STATE OF MICHIGAN

COURT OF APPEALS

MICHIGAN CHIROPRACTIC ASSOCIATION and MICHIGAN CHIROPRACTIC SOCIETY,

Petitioners-Appellees,

v

OFFICE OF FINANCIAL AND INSURANCE SERVICES,

Respondent,

and

BLUE CROSS BLUE SHIELD OF MICHIGAN,

Intervenor-Appellant.

UNPUBLISHED
January 21, 2010

No. 287597
Office of Financial & Insurance Regulation
LC No. 2005-000892

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Before: Bandstra, P.J., and Sawyer and Owens, JJ.

PER CURIAM.

In these consolidated appeals, intervenor Blue Cross Blue Shield of Michigan (BCBSM) and respondent Office of Financial and Insurance Services (OFIS) both appeal by leave granted from an order entered by an independent hearing officer (the IHO) reversing a decision of the Commissioner of Insurance (the commissioner), and remanding the case to the commissioner for further proceedings. The commissioner upheld a reimbursement arrangement, referred to as a "provider class plan," for health services provided by chiropractors for calendar years 2002 and 2003. We reverse the IHO's decision and reinstate the commissioner's decision.

An appeal of a decision by an IHO is governed by § 106 of the Administrative Procedures Act, MCL 24.306, which provides that an administrative decision may be set aside if the substantial rights of the petitioner have been prejudiced because the decision violates the constitution or a statute, is in excess of an agency's statutory authority or jurisdiction, was made upon unlawful procedure resulting in material prejudice, is not supported by competent, material and substantial evidence on the whole record, is arbitrary, capricious, or clearly an abuse or unwarranted exercise of discretion, or is affected by other material and substantial error of law. See *In re 1987-1988 Medical Doctor Provider Class Plan*, 203 Mich App 707, 716; 514 NW2d 471 (1994).

Questions of statutory interpretation are reviewed de novo. *Heinz v Chicago Rd Investment Co*, 216 Mich App 289, 295; 549 NW2d 47 (1996). "If the language of a statute is unambiguous, the Legislature must have intended the meaning clearly expressed, and the statute must be enforced as written." *Sun Valley Foods Co v Ward*, 460 Mich 230, 236; 596 NW2d 119 (1999). Nothing may be read into a statute that is "not within the Legislature's intent as derived from [the] language of the statute." *American Federation of State, Co & Muni Employees v Detroit*, 468 Mich 388, 400; 662 NW2d 695 (2003).

I. IHO's Authority

BCBSM and OFIS first argue that the IHO erred by remanding the case to the commissioner for further proceedings because remand to the commissioner was not an available form of relief. OFIS adds that the IHO erred in reversing the commissioner's decision without having found that the decision was clearly wrong and outside the bounds of reasonableness, and by failing to make detailed findings for BCBSM to use in creating an amended provider class plan. We agree with each of these arguments.

The relief that may be granted by an IHO is governed by MCL 550.1515(3), which provides:

> (3) In an appeal pursuant to this section, the relief available to a person, and the decision of an independent hearing officer hearing an appeal, shall be limited to the following:
>
> (a) Affirming or reversing a determination of the commissioner under sections 509(1) and 510(1).
>
> (b) Determining, based on the information and factors described in section 509(4) and the standards prescribed in section 516, 1 of the following:

(i) That the provider class plan prepared by the corporation under section 511(1) was prepared in compliance with that section and shall be retained as provided in section 506(4).

(ii) That the provider class plan prepared by the commissioner under section 513(2)(a) was prepared in compliance with that section and shall be retained as provided in section 506(4).

(iii) *That a provider class plan* described in subparagraph (i) or (ii) *was not prepared in compliance* with section 511(1) or 513(2)(a), respectively, *and shall not be retained* as provided in section 506(4). *In this case, the hearing officer shall order the corporation to prepare and submit a provider class plan* as provided in subsection (4). Detailed findings must accompany the determination made by the hearing officer pursuant to this subdivision. [Emphasis added.]

Section 515(4) provides that within 180 days after the IHO's decision, the health care corporation (in this case BCBSM) "shall transmit *to the hearing officer* a provider class plan that is *in conformance with the findings of the hearing officer* and that substantially achieves" statutory goals. (Emphasis added.) Further, under § 515(5), the IHO is to review the modified plan and determine whether to retain it. Section 515(5) further provides that if the IHO determines that the modified plan should not be retained, the "commissioner may suspend or limit the corporation's certificate of authority until the corporation submits a provider class plan which the *hearing officer determines* should be retained." (Emphasis added.)

