STATE OF MICHIGAN

IN THE COURT OF APPEALS

MICHIGAN STATE MEDICAL SOCIETY, a Michigan non-profit corporation, and MICHIGAN OSTEOPATHIC ASSOCIATION, a Michigan non-profit corporation,

Plaintiffs-Appellants,

v.

BLUE CROSS BLUE SHIELD OF MICHIGAN, a Michigan non-profit corporation,

Defendant-Appellee.

Court of Appeals No. 269415

Ingham County Circuit Court
Case No. 04-1233 CZ

BRIEF *AMICUS CURIAE* OF AMERICAN MEDICAL ASSOCIATION IN SUPPORT OF PLAINTIFFS-APPELLANTS

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TABLE OF CONTENTS

INDEX OF AUTHORITIES

Cases

Statutes and Regulations

Miscellaneous

QUESTION PRESENTED

1. Did the trial court err in holding that the Blue Preferred Plan (TRUST) Program Professional Provider Agreement applies to physician office services provided to enrollees in the self-insured health plans Blue Cross Blue Shield of Michigan administers as a third-party contractor for GM, Ford, and DaimlerChrysler?

The Trial Court said "no."
Plaintiffs-Appellants and *Amicus Curiae* say "yes."
Defendant-Appellee says "no."

INTERESTS OF *AMICUS CURIAE*

Amicus Curiae, the American Medical Association ("AMA"), an Illinois non-profit corporation headquartered in Chicago, is a professional association of approximately 245,000 physicians, residents, and medical students. Its members practice in every state and in all fields of medical specialization. The AMA was founded in 1847 to promote the science and art of medicine and the betterment of public health, and these remain its core purposes. It is the largest medical society in the United States. The AMA has routinely been granted leave to file briefs *amicus curiae* in courts, state and federal, including within Michigan. *See, e.g.*, *United States ex rel. Swafford v. Borgess Med. Ctr.*, 98 F. Supp. 2d 822 (W.D. Mich. 2002).

The AMA is widely recognized as an authority on issues pertaining to health insurance plans. The AMA repeatedly provides live testimony and official "statements for the record" to Congress and federal agencies, including the United States Department of Labor, on this subject. State regulatory authorities equally recognize the AMA as an authority on issues concerning health insurance. On June 13, 2005 and again on July 8, 2005, the AMA, pursuant to invitation, spoke to the National Association of Insurance Commissioners on issues related to health plan payer contracting and business practices.

In light of the AMA's expertise, its opinions concerning various issues in the present case, specifically the meanings of the terms "sponsorship" and "Benefit Plan Description," may assist this Court in its determination of this case.

ARGUMENT

I. Introduction

One of the most significant problems facing physicians under the managed care system is the inherent disparity of bargaining power between health insurers and physicians. While ostensibly physicians have the right to pick and choose among health insurance networks, selecting those with beneficial contract terms and reimbursement levels, in most cases this is unrealistic. In many regions, a health insurer's market dominance mandates that a physician participate in the available networks. Health insurers move aggressively to restrict reimbursement for out-of-network physicians in an effort to force them to participate. As a result, physicians are coerced into signing provider agreements which are nothing more than contracts of adhesion.

The circumstances in the present case exemplify this inherent disparity. Defendant-Appellee, Blue Cross Blue Shield of Michigan ("BCBSM"), seeks to contort the language of its Blue Preferred Plan (TRUST) Program Professional Provider Agreement ("TRUST Network Agreement") in order to serve its own narrow interests. This agreement, which binds thousands of physicians in the BCBSM Preferred Provider Organization ("PPO")[1] network, requires BCBSM to pay participating physicians directly for services provided to patients enrolled in plans that are either underwritten or sponsored by BCBSM. The physicians, in turn, are required to accept reduced fees and other restrictions for "Covered Services" provided to the patients participating in these plans. (Appellants Brief at 1.)

