ms. Settles has no position. This is a question solely for DHCF and its contractor Chartered, as a matter of contract or negotiation. This purported issue does not justify continuation of appeals against Ms. Settles much less reversal of the coverage determination by OAH in favor of Ms. Settles.

STANDARD OF REVIEW

This Court reviews the ALJ's factual findings "to ensure that they are supported by substantial evidence in the record" under an abuse of discretion standard. *See Odeniran v. Hanley Wood, LLC*, 985 A.2d 421, 424 (D.C. 2009). This Court "must affirm an OAH decision when (1) OAH made findings of fact on each materially contested issue of fact, (2) substantial evidence supports each finding, and (3) OAH's conclusions flow rationally from its findings of fact." *Morris v. EPA*, 975 A.2d 176, 180 (D.C. 2009) (quoting *Rodriguez v. Filene's Basement, Inc.*, 905 A.2d 177, 180 (D.C. 2006) (internal quotation marks omitted)).

SUMMARY OF ARGUMENT

This Court should grant Ms. Settles' pending motion to dismiss the appeals by DC Chartered Health Plan (Chartered) and the District of Columbia Department of Health Care Finance (DHCF). Chartered expressly waived its ability to appeal OAH coverage decisions in favor of its insureds. Its contract (Contract) with DHCF states that the "Contractor shall comply with the District Office of Administrative Hearings decision. The District Office of Administrative Hearings decisions in these matters shall be final and not subject to appeal by the Contractor." (Contract at C.14.8.5, attached to pending motion to dismiss that was referred to this division by Order dated January 23, 2012). The appeal waiver bars Chartered as the "Contractor" and similarly prohibits DHCF from bringing a coverage appeal on Chartered's behalf. Allowing DHCF to appeal the OAH coverage decision would likewise conflict with the OAH finality clause in the Contract to which DHCF is also a party. Accordingly, the Court should dismiss both appeals.

If these appeals are not dismissed, this Court should affirm. Substantial evidence supports the OAH conclusion that Ms. Settles receives reimbursement for her emergency medical care through enforcement of the Chartered Alliance Member Handbook. The Handbook

states that, in the case of an emergency, Alliance enrollees must: call 9-1-1 or go to the nearest emergency room; provide the emergency room employees with her Alliance Member I.D.; and notify Chartered as soon as possible. Ms. Settles fully complied with these three steps: D.C. EMS was notified of Ms. Settles' emergency medical condition via 9-1-1; she went to the closest emergency room at PG Hospital Center; she provided D.C. EMS with her Alliance Member I.D.; and she notified Chartered after her breathing had stabilized and she was able to speak.

Relatedly, this Court should affirm the ALJ's holding, supported by substantial evidence, that the Handbook's three explicit emergency care instructions to insureds conflict with other provisions of the Handbook that exclude out-of-network services. This Court should likewise affirm the conclusion of law that flows rationally, and inevitably, from the factual finding of ambiguity, namely that ambiguity must be construed against the insurer Chartered as the drafter of the Handbook.

In any event, Petitioners' principal defense before OAH and on appeal is that, whatever ambiguity exists in the conflicting statements in the Member Handbook, a separate document (not given to insureds), namely the Contract between Chartered and DHCF, prohibits payment for services, emergency or otherwise, outside Chartered's network of hospitals. But Chartered and DHCF failed to produce to OAH that Contract in its entirety, presumably for tactical reasons involving possible ambiguities regarding emergency coverage in that Contract as well. As a consequence, Chartered and DHCF failed in their burden of production and proof such that OAH could not, and this Court cannot, interpret that Contract as a whole. Because this Court is prohibited from looking outside the OAH administrative record to assess this Contract defense, Chartered and DHCF failed to meet their burden, and this Court must affirm OAH's determination that due to insurer ambiguity the snippets of the Contract introduced before OAH

(and which mirror Member Handbook provisions that were in evidence) do not prohibit insurer reimbursement to Ms. Settles.

Finally, OAH determined that the Access to Emergency Medical Services Act requires "[a]ll health insurers, hospitals or medical services corporations, and health maintenance organizations [to] reimburse for emergency services that are due to a medical emergency." D.C. Code § 31-2802(a). Petitioners argue that this requirement is superseded by subsequent legislation: D.C. Code §§ 7-1405(c) and (d). But § 7-1405(c) only prohibits reimbursement for services that are excluded by the Contract. As we note and as OAH determined, the Contract does not exclude insurer reimbursement for Ms. Settles' emergency services from PG Hospital. And § 7-1405(d) does not preclude reimbursement because it only states that Chartered "is not required to reimburse non-participating hospitals." D.C. Code § 7-1405(d). It does not prohibit Chartered from paying for such services. Additionally, this provision can be read harmoniously to give effect to it and the Access to Emergency Medical Services Act by a construction of the former only to apply to routine medical services, not to emergency medical services. Applying the rules of statutory construction that the specific prevails over the general and implied repeals are disfavored, the City Council did not repeal the fundamental protections of access to and coverage of emergency medical services at one's closest emergency room for Alliance enrollees, who are among the District's most vulnerable residents.