Section 515 clearly and unambiguously limits the relief that may be granted by an IHO to affirming or reversing the commissioner's determination. The IHO was not authorized to remand the case to the commissioner for reconsideration in light of new or additional factors as he did in this case. Further, if an amended class plan must be prepared (as petitioners claim it must), the burden of reviewing the amended plan for statutory compliance falls squarely on the IHO, not the commissioner.[1] Thus, there is no merit to petitioners' argument that an IHO's decision to reverse the commissioner is, in essence, an order of remand.

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[1] Conversely, if no appeal is taken from a commissioner's decision finding deficiencies, the process of amending the provider class plan continues before the commissioner, pursuant to MCL 550.511 and MCL 550.513.

Petitioners note that in *In re 1987-1988 MD PCP*, 203 Mich App at 731, this Court stated that after the IHO determines whether to affirm or reverse the commissioner's decision under § 510(1), "[t]he approval process for provider class plans then continues before the [commissioner]." This statement must be understood in context. If the IHO *affirms* a commissioner's decision to *reject* a plan, the modification process continues before the commissioner under §§ 511 and 513, as if no appeal had been taken. However, as earlier recognized by the Court in *In re 1987-1988 MD PCP*, if the IHO *reverses a commissioner's decision to approve* a provider class plan, the process of amending the plan continues before the IHO. See *id*. at 714-716.

Additionally, the IHO did not find that the provider class plan failed to meet statutory goals set out in MCL 550.1504(1). Rather, the IHO reversed and remanded for reconsideration of various factors. Thus, he did not order BCBSM to prepare an amended plan, or make the detailed findings required by the statute in order to guide BCBSM in the preparation of an amended provider class plan. This Court has held that a commissioner's determination must not be disturbed unless it is so clearly and extremely wrong that it is equivalent, in its degree of error, to a confiscatory or oppressive rate (in the utilities law arena). *In re 1987-1988 MD PCP*, 203 Mich App 729. In this case, the IHO reversed the commissioner without finding the extreme level of error necessary to warrant overturning the commissioner's decision. Instead, he reversed and remanded for reconsideration of factors that, in his opinion, the commissioner "should have considered." As discussed later, the IHO impermissibly substituted his judgment for that of the commissioner.

In sum, the IHO's disposition of this case was not permitted by the Nonprofit Health Care Corporation Reform Act (NHCCRA), MCL 550.1101 *et seq*., in form or in substance. Because the IHO acted outside his authority, and committed material and substantial errors of law, reversal is warranted under MCL 24.306.

II. The Commissioner's Decision

BCBSM and OFIS next argue that the IHO erred by substituting his judgment for that of the commissioner concerning petitioners' claim of discrimination and the 1999 settlement agreement.

On appeal from the commissioner's decision, the IHO was not permitted to make a de novo determination whether BCBSM achieved the access, quality, and cost containment goals set by the NHCCRA. *In re 1987-1988 MD PCP*, 203 Mich App at 725-728. Rather, the Legislature intended that the commissioner be primarily responsible for regulating BCBSM. *Id*. at 727. Balancing the often conflicting goals of the statute requires considerable expertise. *Id*. at 727, 729. Therefore, the commissioner's decision is entitled to deference, and the IHO may not substitute his judgment for that of the commissioner. *Id*. at 727-729.

The statutory goals set by MCL 550.1504 are defined in terms of reasonableness, and the commissioner is granted wide discretion to determine what is reasonable. *Id*. at 728-730. The commissioner's exercise of that discretion must be respected. *Id*. at 729. Therefore, the commissioner's determination that BCBSM sufficiently met its statutory goals could not be disturbed unless it was so clearly and extremely wrong as to be the equivalent, in its degree of error, of a confiscatorily low rate or an oppressively-high rate (in the utility rates arena). *Id.* "On matters of judgment, the [commissioner's] judgment cannot be replaced by that of an IHO." *Id*. at 730. Thus, while the IHO may gather facts to support the commissioner's decision or to show that the facts relied upon by the commissioner were inaccurate or incomplete, the fact-finding process cannot be used to challenge the commissioner's judgment. *Id*. "The Legislature delegated the authority to regulate and supervise nonprofit health care corporations to the [commissioner], not to anyone else." *Id*.

