

STATE OF MICHIGAN
COURT OF APPEALS

HILLSDALE COMMUNITY HEALTH
CENTER,

Plaintiff-Appellee,

v

PIONEER STATE MUTUAL INSURANCE
COMPANY,

Defendant-Appellee,

and

EMPIRE BLUE CROSS BLUE SHIELD,

Defendant-Appellant.

UNPUBLISHED
September 8, 2009

No. 285681
Hillsdale Circuit Court
LC No. 07-000311-NF

HILLSDALE COMMUNITY HEALTH
CENTER,

Plaintiff-Appellee,

v

PIONEER STATE MUTUAL INSURANCE
COMPANY,

Defendant-Appellee,

and

EMPIRE BLUE CROSS BLUE SHIELD,

Defendant-Appellant.

No. 287126
Hillsdale Circuit Court
LC No. 07-000311-NF

Before: Jansen, P.J., and Hoekstra and Markey, JJ.

PER CURIAM.

In Docket No. 285681, defendant Empire Blue Cross Blue Shield (Empire) appeals as of right the trial court's order denying its motion for summary disposition and granting the summary disposition motion of plaintiff Hillsdale Community Health Center (HCHC). In Docket No. 287126, Empire appeals as of right the trial court's order granting HCHC's motion for attorney fees. We affirm.

I. Basic Facts and Procedural History

On August 14, 2005, Makenzie Wirick, then 16 years old, was injured in an automobile accident. Wirick's mother, Laura Charland, had a no-fault automobile insurance policy with defendant Pioneer State Mutual Insurance Company (Pioneer). Because Wirick was a permissive user of the insured automobile, Wirick was entitled to no-fault benefits under the policy. In addition, Wirick was a dependent beneficiary of an ERISA¹-qualified employee health benefit plan. The plan, the Pepsi Bottling Group Self Insured National PPO Plan (the PBG Plan or the Plan), was issued by Wirick's father's employer, the Pepsi Cola Bottling Company, and administered by Empire.

After the automobile accident, Wirick received inpatient treatment at Borgess Medical Center (Borgess), St. Mary's Health Services (St. Mary's), and Mary Free Bed Rehabilitation Hospital (Mary Free Bed). She was discharged on December 9, 2005. Then, from December 19, 2005, through March 2007, Wirick received physical and outpatient therapy² from HCHC.

In a separate lawsuit, Borgess, St. Mary's, and Mary Free Bed sued Empire and Pioneer for payment of services rendered to Wirick (*Wirick I*). The three health care providers sought "a determination of priority," as both Pioneer and Empire claimed that the other had primary coverage. *Wirick I* ended with a June 2007 order from the trial court declaring that Empire had primary coverage.

HCHC also sued Empire and Pioneer for payment of services rendered to Wirick. In its complaint, HCHC alleged that Empire's refusal to pay for the services was unreasonable and was a breach of the Uniform Trade Practices Act, MCL 500.2001 et seq. HCHC also alleged claims of breach of contract and equitable subrogation.

Empire moved for summary disposition. In its motion, Empire asserted that although it had "authorized payment of certain medical expenses," "it subsequently denied coverage of some of the medical services" that HCHC provided to Wirick. Specifically, Empire claimed that, in accordance with the PBG Plan, it had "paid for at least 20 physical therapy visits, and paid for at least 10 outpatient therapy visits" in calendar years 2006 and 2007, but it had denied payment for subsequent therapy visits in each calendar year because Wirick had not obtained

¹ Employee Retirement Income Security Act, 29 USC 1001 et seq.

² The outpatient therapy included speech and occupational therapy.

precertification as required by the Plan. Empire made three arguments in its motion for summary disposition. First, Empire argued that HCHC's state law claims were preempted by ERISA. Second, recognizing that the extraordinary preemptive force of ERISA converts a state law claim into a federal claim, Empire argued that HCHC lacked standing to assert an ERISA claim because HCHC had not received an assignment of benefits from Wirick. Third, Empire argued that even if HCHC had standing to sue, its decisions to deny payment for the services must be affirmed (1) because the decisions were not arbitrary and capricious due to the fact that Wirick had not obtained precertification and (2) because Wirick had failed to exhaust the administrative remedies set forth in the PBG Plan.

HCHC cross-moved for summary disposition under MCR 2.116(C)(10) and (I)(2). HCHC claimed that Empire's ERISA arguments were "variously irrelevant and erroneous." And the trial court agreed. It stated that Empire's "whole defense" was a "defense of smoke and mirrors in order not to . . . pay what they had an obligation to pay. Their acts [were] totally arbitrary, capricious, reprehensible, unconscionable." Judgment was entered against Empire and Pioneer.