ARGUMENT

I. CHARTERED (AND THUS, DCHF) WAIVED ANY RIGHT TO APPEAL AN OAH COVERAGE DETERMINATION IN FAVOR OF THE INSURED.

As a threshold matter, pending before this division is Ms. Settles' motion to dismiss the appeals because Chartered expressly waived any appeal to this Court from an OAH final order in

favor of its insured.[4] The Contract cited in the motion required Chartered, as the "Contractor", "to comply with the District Office of Administrative Hearings decision. The District Office of Administrative Hearings decisions in these matters shall be final and not subject to appeal by the Contractor." (*Id.* at C.14.8.5.) This Contract waiver plainly trumps the boilerplate OAH form attachment that "the appeal rights of any party aggrieved by this Order are stated below." (App. 2, at 8.)

In order for the OAH decision to be "final," it cannot be subject to appeal by DHCF on behalf of the Contractor. More fundamentally, the Contract goes on to state in the very next Section that, following the OAH decision, "the service shall be authorized or provided no later than two (2) Business Days after reversal or notification of reversal from the District." (Contract at C.14.8.6.) That provision is not limited to the "Contractor" and necessarily means *no* appellate challenges by any person or entity to an OAH benefits ruling in favor of the beneficiary.

Allowing DHCF to appeal an OAH decision ordering the Alliance program to reimburse Ms. Settles reads out of the Contract and thus cancels the important protections for *pro se* medical claimants established by the Contract's finality and appellate waiver provisions. Proxy appeals by DHCF are at odds with the plain language of the Contract to which DHCF is a signatory party, even if otherwise authorized by the generic authority of D.C. APA, D.C. Code §

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[4] Because DHCF and Chartered were the only parties with access to the entire Contract, there was no possibility of pro se Ms. Settles reading or understanding 500 pages of legalese in order to identify and introduce these Contract provisions into the record during the OAH proceedings. Of course, the appeal waiver in the Contract was not relevant until OAH decided the merits and informed parties of appeal rights. While Chartered (in its opposition to Ms. Settles' pending motion to dismiss) makes the argument based on this form attachment about appeal rights, a boilerplate form does not and cannot revive appeal rights that have been waived. This frivolous argument by Chartered does not excuse the lack of candor to the OAH tribunal by the attorneys for both contract parties who appeared and indeed requested OAH to stay its Order pending the appeal (without disclosing that the appeal was waived by Chartered).

2-510. Moreover, as a standing issue, it is difficult to conceive how DHCF is aggrieved within the meaning of the District's APA by OAH's coverage decision in favor of District resident Ms. Settles. Whether paying benefits is consistent with the Alliance program is exactly what OAH was asked to decide. If DHCF wants to pursue an appeal against Chartered, this Court should dismiss both appeals as to Ms. Settles, dismiss Ms. Settles entirely from that DC-Chartered dispute as to which Ms. Settles has no position, and decide on the merits (or lack thereof) the District's strained reading of what the OAH decided (which is particularly strained where Chartered does not contest its liability vis-a-vis DCHF for Ms. Settles' bills).

This Contract waiver is fully briefed on the motion. It is ripe for decision now. Its merits and case authorities supporting dismissal are not reargued in detail in this brief. That motion, when and if granted, would moot this brief.

II. SUBSTANTIAL EVIDENCE SUPPORTS THE ALJ'S FINDING THAT THE MEMBER HANDBOOK CONTAINS LANGUAGE THAT ON ITS FACE SUPPORTS INSURER PAYMENT FOR MS. SETTLES' EMERGENCY CARE.

In the Member Handbook, Chartered instructed:

WHAT TO DO IF YOU HAVE AN EMERGENCY:
1. Call 9-1-1 or go to your nearest emergency room.
2. Show the Emergency Room (ER) your Chartered Member I.D. Card.
3. As soon as you can, call your PCP.

(App. 3, Handbook at 5.) The Handbook's three numbered instructions do not specify that only in-network providers will be covered; the command to "go to your nearest emergency room" conveys the opposite meaning. Taken together, the Handbook instructions require Alliance members to call emergency services administered by the District of Columbia and to provide information about their Alliance coverage, assuring that the Alliance member is brought to an appropriate in-network facility unless his or her medical condition requires faster treatment as the paramedics must have determined to be the case with Ms. Settles.

Enrollees, like Ms. Settles, can be expected to rely on the Handbook to obtain medical care during an emergency. Denying reimbursement to an Alliance enrollee who follows the Handbook but who is nevertheless taken by District of Columbia employees to an out-of-network provider would cause grave hardship and injustice. On the record before her, the ALJ properly concluded that Ms. Settles may enforce the Handbook to receive reimbursement. *Kaufman v. Int'l Bro. of Teamsters*, 950 A.2d 44, 49 n.7 (D.C. 2006) (promissory estoppels); *Broderick v. Catholic Univ. of America,* 174 U.S. App. D.C. 183, 530 F.2d 1035, 1039-40 (1976); *see generally* 4 WILLISTON ON CONTRACTS §8.4 (4th ed. 1993 & 2011 Supp.) ("the binding thread in all the classes of cases [holding promises made enforceable by promissory estoppel] is the justifiable reliance of the promise and the hardship involved in refusal to enforce the promise.").

A. Substantial evidence supports the ALJ's finding that the Handbook is ambiguous, and under District law the insurer ambiguity must be construed against Chartered.