In *In re 1987-1988 MD PCP*, "there was no meaningful dispute about the facts relied upon by the [commissioner] in his lengthy and detailed determination report. *Id*. "What the appeal process produced . . . was testimony about *what those facts meant* with respect to

statutory goals." *Id*. (emphasis added). This Court observed that "[t]here can be as many opinions on this subject as there are persons who think about it." *Id*. The Court stated that while others may disagree with the commissioner's judgment, standards, and conclusions, "only the opinion or judgment of the [commissioner] matters." *Id*.

On appeal, this Court may examine the commissioner's determination report and the record (if any) developed before the IHO to determine whether to remand the case to the IHO for further proceedings, or to simply affirm the commissioner's decision. *Id*. at 730-731. Where this Court finds that the commissioner's "determination was based upon facts and standards that are not beyond the wide range of reasonableness within which the [commissioner] proceeded," and was "within the range of reasonable discretion afforded" to the commissioner, it must be reinstated and remand is unnecessary. *Id*.

A. Anti-Discrimination Provisions

On appeal, BCBSM and OFIS argue that the IHO erred in finding that statutory anti-discrimination provisions were applicable in this case, and in substituting his judgment for that of the commissioner. We agree.

Before the IHO, petitioners claimed that the commissioner erred by not considering the effect of BCBSM's discriminatory treatment of chiropractors on whether the plan achieved its statutory access and cost containment goals. Petitioners argue that provider class discrimination is prohibited by health care legislation and must be considered. Further, the statute defining the scope of a chiropractor's license is also health care legislation that must be considered. Petitioners argue that BCBSM's discriminatory reimbursement practices reduce consumer access to services that chiropractors could provide, but are not being reimbursed for. Petitioners further argue that there is a possibility that BCBSM may have met its statutory cost containment goal due to the savings resulting from its unlawful discrimination against chiropractors.

MCL 550.1502(1) provides that BCBSM "may enter into participating contracts for reimbursement with professional health care providers practicing legally in this state . . . for health care services that the professional health care providers . . . may legally perform." "A participating contract may cover all members [i.e., subscribers][2] or may be a separate and individual contract on a per claim basis." *Id*. Section 502 further provides:

> (3) *A health care corporation shall not restrict the methods of diagnosis or treatment of professional health care providers who treat members*. Except as otherwise provided in section 502a, each member of the health care corporation shall at all times have a choice of professional health care providers. *This subsection does not apply* to limitations in benefits contained in certificates, *to the reimbursement provisions of a provider contract or reimbursement arrangement*, or to standards set by the corporation for all contracting providers. A health care corporation may refuse to reimburse a health care provider for health care services

[2] See MCL 550.1106(3).

> that are overutilized, including those services rendered, ordered, or prescribed to an extent that is greater than reasonably necessary. [Emphasis added.]

It is this subsection, protecting patient choice, upon which petitioners base their discrimination claim.

Petitioners correctly note that MCL 550.1509(4)(d) requires that, in determining whether a provider class plan complies with statutory goals, the commissioner "shall consider . . . [h]ealth care legislation," including § 502. However, MCL 550.1502(3) clearly and unambiguously states that it "does not apply . . . to the reimbursement provisions of a provider contract or reimbursement arrangement." MCL 550.1107(8) defines a "provider contract" as "an agreement between a provider and a health care corporation that contains provisions *to implement the provider class plan*." (Emphasis added.) Similarly, MCL 550.1108(1) defines a "reimbursement arrangement" as "policies, practices, and methods by which a health care corporation makes payments to a provider *to implement the provider class plan*." (Emphasis added.) Lastly, MCL 550.1107(7) defines a "provider class plan" as "a document *containing a reimbursement arrangement* and objectives for a provider class, and, in the case of those providers with which a health care corporation contracts, provisions that are included in that contract." (Emphasis added.) Thus, it is evident that the reimbursement provisions of the provider class plan at issue in this case are expressly exempted from § 502(3).[3] Contrary to petitioners' argument, BCBSM's disparate treatment of chiropractors in the reimbursement provisions of the provider class plan is not unlawful.

This Court has recognized that "[t]o a great extent, the third sentence of § 502(3) takes away what the first purports to grant and commits the scope of defendant's coverage obligations to the hands of the contracting parties." *Cowan v Blue Cross & Blue Shield of Michigan*, 166 Mich App 568, 571; 421 NW2d 243 (1988). "This language evidences a legislative intention to commit the scope of covered therapeutic services to the contracting parties, at the expense of both the doctor-patient relationship and the patient's freedom of choice." *Id*. at 571-572. While this may seem unfair, courts may not inquire into the wisdom of legislative policy choices; arguments that a statute is unwise or results in bad policy must be addressed to the Legislature. *Oakland Co Bd of Co Rd Comm'rs v Michigan Prop & Cas Guaranty Ass'n*, 456 Mich 590, 613; 575 NW2d 751 (1998); see also *Cowan*, 166 Mich App at 573.