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[1] A PPO is defined as "an organization providing health care that gives economic incentives to the individual purchaser of a health-care contract to patronize certain physicians, laboratories, and hospitals which agree to supervision and reduced fees." Merriam-Webster's Medical Dictionary (2002).

Section 1.04 of the TRUST Network Agreement defines "Covered Services" as "those health care services cited in Certificate(s)." Section 1.03 of the agreement defines "Certificate" as "Certificates/Riders/Benefit Plan Descriptions issued by BCBSM or under its sponsorship." *Id.* Therefore, physicians bound by the TRUST Network Agreement are required to adhere to the reduced fees and restrictions only with respect to services cited in "Certificates/Riders/Benefit Plan Descriptions" issued by BCBSM or under its "sponsorship."

BCBSM, however, contends that "Covered Services" should include those provided under employee benefit plans sponsored by GM, Ford, and DaimlerChrysler ("automakers"). In 2003, the automakers agreed in collective bargaining agreements to establish these self-insured plans ("New Health Plans") to replace the existing health insurance plans for their employees. *Id.* at 2-3. Each of the automakers entered into agreements with BCBSM under which BCBSM would provide certain administrative services for the plans, while the automakers themselves would be responsible for the underwriting. Without consulting the physicians in BCBSM's PPO network, however, BCBSM agreed with the automakers to make the PPO network discounts available to enrollees of the New Health Plans. *Id.*

Plaintiffs-Appellants, the Michigan State Medical Society ("MSMS") and the Michigan Osteopathic Association ("MOA"), believe that this action violated the TRUST Network Agreement. Specifically, BCBSM wrongfully included services provided under the New Health Plans as "Covered Services" under the TRUST Network Agreement. BCBSM failed to issue a certificate, rider or benefit plan description citing these services, and BCBSM was not the sponsor of the plans. BCBSM argues that the services were

cited in various publications, such as various administrative manuals, which it deemed to be benefit plan descriptions, as the term is used in the TRUST Network Agreement. (Appellee Brief at 6.) In addition, BCBSM claims that it is a "sponsor" of the New Health Plans, because it provides administrative support for them. *Id.* at 20.

This Brief *Amicus Curiae* addresses the specific issue of whether the trial court erred by accepting the BCBSM definitions of "sponsorship" and "Benefit Plan Descriptions."

II. Standard of Review

The trial court's grant of summary disposition to Defendant/Appellee is reviewed on a de novo basis by this Court. *Breighner v. Mich. High Sch. Athletic Ass'n*, 471 Mich. 217, 225, 683 N.W.2d 639, 644 (2004) and *Rory v. Cont'l Ins. Co.*, 473 Mich. 457, 464, 703 N.W.2d 23, 28 (2005).

III. Discussion

A. The term "sponsor," as used in reference to employee benefit plans, refers to those entities assuming primary financial and legal responsibilities over the plan.

"Sponsorship" is an obvious derivation from the underlying root, "sponsor." The word "sponsor," when used in reference to employee benefit plans, has a specific meaning within the health insurance industry. In this context, the term refers to the entity that establishes or maintains a plan, which, in the case of most employee benefit plans, is a single employer, a group of employers acting jointly, or a union. The term generally denotes the entity that assumes primary financial and legal responsibility over a plan. It does not simply refer to the assumption of *any* responsibility, as the trial court suggests.

(Jan. 24, 2006 Op. at 10.) In the present case, BCBSM is not a "sponsor," as the New Health Plans require the automakers to assume such responsibilities.

1. With respect to employee benefit plans, the term "sponsor" refers to the employer, a group of employers acting jointly, or an employee organization such as a union.

Defining the term "sponsor" as referring to the automakers, rather than BCBSM, is consistent with the Employee Retirement Income Security Act of 1974 ("ERISA").[2] ERISA defines "plan sponsor" as:

> (i) the employer in the case of an employee benefit plan established or maintained by a single employer,
>
> (ii) the employee organization in the case of a plan established or maintained by an employee organization, or
>
> (iii) in the case of a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan.