There is substantial evidence that the Handbook – which, as OAH found, is itself a separate contractual promise of coverage for the consideration paid to Chartered by DHCF for Alliance enrollees – is at best ambiguous as to coverage for emergency medical care. *See Price v. Doe*, 638 A.2d 1147, 1152 (D.C. 1994). Chartered and DHCF emphasize Handbook provisions derived from the selected Contract provisions that it placed in the record: Section C.8.3.3.1 excludes emergency screening and stabilization services outside the District, and Section C.8.3.3.3 excludes services "furnished by Providers that are not members of Contractor's Network." (App. 4.) But Petitioners ignore other provisions of the Handbook and prevented OAH from analyzing any other Contract provisions. As the ALJ correctly found on the basis of substantial evidence of ambiguity in the Member Handbook, insurer ambiguity must be

construed in favor of Ms. Settles. If an insurance company wishes to exclude services, "it must do so clearly. Ambiguous language in an insurance contract will be construed against the company." *Meade v. Prudential Ins. Co.*, 477 A.2d 726, 728 (D.C. 1984) (citing *Vaulx v. Cumis Ins. Soc'y, Inc.*, 407 A.2d 262, 264 (D.C. 1979)); *Price*, 638 A.2d at 1152 (refusing to enforce ambiguous exclusion because "ambiguities in insurance contracts are resolved favorably to the insured" (quoting *Continental Casualty Co. v. Beelar*, 405 F.2d 377, 378 (D.C. Cir. 1968))). As OAH noted, "when it is so easy for an insurance carrier, which drafts the form of offer and the policy, to be clear about conditions, it would not be proper to construe the ambiguity in the carrier's favor, given all the interests at stake." (App. 2, Order at 6.)

It would also be unreasonable to construe the out-of-network provisions to preclude emergency care reimbursement in this case. The Members Handbook exclusion is phrased in terms of "if you decide that you want a service that we do not pay for." (App. 3, Handbook at 16.) At no point did Ms. Settles make a decision to seek out-of-network care. Instead, she was taken "without her knowledge or consent" outside the network of providers by D.C. EMS. (App. 2, Order at 3.) As Ms. Settles stated, "I had no idea where I was going." (Tr. at 47.) To avoid manifest unfairness to Ms. Settles, the Court could readily construe the Handbook to include a knowledge or consent requirement. Some decision, or at the very least awareness, must be made by the enrollee to seek out-of-network care in order for the Handbook (or the Contract clause on which it is based) to preclude reimbursement. *See, e.g.*, *Pacific Life & Annuity Co. v. Co. Division of Insurance*, 140 P.3d 181, 184 (Colo. App. 2006) (interpreting Colo. Rev. Stat. § 10-16-704(2)(i)(I) to preclude coverage for out-of-network care only if, among other things, the insured knowingly sought services from a nonparticipating provider). At best, the Contract

and the Handbook are ambiguous, in which case the ambiguity must be construed in favor of Ms. Settles.

Chartered claims that another OAH decision finding that Unison Health Plan was not required to reimburse emergency medical services is somehow persuasive authority here. (Chartered Br. at 13, attaching as App. 1 the OAH Final Order *Eshete v. Dist. of Columbia Dep't of Health Care Fin.*, Case No. 2010-DCHR-00093). Of course, that other OAH decision is of little weight here. The circumstance of lack of control over the D.C. EMS decision of which emergency room is wholly different and the decision did not address the facts and the language of the Member Handbook that the ALJ found dispositive here. It particularly does not address the ambiguity in Chartered's Member Handbook for emergency services and its unrestricted reference to "nearest emergency room" in its paragraph captioned "WHAT TO DO IF YOU HAVE AN EMERGENCY." *Eshete* involved a different insurance company with its own Handbook and contractual relationship with the District of Columbia.

B. Substantial evidence supports the ALJ's conclusion that Ms. Settles may enforce her Member Handbook against her insurer.

The Handbook is binding on Chartered as an agreement between Chartered and Alliance enrollees. In consideration for that agreement, potential Alliance enrollees enroll in the Alliance program and Chartered becomes their managed care organization, and in return, Chartered receives a capitation payment from the District government. Ms. Settles, as a Chartered insured, has her coverage defined by the Handbook and therefore is entitled to rely on it to obtain that promised coverage for emergency medical care. Indeed, Chartered's Member Handbook instructs each Member: "If you believe your benefits were unfairly denied . . . , you have a *right* to file an Appeal with Chartered and request a Fair Hearing before the D.C.'s Office of Administrative Hearings." (App. 3, Handbook at 17 (emphasis added).)

Ms. Settles complied with and reasonably relied upon the Handbook's numbered instructions. The ALJ so found and that finding is supported by substantial evidence. Upon suffering an emergency that rendered her "[s]uddenly not able to . . . speak," (*id.* at 5), she "[c]all[ed] 9-1-1" and was taken to the "nearest emergency room" at PG Hospital by decision of the EMS personnel. (*Id.*) The next-closest hospital was nearly twice as far away. (*See* note 2 *supra.*) Ms. Settles then provided the EMS with her "Chartered Member I.D. Card." (*Id.*) She was unable to notify Chartered while in intensive care but called Chartered "[a]s soon as" she could when she got home. (*Id.*) The Handbook includes broad language of a right to seek emergency care from *any* provider, specifying that emergency care coverage should be sought at the "nearest emergency room," without any limit. Ms. Settles may enforce these provisions of the Handbook to receive coverage of her emergency medical services at PG Hospital Center. Any decision to the contrary would unreasonably withhold reimbursement for Ms. Settles' emergency medical services at the nearest emergency room for a life-threatening condition that precluded her ability to speak.