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[3] Below, petitioners conceded that the anti-discrimination provision contained in MCL 550.1502a(11), cited by the IHO, governs only prudent purchaser agreements and, therefore, does not apply to this case. Nonetheless, petitioners continue to rely on the commissioner's so-called "*Healthy Blue*" decision, *Michigan Chiropractic Society v Blue Cross Blue Shield of Michigan*, unpublished opinion of the Insurance Commissioner, issued July 5, 2007 (No. 2005-399), which holds that BCBSM cannot discriminate against chiropractors in its PPO certificate. However, the *Healthy Blue* decision is based on § 502(3), which, as previously indicated, does not apply to reimbursement provisions, and on § 502a(11), which applies solely to prudent purchaser agreements. The decision also relies on MCL 550.1607(3), which allows the commissioner to disapprove *certificates* that are unjust, unfair, or inequitable, and again, does not govern reimbursement provisions contained in a provider class plan. Therefore, the *Healthy Blue* decision is inapposite.

We recognize that, unlike *Cowan*, the present case involves BCBSM traditional health care coverage, not an HMO, and the offending exclusion is not found in the insurance certificate. Nonetheless, because the exclusion is found in the reimbursement provisions of the provider class plan, it is outside the scope of the statutory patient choice provision. Thus, the *Cowan* Court's analysis is appropriate. Under the clear and unambiguous language of the statute, BCBSM's disparate treatment of chiropractors in its provider class plan is not unlawful.

Petitioners note that the attorney general has interpreted § 502(3) as "requir[ing] BCBSM to provide payment for covered health services rendered by any health care provider licensed to perform those services." OAG 1994, No 6809, p 2 (June 30, 1994); see also OAG 1989-1990, No 6621, p 3 (July 13, 1989); OAG 1989-1990, No 6567, pp 2-3 (February 1, 1989); OAG 1985-1986, No 6410, pp 1-2 (December 22, 1986). The attorney general concluded that BCBSM "may not restrict its payment for covered health care services to certain classes of health care providers where other provider classes are authorized under their licensing statutes to perform the same services." *Id*. However, relying on *Cowan*, the Attorney General has recognized that the patient choice rights granted by § 502(3) are inapplicable to reimbursement provisions. OAG 1989-1990, No 6621, p 3.

Attorney General opinions are not binding on this Court, but they can be persuasive authority. *Risk v Lincoln Charter Twp Bd of Trustees*, 279 Mich App 389, 398-399; 760 NW2d 510 (2008). We conclude that the cited opinions are not persuasive because only one addresses the limitations expressed in the third sentence of § 502(3), and none indicate whether the offending limitations were contained within the reimbursement provisions of a provider class plan. Ultimately, this Court must enforce the statute as written, and questions concerning the wisdom of legislative policy choices must be addressed to the Legislature. *Oakland Co Bd of Co Rd Comm'rs*, 456 Mich at 613.

The OFIS determination report adopted by the commissioner discusses BCBSM's failure to reimburse chiropractors for services that they are licensed to perform, while reimbursing other classes of providers for the same services. Thus, it is evident that the determination report accepts as true petitioners' premise that the various disputed services are within the scope of a chiropractor's license. Moreover, while § 502(3) is not specifically mentioned, it is also evident that the commissioner considered petitioners' discrimination claim.

In his opinion and order, the IHO summarized OFIS's determination report. The IHO thus recognized that the discrimination and scope of license issues were addressed in the determination report. The IHO agreed that, given the undisputedly high participation rates of chiropractors in the provider class plan, "the Commissioner's determination that BCBSM had met its goal of reasonable access to care was within the 'wide range of reasonableness' accorded to her discretion." Nonetheless, the IHO found:

> However, the Commissioner did not consider or address whether BCBSM's exclusion of an entire class of providers from reimbursement for certain services affected subscribers' access to those services.
>
> The Act is clear that it requires BCBSM to assure reasonable access to "certificate-covered services." While there is no requirement in the Act that BCBSM cover every service a given provider is licensed to provide, it is difficult

> to affirm this decision on "access" which does not take into consideration reimbursement for services to one class of health care provider, and denial of the same for the same services to another class of providers. This is not a question of the IHO deciding what is or is not fair to the competing classes of health care providers. It is a question of affirming or rejecting the conclusion that the plan in question assures to subscribers reasonable access, reasonable cost and reasonable quality of care from the provider class under circumstances that appear to be discriminatory and prohibited by Section 502a(11) of Act 350, MCL 550.1502(3), and Section 3(7) of the Preferred Provider Act, MCL 550.53(7).