29 U.S.C. § 1002(16)(B) (2006). BCBSM does *not* fall within this definition.

While it is true that the TRUST Network Agreement does not expressly incorporate the ERISA definitions, ERISA's definition of "sponsor" is a term of art commonly used within the health insurance industry, due to the widespread applicability of ERISA to health insurance plans. Most private sector health plans are currently

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[2] ERISA, codified as Chapter 18 of the United States Labor Code, 29 U.S.C. §§ 1001-461 (2006), is a federal statute enacted to protect the interests of participants in employee benefit plans and their beneficiaries by: (1) requiring the disclosure and reporting to participants and beneficiaries of financial and other information, (2) establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and (3) providing for appropriate remedies, sanctions, and ready access to the Federal courts. *See* U.S. Dep't of Labor, *Employee Retirement Income Security Act—ERISA*, *available at* http://www.dol.gov/dol/topic/health-plans/erisa.htm; *see also* Leonard A. Nelson, *Aetna v. Davila/Cigna v. Calad: A Missed Opportunity*, 31 Wm. Mitchell L. Rev. 843, 845 (2005).

covered by ERISA. U.S. Dep't of Labor, *Health Plans & Benefits*, *available at* http://www.dol.gov/dol/topic/health-plans/index.htm. In fact, ERISA governs approximately 2.5 million health benefit plans sponsored by private sector employers nationwide, providing a wide range of medical, surgical, hospital and other health care benefits to some 131 million Americans. Employee Benefits Security Administration, U.S. Dep't of Labor, *Fact Sheet: Workers' Right to Health Plan Info.*, *available at* http://www.dol.gov/ebsa/newsroom/fserisa.html. As such, the TRUST Network Agreement was obviously drafted with the ERISA definitions in mind. Certainly, nothing in the record suggests otherwise.

In addition, unless a plan specifically designates a third party, such as the insurer, to assume the legal responsibilities mandated by ERISA, such responsibilities generally fall on the plan "sponsor." These responsibilities include duties relating to funding, reporting, and disclosure. David L. Bacon et al., *Employee Benefits Guide, Volume 1: ERISA, COBRA, Other Laws* § 3.01[2] (Matthew Bender 2006). Thus, it is the "sponsor" of a plan that assumes most of the legal duties, as well as the penalties for noncompliance, required under ERISA. *Id.* In the present case, the New Health Plans fail to identify BCBSM as undertaking such duties under ERISA. BCBSM simply undertook certain "administrative" functions, such as receiving and processing claims and disbursing payments to providers. (Appellants Brief at 2-3.)

BCBSM's contention that ERISA terminology should not be applied to the TRUST Network Agreement, simply because the agreement itself is not an employee benefit plan, is disingenuous. (Appellee Brief at 21.) In requiring that "Covered Services" should include benefits provided under plans "under its sponsorship," BCBSM

surely contemplated that the plans to which it was referring in this provision would predominantly be ERISA-covered plans. BCBSM even concedes that the New Health Plans are ERISA plans. Thus, the term "sponsor" is clearly used in the context of ERISA plans and should be consistent with ERISA terms.

BCBSM also argues that the context of the term, as it is used in reference to ERISA plans, should not be considered, as "[u]nambiguous contracts are not open to judicial construction and must be enforced as written." (Appellee Brief at 21.) This, however, does not preclude considering the context of contractual language in determining the "ordinary" meanings of unambiguous terms. *United States v. Lennox Metal Mfg. Co*., 225 F.2d 302, 311 (2d Cir. 1955) ("It is regarded by many authorities as a fallacy that, in interpreting contractual language, a court may not consider the surrounding circumstances unless the language is patently ambiguous...The text should always be read in its context. Indeed, text and context necessarily merge to some extent"); *Minco Inc. v. Combustion Eng'g*, 95 F.3d 1109, 1117 (Fed. Cir. 1996) (contractual language is to be given its plain and ordinary meaning in the context of the entire contract.); *United States Dev. Corp. v. Peoples Federal Sav. & Loan Ass'n.*, 873 F.2d 731, 735 (4th Cir. 1989) (the court must interpret their ordinary meanings in the context in which the words are used, with an eye toward the contract as a whole).