In addition to Ms. Settles justified reliance on the emergency services portion of the Handbook, that Handbook gives direct contract rights to Ms. Settles (including a coverage appeal to OAH) in consideration of the capitation payment to Chartered by DHCF for her coverage. But even if it did not, she has the same rights as an intended third-party beneficiary of the Contract between the District and Chartered because "the contracting parties had an express or implied intention to benefit directly the party claiming such status." *Fort Lincoln Civic Assoc., Inc. v. Fort Lincoln New Town Corp.*, 944 A.2d 1055, 1064 (D.C. 2008). The District intended to give Alliance Enrollees the benefit of Chartered's promised performance. It is undisputed that the "[t]arget populations under the Contract consist primarily of 94,000 children and their parents

enrolled in Medicaid . . . [and] approximately 50,000 individuals enrolled under the Alliance Program." (*Id.* at C.2.4.) Taking into account the Contract as a whole, *W. Union Tel. Co. v. Massman Constr. Co.*, 402 A.2d 1275, 1277 (D.C. 1979) (citation omitted), and the legislation which authorizes the Mayor "to provide by contract or by other means comprehensive community-centered health care and medical services *for residents of the District of Columbia*," D.C. Code § 7-1405(a) (emphasis added), the District of Columbia intended to benefit directly enrollees of the Alliance Program. *Fort Lincoln Civic Assoc.*, 944 A.2d at 1064.

The direct intention to benefit Alliance enrollees distinguishes this contract from most government contracts. Medicaid provider contracts, for instance, are unlike most government contracts in that Medicaid Enrollees may recover as third-party beneficiaries. *See Smallwood v. Cent. Peninsula Gen. Hosp.*, 151 P.3d 319, 324-26 (Alaska 2006) (holding that Medicaid members were intended third-party beneficiaries of provider contracts with the State); *Mallo v. Pub. Health Trust of Dade Cnty., Fla.*, 88 F. Supp. 2d 1376, 1385 (S.D. Fla. 2000) (same). Similarly, the Alliance Contract is unlike most government contracts because the parties intend to directly benefit a distinct class – Alliance enrollees – thereby giving them the power to enforce the Contract as third-party beneficiaries.

Here, "a right to performance in the beneficiary is appropriate to effectuate the intention of the parties." *Id.* (quoting RESTATEMENT (SECOND) OF CONTRACTS § 302 (1981)).

III. PETITIONERS' LIMITED CONTRACT EXCERPTS FAILED TO ESTABLISH THEIR STATUTORY DEFENSE THAT INSURER PAYMENT VIOLATED THE CONTRACT AS A WHOLE.

Chartered's defense, joined by DHCF, was that it could not be required to provide coverage not specified in its Alliance contract with the District, regardless of any contractual

obligation the Handbook created to Ms. Settles.[5] Even if such a defense is legally viable, Chartered failed to support that defense by producing to OAH its full Alliance contract, or even enough of it to place the snippets it did offer into proper context. It was Chartered's burden to establish its defense, as the ALJ correctly found. D.C. Code § 2-509(b); *see also* Tr. at 12. Chartered failed at OAH and also on appeal for want of proof because the record is fatally incomplete to establish the Contract defense.

This Court looks to the entire Contract to interpret specific provisions. "The first step in contract interpretation is determining what a reasonable person in the position of the parties would have thought the disputed language meant." *Malik Corp. v. Tenacity Group, LLC*, 961 A.2d 1057, 1060 (D.C. 2008) (quoting *1010 Potomac Assocs. v. Grocery Mfrs.*, 485 A.2d 199, 205 (D.C. 1984)). And to "discern[] what a reasonable person in the position of the parties meant, we interpret the Contract as a whole, giving a 'reasonable, lawful and effective meaning to all its terms.'" *Id.* (quoting RESTATEMENT (SECOND) OF CONTRACTS §§ 202(2), 203(a) (1981)); *Akassy v. William Penn Apts., Ltd. P'ship,* 891 A.2d 291, 303 (D.C. 2006).

Because the entire Contract is not in the OAH record, Petitioners failed to meet their burden in the OAH proceeding and cannot establish reversible error here. *See, e.g., Rel-Reeves, Inc. v. United States*, 534 F.2d 274, 286 (Ct. Cl. 1976) (rejecting claim for failure of proof where party failed to provide the court with the complete contract and introduced no testimony showing that the missing portions were insignificant or had no impact on the claim) (citing 13 Williston, A Treatise on the Law of Contracts, § 1599 (3d ed. H.E. Jaeger 1970); 7 Wigmore, Evidence,

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[5] Petitioners' statutory and regulatory arguments are derivative of their Contract claim. Petitioners maintain that the Alliance Program's statute and regulations prohibit payments and services that are not covered by the Contract. To succeed on these statutory and regulatory claims, Petitioners must prove that Ms. Settles' emergency medical services were not covered by the Contract.