With regard to whether the commissioner erred in finding that BCBSM met its cost containment goal, the IHO found no error in the commissioner's growth and inflation analysis. He nonetheless added:

> However, because this matter is being sent back, the issue of the effect of the impact of BCBS's discriminatory policy on the stated cost objective should be revisited. Depending how close the numbers are it may be that the issue of the use of GDP or GNP will have to be revisited by the Commissioner.

The IHO concluded that the commissioner "should have considered the question of whether the discriminatory treatment . . . affected the cost, quality or access" goals for the chiropractor provider class plan. Therefore, the IHO "remanded [the case] for further proceedings not inconsistent with the statute."

We believe that the IHO erred as a matter of law because, as discussed previously, § 502(3) does not apply to the reimbursement arrangements contained in a provider class plan. The IHO recognized that the effect of BCBSM's disparate treatment of chiropractors upon the access and cost containment goals was in fact addressed by the commissioner in the determination report. However, the IHO disagreed with the commissioner's resolution of these issues and agreed with petitioners that these questions merited further consideration and analysis. In doing so, the IHO unlawfully substituted his judgment for that of the commissioner concerning the meaning and import of undisputed facts and thereby exceeded his authority.

B. 1999 Settlement Agreement

BCBSM and OFIS also both argue that the IHO erred in finding that the commissioner was required to consider the 1999 settlement agreement and in substituting his judgment for that of the commissioner on this issue. We again agree.

In their appeal to the IHO, petitioners argued that the commissioner erred by not considering the 1999 settlement agreement, which they claimed was a judicial action that affected the goals of access and cost containment and, therefore, should have been considered.

Petitioners note that MCL 550.1509(4)(c) requires that, in determining whether a provider class plan meets statutory goals, the commissioner "shall consider . . . [i]nformation submitted or obtained for the record concerning . . . administrative agency or judicial actions." Petitioners have not provided any authority in support of their argument that a settlement agreement is a judicial action. It is well-settled that "[a]n agreement to settle a pending lawsuit is a contract and is to be governed by the legal principles applicable to the construction and

interpretation of contracts." *Reagan v Ford Motor Co*, 207 Mich App 566, 571; 525 NW2d 489 (1994). To be enforceable, a settlement agreement must not only satisfy contract principles, but it must either be made in open court, or it must be in writing and signed by the party to be charged. *Kloian v Domino's Pizza, LLC*, 273 Mich App 449, 456; 733 NW2d 766 (2006). An unambiguous settlement contract will be enforced according to its own terms. *Id*. at 461. Thus, a settlement agreement is a contract, not a judicial action.

Nonetheless, the commissioner considered the 1999 settlement agreement, which was discussed in the OFIS determination report. In his opinion and order, the IHO recognized that the issue was discussed.

As noted previously, with regard to the statutory cost-containment goal, the IHO found no error in the commissioner's growth and inflation analysis. The IHO nonetheless remanded the issue to the commissioner for reconsideration. The IHO concluded that the commissioner "should have considered the question of whether . . . the 1999 Agreement affected the cost, quality or access" goals for the chiropractor provider class plan. He remanded the matter to the commissioner "for further proceedings not inconsistent with the statute." *Id*.

It is apparent that the IHO disagreed with the commissioner's resolution of the parties' arguments concerning the meaning and import of the 1999 settlement agreement. In particular, the IHO rejected the commissioner's determination that the provider class plan review process was not the appropriate forum to resolve disputes concerning the meaning and enforcement of the agreement. Instead, the IHO determined that, as urged by petitioners, the issue merited further consideration and analysis by the commissioner. In doing so, the IHO substituted his judgment for that of the commissioner and thereby exceeded his authority.

In sum, we conclude that the IHO reversed the commissioner's decision without finding the extreme level of error necessary to warrant overturning the decision and that he acted outside the scope of his authority by remanding the case for reconsideration. The commissioner's decision was based on facts and standards that are not beyond the wide range of reasonableness granted by the statute. The commissioner properly considered applicable health care laws, as well as the 1999 settlement agreement, and the IHO impermissibly substituted his judgment for that of the commissioner.

Accordingly, we reverse the IHO's decision and reinstate the decision of the commissioner.

/s/ David H. Sawyer
/s/ Donald S. Owens