Thus, in determining the meaning of "sponsor," this Court should consider the fact that the term "sponsor" was employed with ERISA plans in mind. As BCBSM does not fall within the ERISA definition and has not assumed the financial and legal duties concomitant with plan sponsorship, the automakers—and not BCBSM—should be considered the sponsors of the New Health Plans.

2. The trial court's definition of the term "sponsor" is at odds with common usage and would lead to absurd results.

Further, the trial court misconstrues the ordinary, common meaning of the term "sponsor." According to the trial court, "'sponsor' simply means to assume responsibility for." (Jan. 24, 2006 Op. at 10.) Thus, BCBSM should be considered the "sponsor" of the New Health Plans, because it "takes on the responsibilities for processing claims, paying claims, adjudicating claims, describing benefits, and maintaining the description of benefits." *Id.* This definition, however, is at odds with the common meaning of the term "sponsor" and should not be applied. Review of the Black's Law definition of 'sponsor' shows the following common law definition:

> At common law, a "sponsor" is:
>
> 1. one who acts as a surety for another;
> 2. a legislator who proposes a bill; or
> 3. one who voluntarily intervenes for another without being requested to do so.

Black's Law Dictionary 1410 (7th ed. 1999). BCBSM does not meet the terms of any of these definitions. The second and third clearly describe a different relationship than that between BCBSM and the New Health Plans. The first definition correlates sponsorship with "surety," which means one "who is primarily liable for the payment of another's debt or the performance of another's obligation." *Id.* at 1455. Thus, sponsorship involves both financial and legal responsibility. When applying this definition to the present case, it clarifies more precisely who the sponsor is.

In addition the trial court's definition is overly broad and will lead to illogical ends if employed in future interpretation of the TRUST Network Agreement. There are

just too many individuals who arguably "assume responsibility" for one obligation or another under the New Health Plans. As Appellants correctly indicate in their brief, numerous individuals assume these responsibilities, yet they would not be considered "sponsors" of the plan under any reasonable definition of the term. (Appellants Brief at 18.) For instance, the providers bear significant responsibilities in connection with the submission and processing of claims. The enrollees have responsibility for making co-payments and for providing information necessary for processing claims. *Id.* BCBSM likewise has limited responsibilities in connection with the plan administration. Such a broad definition would suggest that individuals having even a minimal role in administering a plan could be considered a "sponsor."

When a plan is self-insured, it is the employer who has ultimate responsibility for paying all claims and administrative expenses, providing all legally required disclosures, and performing other duties under ERISA. This Court should limit the ambit of "sponsorship" to those who actually have such responsibilities. Here, that is the automakers.

Contractual terms should be construed in a manner that avoids absurd results. Rather, they should be interpreted to effectuate the intent of the parties, with the presumption that neither party intended to impose an unjust or absurd condition on the other. *Knox v Knox*, 337 Mich. 109, 120, 59 N.W.2d 108, 113 (1953); *Port Huron Area Sch. Dist. v. Port Huron Education Ass'n.*, 120 Mich. App. 112, 116, 327 N.E.2d 413, 415 (1982); *Hercules Drawn Steel Corp. v. Doran Elec. Co.*, 64 Mich. App. 117, 121, 235 N.E.2d 82, 85 (1975). In the context of this case, the parties must have intended that "sponsor" would have the meaning ascribed to it by the statute that pervades the

regulation of employee health insurance plans, ERISA.

B. The term "Benefit Plan Description," as used in reference to employee benefit plans, refers to documents issued to participants and beneficiaries to inform them of their rights and benefits under a plan.

In the health insurance industry, including that part of the industry pertaining to employee health insurance, the term "Benefit Plan Description" specifically refers to documents issued primarily for the purpose of informing participants and beneficiaries about their rights and benefits under an employee benefit plan.