§ 2105 (3d ed. 1940)); *May Constr. Co. v. Benton Sch. Dist. No. 8*, 895 S.W.2d 521, 523 (Ark. 1995) (appellant failed to prove error because entire contract was not in evidence). The Court cannot assess contrary provisions and ambiguities in a document that Petitioners chose to keep out of the administrative record while arguing that "the contract" required denial of the emergency services claim. Without the full document, the Court cannot ascertain a "reasonable, lawful and effective meaning to all its terms." *Malik Corp*, 961 A.2d at 1060 (quoting RESTATEMENT (SECOND) OF CONTRACTS §§ 202(2), 203(a) (1981)).

This Court must review OAH decisions based "upon the exclusive record for decision before . . . the agency." D.C. Code § 2-510; *Levelle, Inc. v. D.C. Alcoholic Bev. Control Bd.*, 924 A.2d 1030, 1038 (D.C. 2007) ("Where a party to an administrative dispute has been given a fair opportunity to present evidence and make his contentions in administrative proceedings, with rare exceptions he will be bound by the record there made." (quoting *Williams v. Robinson*, 432 F.2d 637, 642 n.17 (D.C. Cir. 1970)). Petitioners failed to establish a record sufficient to determine that the Contract prohibits reimbursement to Ms. Settles. *See Van Durr v. Kator & Scott, Chartered,* 788 A.2d 579, 580-81 (D.C. 2002) (affirming where appellant failed to provide "a record sufficient to show affirmatively that the trial court committed any error" by not including "in the record on appeal a transcript of the trial or other proceedings"); *Cobb v. Standard Drug Co., Inc.,* 453 A.2d 110, 112 (D.C.1982) (appellate review is limited to matters appearing in the record).

If able to view the entire Contract, it could leave a "reasonable person in the position of the parties" with the impression that coverage of Ms. Settles' emergency care is required. *Malik Corp.*, 961 A.2d at 1060. For this Court's information, Section C.6.6.2.6.4 of the Contract, a provision not introduced by Chartered or DCHF, requires a Contractor to instruct enrollees in the

Handbook as to their "right" to seek emergency care "from any Provider . . . regardless of the Provider's network status." (Contract at C.6.6.2.6.4.)[6] Nor did Chartered or DHCF introduce the provision stating that "prior authorization is not required for emergency services." (*Id.* at C.6.6.2.31.2). When interpreting each clause, in light of the entire Contract and "giving a 'reasonable, lawful and effective meaning to all its terms,'" *Malik Corp.*, 961 A.2d at 1060 (quoting RESTATEMENT (SECOND) OF CONTRACTS §202(2)), the limited provisions given to OAH by contract parties Chartered and DHCF are not in the full context of the contract as a whole. It is for precisely this reason that Contract snippets fail as a matter of proof.

DCHF argued in the now-denied motion for summary reversal that Section C.6.6.2.6.4 only applies to Medicaid enrollees. (*See* DHCF Reply to Opposition to Motion for Summary Reversal, at 4.) But the Contract imposes no such limit on this provision. The Contract requires Chartered to provide a Member Handbook for all Alliance enrollees, stating that "Contractor shall provide to each Enrollee an Enrollment package that includes . . . An Enrollee Handbook." (Contract at C.6.5.2.2.) It notes that the "Enrollee Handbook shall be specific to the DCHFP [DC Healthy Families Program (Medicaid)] or the Alliance program," (*id.* at C.6.6.2.4), but goes on to require certain content. For instance, the Contract requires "[a] complete and accurate list of all services and benefits that are covered by Contractor, including limitations and exclusions,

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[6] The contention that this provision applies only to Medicaid is clearly incorrect. The Handbook provisions apply to both Medicaid and Alliance programs and explicitly mandate separate handbooks for each:

> C.6.6.2.4 The Enrollee Handbook shall be specific to the DCHFP or the Alliance program and Contractor shall not use one Enrollee Handbook for both programs. Additionally, the Enrollee Handbook shall not contain information for programs or services not included in the Contract unless specifically noted otherwise or for other District programs, unless such information is provided in order to facilitation care coordination efforts.

as well as any services and benefits that are not contained in the Contract . . . ." (Id. at C.6.6.2.6.2.) In the list of items that are required to be included in the Handbook, whether for Alliance or Medicaid enrollees, the Contract states that the Handbook must include "[a]n explanation of what to do in an emergency, including information about the use of 911 in case of life-threatening situations, where and how to gain access to the Contractor's Emergency Services twenty-four (24) hours a day, seven (7) days a week and the right to seek care from any Provider in the event of an emergency, regardless of the Provider's network status." (*Id.* at C.6.6.2.4.) As the Contract required, Chartered distributed a Member Handbook including this content. It instructed Alliance enrollees as to the limitations of coverage to in-network providers, and it instructed enrollees as to their right to seek emergency services at the "nearest emergency room." (App. 3, Handbook at 14, 5.) DCHF claims that these Contract provisions are limited to Medicaid enrollees, but it only points to extrinsic statements made by a DC employee after-the-fact and not to the Contract itself. As such, "[e]xtrinsic or parole evidence which tends to contradict, vary, add to, or subtract from the terms of a written contract must be excluded." *Affordable Elegance Travel, Inc. v. Worldspan*, 774 A.2d 320, 327 (D.C. 2001) (internal quotation marks and citation omitted).

Of course, none of the above two paragraphs was in the OAH record, by tactical choice of DHCF and Chartered. The Court cannot substantively rely on Contract provisions that support Ms. Settles' position. But it can consider the existence of such provisions in deciding whether petitioners provided an adequate record to OAH, or whether they forfeited their defense by relying only on out-of-context snippets of a lengthy and interrelated Contract. This omission of the full Contract and particularly these critical Contract clauses (which speak for themselves and are so compelling that DHCF in its motion reply felt compelled to submit a *declaration* to

this Court that the words are not meant to apply to the Alliance program) illustrates the fundamental importance of this Court's "full contract" rule and its refusal to rely on excerpts. Because the contents of the Handbook are specified in the Contract, the tactical omission of the Contract source for these other Handbook provisions is a failure of proof that supplies an additional basis to reject the Contract defense.

IV. OAH, WHICH HAS FINAL CONTRACT AUTHORITY TO DECIDE COVERAGE, CORRECTLY REJECTED CHARTERED'S CONTRACT DEFENSE.

The Contract defense of non-covered services asserted by Chartered and DHCF contradicts the Contract's finality clause for an OAH determination that the services were covered.

A. OAH found that Ms. Settles had covered emergency services under the Member Handbook, and therefore Contract exclusions for non-covered services are no longer available as a Contract defense.

The defense that out-of-network hospital services were not covered by the Member Handbook was properly rejected by OAH. The ALJ found that these emergency services were in fact covered by the Members Handbook under these unique factual circumstances. The ALJ further found that out-of-network hospital references (from the Handbook and the Contract) were ambiguous in light of other specific Handbook references to the steps to obtain emergency care applied to these circumstances where Ms. Settles exercised no choice of emergency room.

The Contract vests the coverage decision exclusively and with finality in OAH. Here, OAH determined that this emergency service for this insured was a covered service due to insurer ambiguity in these facts. Thus, here, the Contract as a whole, giving meaning to its OAH finality clause, includes necessarily as a covered Contract service what OAH determines is a covered service, here Ms. Settles' emergency medical expenses. Thus, the Chartered and DHCF

Contract defense that Ms. Settles' services were not covered is contradicted by the equally binding Contract language of OAH finality accompanied by a short time limit for Chartered to implement the OAH coverage decision. This Contract ambiguity is fatal to the Contract defense in this Court because insurance ambiguities must be construed in favor of the insured Ms. Settles. The OAH decision covering Ms. Settles' emergency medical care expenses under her insurance policy cannot be an excluded coverage under the Contract because the Contract adopts the OAH coverage decision as final.

Ms. Settles, as a Chartered insured, has an absolute "right" to enforce the finality of the OAH decision on her appeal. Indeed, Chartered's Member Handbook given to Ms. Settles, instructs each Member: "If you believe your benefits were unfairly denied . . . , you have a *right* to file an Appeal with Chartered and request a Fair Hearing before the D.C.'s Office of Administrative Hearings." (App. 3, Handbook at 17 (emphasis added).) The Member Handbook states unequivocally at page 18 that, as a Member, "you have the right to a Fair Hearing" and that "[y]ou may request a Fair Hearing from the Office of Administrative Hearings . . ." (*id.* at 18). That process includes OAH finality and Chartered's express waiver of any appeal from an adverse decision of OAH.

V. ALTERNATIVELY, THE DISTRICT'S ACCESS TO EMERGENCY MEDICAL SERVICES ACT, D.C. CODE § 31-2802, REQUIRES THE ALLIANCE PROGRAM TO PAY MS. SETTLES' EMERGENCY MEDICAL SERVICES, AND THIS STATUTE IS NOT IMPLIEDLY REPEALED BY D.C. CODE § 7-1405.

Petitioners argue that District of Columbia Regulations, and D.C. Code § 7-1405(c) and (d), prohibit coverage of Ms. Settles' emergency medical services. But none precludes reimbursement of Ms. Settles' emergency services at PG Hospital Center. On its face, the

Access to Emergency Medical Services Act (AEMSA), D.C. Code § 31-2802, requires reimbursement.

A. D.C. Regulations, cited by Chartered, are irrelevant and do not preclude insurer payment of Ms. Settles' emergency medical services.

Petitioners claim that District regulations prohibit Ms. Settles from asserting a contract right to insurance payment under her policy. Sections 3302.2 and 3302.3 provide, respectively, that "[n]othing *in this chapter* shall be deemed to create or constitute an entitlement or right to medical services from the District government or its agent" and "[n]othing *in this chapter* shall be deemed to create or constitute an entitlement or right to payment for services by the District of Columbia or its agent." 22 DCMR §§ 3302.2, 3302.3 (emphasis added). But Ms. Settles does not assert an entitlement or right "in this chapter" of the Regulations. Ms. Settles relies upon Chartered's Handbook. The regulations do not preclude contract enforcement of these provisions, including the pertinent District law that insurance ambiguities are construed against the insurer and in favor of the insured, as the ALJ correctly found.