One common form of a "Benefit Plan Description" (or "plan description")[3] is the "summary plan description," a document required under ERISA to "apprise the plan's participants and beneficiaries of their rights and obligations under the plan." 29 C.F.R. § 2520.102-2 (2006). The summary plan description is understood to contain all or substantially all of the categories of information required under Section 102(b) of ERISA (29 U.S.C. § 1022(b) (2006)) and the Department of Labor regulations at 29 C.F.R. § 2520.102-3 (2006). Essentially, it is a document provided to the enrollees that describes: (1) the basic plan provisions; (2) the details of the plan's administrative operation; (3) who are the plan administrator and fiduciaries; (4) how to file claims for benefits; (5) what rights are available to the enrollees under ERISA; and (6) how to enforce these rights. 29 C.F.R. § 2520.102-3.

Prior to recent, technical clarifications in the law, plan descriptions were defined as containing the same elements as summary plan descriptions. 29 U.S.C. § 1022(b) (1996) (repealed 1997), attached as Ex. A . In fact, the plan description consisted of the summary plan description. 29 C.F.R. 2520.102-1 (2001) (repealed 2002), attached as Ex.

[3] Under 29 U.S.C. § 1002(3), "benefit plan" and "plan" are synonymous.

B. In practice, though, separate plan descriptions were rarely prepared, and instead, there were only summary plan descriptions serving in their place. *See* Bacon § 3.02[1], *supra*, at 6. The practical effect of both documents had come to be identical, as the information contained in them were largely identical. This redundancy was ultimately confirmed in law, as the term "plan description" was eventually removed from ERISA and the Department of Labor regulations, and in its place was just the "summary plan description." *Compare* Exs. A and B *with* 29 U.S.C. § 1022(b) (current). Nonetheless, the term "plan description" is still commonly used and continues to have the same meaning it did in the past. In fact, it is often used interchangeably with the term summary plan description. *See, e.g., Brewer v. Lincoln Nat'l Life Ins. Co.*, 921 F.2d 150, 153 (8th Cir. 1990) (discussing ERISA's summary plan description requirement, the court stated that insurers are "required to furnish ***plan descriptions*** 'written in a manner calculated to be understood by the average plan participant'" (emphasis added)).

BCBSM, however, argues that summary plan descriptions have a significantly narrower connotation than the more broadly defined term "Benefit Plan Description." According to BCBSM, the "Benefit Plan Description" refers to "***any*** written document, prepared or issued by BCBSM, which describes benefits covered under ***any*** PPO health care plan." (Def.'s Resp. to Pls.' Mot. For Summ. Disposition at 9.) (Emphases added.) BCBSM further states that the term "is so broad that it clearly encompasses all of the documents that are issued by BCBSM which describe covered benefits, exclusions, co-payments, and deductibles." (Appellee Brief at 22.)

This is simply untrue, as the term "Benefit Plan Description" is largely interchangeable with the summary plan description. Certainly, the BCBSM definition of

Benefit Plan Description is at odds with the ERISA definition. Moreover, an overly-broad definition of plan description, as BCBSM espouses, would allow BCBSM to single-handedly expand the covered services under the TRUST Network Agreement simply by preparing "any" written document purporting to describe the benefits provided under one of its plans, regardless of how tangential those documents might be and regardless of the persons to whom those documents might be distributed. Allowing the TRUST Network Agreements to be interpreted in such a manner would not only belie the accepted usage of the term "Benefit Plan Description," it would be unfair and unjust. BCBSM should not be granted such an extraordinary, unilateral privilege.

CONCLUSION AND RELIEF REQUESTED

Amicus Curiae, the American Medical Association, requests that this Court reverse the trial court's February 3, 2006 Order denying Plaintiffs-Appellants' Motion for Summary Disposition and granting summary disposition in favor of Defendant-Appellee. The trial court erroneously interpreted the terms "sponsorship" and "Benefit Plan Description," as employed in the TRUST Network Agreements.

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