B. D.C. Code § 7-1405(c) does not preclude insurer payment ordered by OAH for emergency services as to which exclusion was found to be ambiguous.

Petitioners argue that D.C. Code § 7-1405(c) precludes reimbursement. It does no such thing and is easily harmonized with the OAH order.

The statute states:

> Notwithstanding any other provision of the District's health insurance laws, a health maintenance organization that has a contractual obligation to provide health care services to persons enrolled in the D.C. HealthCare Alliance ("Alliance") shall be required to provide to persons enrolled in the Alliance only those health benefits specified in its contract with the District of Columbia.

D.C. Code § 7-1405(c). But as OAH held, the Contract requires Chartered to cover Ms. Settles' emergency services. (App. 2, Order at 1.) The Contract states that the decisions of the OAH

"shall be final." (Contract at C.14.8.5.) Accordingly, as authoritatively found by OAH, Ms. Settles' emergency services are "benefits specified in its contract with the District." D.C. Code § 7-1405(c). As discussed above, a reading of the entire Contract underscores that Ms. Settles' emergency services are specified.

Moreover, subsection (c) applies only to a "health maintenance organization." Chartered does not argue that it is a "health maintenance organization," and there is no evidence in the record of its status as such. Instead, Chartered's Handbook refers to Chartered as a "Managed Care Organization" (App. 3, Handbook at 2), and the ALJ referred to Chartered as a "medical services corporation or health insurer." (App. 2, Order at 7.) On this record, DHCF has not proven that Chartered is a health maintenance organization such that D.C. Code § 7-1405(c) would even apply. Thus, subsection (c)'s "notwithstanding" clause that is present in only that subsection does not apply either, and there is no arguable legal basis to disregard other D.C. Code provisions that mandate insurer payment for emergency care.

C. D.C. Code § 7-1405(d) does not preclude insurer reimbursement and the Access to Emergency Medical Services Act (AEMSA) requires Chartered to reimburse Ms. Settles for her emergency medical services at PG Hospital Center.

Petitioners also argue that subsection (d) prohibits Chartered from reimbursing Ms. Settles' emergency care. But the statute is not that strong and is easily harmonized with the contract duty found by OAH (whose ultimate source is the statute creating The Alliance program). D.C. Code § 7-1405 provides:

> (d) A health maintenance organization or health insurer under contract to the District to deliver services to persons enrolled in the Alliance is not required to reimburse non-participating hospitals for services provided to Alliance enrollees.

The statute generally provides that a health insurer is not required to reimburse out-of-network hospital services; the insurer may still do so. Moreover, AEMSA mandates that health insurers reimburse emergency services.

Emergency services are different. Unlike routine services, every person in the United States is guaranteed the right to receive emergency services, regardless of insurance coverage. The Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd. And like many States, the District of Columbia requires "[a]ll health insurers, hospitals or medical services corporations, and health maintenance organizations [to] reimburse for emergency services that are due to a medical emergency."[7] D.C. Code § 31-2802(a) ("Access to Emergency Medical Services Act (AEMSA)"). The law makes no distinction between in-network and out-of-network and does not permit exceptions for pre-authorization. "A health insurer . . . may not deny reimbursement, except for co-payments, deductibles, and co-insurance, for the provision of emergency services that are due to a medical emergency solely because the member failed to obtain pre-authorization for emergency services from the health insurer . . . ." *Id.* at § 31-2802(d). The District recognizes by its specific statute that emergency services are so

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[7] *See, e.g.*, Cal. Health and Safety Code § 1374.34(c) (requires health plans to cover emergency services and appropriate out-of-network emergency care); Ga. Code Ann. § 33-20A-9 (prohibits managed care entities from denying reimbursement for emergency services); Ind. Code § 27-13-36-9(c) (requires health maintenance organizations to cover emergency services without prior approval or regard for the contract between the HMO and provider); Kan. Stat. Ann. § 40-4603 (requires health plans to cover emergency services regardless of whether prior authorization was obtained); N.M. Stat. § 59A-57-4(B)(3)(d) (requires managed health plans to cover emergency services without prior authorization and appropriate out-of-network emergency care); N.C. Gen. Stat. § 58-3-190 (requires health insurance companies to cover emergency services, even if the provider is not under contract with the insurer); Ohio Rev. Code § 1753.28(C) (requires health insuring corporations to cover emergency services without prior authorization and appropriate out-of-network emergency care); Tenn. Code § 56-7-2355(b) (requires health benefit plans to cover emergency services regardless of whether provider has a contractual agreement with the health benefit plan).

fundamental that health insurers must pay for it.[8] The D.C. Council Committee on Consumer and Regulatory Affairs stated that AEMSA ensures that a person "can access emergency medical services promptly without the real financial concerns that their health insurance will hold the enrollees fully responsible for costs of the care." D.C. Council Comm. on Consumer and Regulatory Affairs, Report on Bill 12-193, "The AEMSA of 1997", 3 (February 24, 1998) ("Committee Report").

Section 7-1405(d) limited Chartered's liability for hospitals' "services" outside the network of providers. Unlike § 1405(c), subsection (d) contains no proviso that it applies "[n]otwithstanding any other provision of the District's health insurance laws." D.C. Code § 7-1450(c). The "usual rule [is] that 'when the legislature uses certain language in one part of the statute and different language in another, the court assumes different meanings were intended.'" *Sosa v. Alvarez-Machain*, 542 U.S. 692, 711 n.9 (2004) (quoting 2A Norman J. Singer, Sutherland Statutes and Statutory Construction § 46:06, at 194 (6th rev. ed. 2000)). Applying the canon of *expressio unius est exclusio alterius*, which "asserts that the express inclusion of one (or more) thing(s) implies the exclusion of others from similar treatment," *In re Uwazih*, 822 A.2d 1074, 1078 n.5 (D.C. 2003) (quoting William D. Popkin, Materials on Legislation: Political Language and the Political Process 217 (3d ed. 2001)), the Council intended emergency care requirements like AEMSA to apply to "health insurers," like Chartered, along with other provisions of the District's health insurance laws.

Reading both statutes together can give effect to both. There is the statutory distinction between emergency care in one statute and generic hospital "services" in the other. A sensible

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[8] Given the clear expression of public policy in the Access to Emergency Medical Services Act to require coverage of emergency medical services regardless of the provider's status, the Contract and the Handbook must be construed to include coverage of emergency services. RESTATEMENT (SECOND) OF CONTRACTS § 5, comm. a.

construction of both is that § 7-1405(d) does not apply to emergency services. Such a construction is particularly justified here where Ms. Settles did not choose to be taken to an out-of-network hospital and D.C. EMS chose to take her to the "nearest emergency room" per the Handbook.

Such a harmonious construction is justified by multiple rules of statutory construction. The more general reference to hospital "services" did not repeal by implication the Access to Emergency Medical Services Act. "In the absence of any express repeal or amendment, [a] later statute is presumed to be in accord with the legislative policy embedded in [a] prior statute [] so as to allow the prior and later statutes to be construed together." *Richardson v. United States*, 927 A.2d 1137, 1143 (D.C. 2007) (modifications in original) (internal quotation marks and citations omitted). Second, "the specific governs the general." *Long Island Care at Home, Ltd. v. Coke*, 551 U.S. 158, 170 (2007). AEMSA governs "emergency services," whereas § 7-1405(d) applies generally to hospital "services." Here, it is a more reasonable construction that the "emergency" statute is the more specific law and that it too must be given effect.

Finally, as always, this Court must "'presume[] [that the legislature] acted rationally and reasonably,' and . . . 'eschew interpretations that lead to unreasonable results.'" *Grayson v. AT&T Corp.*, 15 A.3d 219, 238 (D.C. 2011) (en banc) (citation omitted). Section 7-1405(d) could not have repealed such a fundamental protection as the right to access emergency care for Alliance enrollees – who are already D.C.'s poorest and most vulnerable residents – without reference or discussion. It is reasonable to assume that the Council expected AEMSA would cover out-of-network emergency care for Alliance members, given that States with similar

programs recognize such fundamental protections.[9] And it is simply unreasonable not to reimburse an enrollee who did everything she reasonably could have done to seek emergency services from a network provider – and everything her insurance handbook told her to do – by calling "9-1-1," going to the "nearest emergency room," and providing the EMS with her insurance card. (App. 3, Handbook at 5.)

The statutes must stand together. Each can be given effect: Section 7-1405(d) for out-of-network *non-emergency* hospital care, and AEMSA to reimburse emergency services, especially where a D.C. ambulance driver in the District took the patient to the nearest emergency room and the patient had no physical capability to communicate, much less direct, the driver to another in-network emergency room.

Ms. Settles' inability to speak constituted a "medical emergency." D.C. Code § 31-2801(3). Prince George's Hospital provided "emergency services" that were "furnished in the emergency department of a hospital for the treatment of a medical emergency" and "[a]ncillary services routinely available to the emergency department of a hospital for the treatment of a medical emergency." *Id.* at § 31-2801(2). Therefore, AEMSA applies, and Chartered is required "to reimburse for emergency services that are due to a medical emergency." D.C. Code § 31-2802(a). Ms. Settles need not suffer "the real financial concerns that [her] health insurance will hold the enrollees fully responsible for costs of the care." Committee Report at 3.

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[9] The District's reimbursement mandate for emergency care conforms with other state programs in Connecticut, Conn. Agencies Regs. § 17b-262-532(a); New York, N.Y. Comp. Codes R. & Regs. tit. 18, §§ 505.4(d)(1)(ii), 505.4(e); Minnesota, Minn. Stat. § 256B.0625(4); Washington, Wash. Admin. Code § 182-538-100(7)(a); and with Medicaid. 42 U.S.C. § 1396u-2(b)(2)(A)(i) (requiring "[e]ach contract" with a managed care organization or primary care case manager "to provide coverage for emergency services . . . without regard to prior authorization or the emergency care provider's contractual relationship with the organization").

CONCLUSION

Because Chartered is prohibited by contract from taking this appeal when its insured prevails at OAH, this Court should dismiss Petitioners' consolidated appeal. Alternatively, this Court should affirm OAH's final order as supported by substantial evidence and from which its conclusion of law construing insurer ambiguity against the insurer flows rationally and inevitably.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that I caused a true and correct copy of the foregoing Brief of Respondent to be delivered by first-class mail, postage prepaid, this 22nd day of February 2012, to each of the following:

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