Approximately a month later, HCHC filed a satisfaction of judgment, acknowledging that the judgment had been satisfied by Pioneer. Because Empire had previously been determined to have primary coverage, Pioneer then filed a motion to recoup against Empire. The trial court refused to rule on the motion because Empire had already filed its claim of appeal, but informed the parties that its position was that "Empire owes" Pioneer and that was implied in the final judgment.

II. Docket No. 285681

Empire asserts that the trial court erred in multiple respects when it denied its motion for summary disposition and granted summary disposition to HCHC. First, Empire argues that the trial court erred in determining that HCHC had standing to sue under ERISA. Second, Empire claims that the trial court erred in concluding that its denials of the claims for payment were arbitrary and capricious. Third, Empire claims that the trial court erred in determining that exhaustion of the administrative remedies would have been futile.³

A. Mootness

Before addressing Empire's arguments, we first address HCHC's claim that Empire's appeal is moot. HCHC argues that because Pioneer satisfied the judgment, and thereby discharged any liability Empire may have to HCHC, Empire has suffered no harm for which this

³ Empire also claims that the trial court erred in denying its motion for summary disposition because HCHC never pleaded an ERISA claim. However, Empire did not brief the merits of this alleged error. "It is axiomatic that where a party fails to brief the merits of an allegation of error, the issue is deemed abandoned by this Court." *Prince v MacDonald*, 237 Mich App 186, 197; 602 NW2d 834 (1999). Accordingly, Empire has abandoned the issue.

Court can craft a remedy. For the same reason, HCHC asserts that Empire does not have appellate standing because it is no longer an “aggrieved party” under MCR 7.203(A).

In arguing that Empire’s appeal is moot, HCHC relies on *Horowitz v Rott*, 235 Mich 369, 370; 209 NW 131 (1926), in which our Supreme Court was “confronted with the question whether [it] may review a judgment which has been satisfied and no longer exists.” The Court concluded that “[w]hen the judgment was rendered, two courses were open to defendant. He could satisfy the judgment or review it in this court; he could not do both. He chose by his voluntary act to satisfy it. When the judgment was satisfied, the case was at an end.” *Id.* at 372. See also *Becker v Halliday*, 218 Mich App 576, 578; 554 NW2d 67 (1996) (“The general rule states that a satisfaction of judgment is the end of proceedings and bars any further effort to alter or amend the final judgment.”).

Here, Empire did not satisfy the judgment; rather, it was Pioneer who voluntarily satisfied the judgment. Empire chose to appeal the judgment. Thus, as to Empire, the judgment was involuntarily satisfied. An involuntary satisfaction of a judgment does not render an appeal moot. *Kusmierz v Schmitt*, 268 Mich App 731, 740 n 3; 708 NW2d 151 (2005), reversed in part on other grounds 477 Mich 934 (2006). Accordingly, Pioneer’s satisfaction of the judgment does not render Empire’s appeal moot.

Empire also remains an aggrieved party. To have appellate standing, the party filing the appeal must be an “aggrieved party.” MCR 7.203(A); *Manuel v Gill*, 481 Mich 637, 643; 753 NW2d 48 (2008). “To be aggrieved, one must have some interest of a pecuniary nature in the outcome of the case, and not a mere possibility arising from some unknown and future contingency.” *Federated Ins Co v Oakland Co Rd Comm*, 475 Mich 286, 291; 715 NW2d 846 (2006) (quotation omitted). “A party who could not benefit from a change in the judgment has no appealable interest.” *Manuel, supra* at 644 (quotations omitted). After Pioneer satisfied the judgment, it attempted to recoup from Empire the benefits that Empire as the primary insurer was contractually obligated to pay. According to the trial court’s statements at the hearing on Pioneer’s motion to recoup, Empire is obligated to reimburse Pioneer. However, if the judgment is reversed as to Empire, Empire would no longer be subject to a recoupment action by Pioneer. Therefore, Empire could benefit from a change in the judgment, and it is an aggrieved party. *Id.*

B. Standing

Empire argues that HCHC does not have standing to sue because HCHC did not obtain an assignment of benefits from Wirick until after the complaint was filed. Whether a party has standing is a question of law that is reviewed de novo. *Michigan Citizens for Water Conservation v Nestlé Waters North America, Inc*, 479 Mich 280, 291; 737 NW2d 447 (2007).

ERISA authorizes a “participant” or a “beneficiary” of an employee health benefit plan to bring a civil action “to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan[.]” 29 USC 1132(a)(1)(B). A health care provider has standing to sue as a “beneficiary” if it has received an assignment of benefits from a plan beneficiary. *Cromwell v Equicor-Equitable HCA Corp*, 944 F2d 1272, 1277 (CA 6, 1991); *Hermann Hosp v MEBA Medical & Benefits Plan*, 845 F2d 1286, 1289-1290 (CA 5, 1988).

In their briefs on appeal, Empire and HCHC focus almost exclusively on whether the assignment of benefits that HCHC obtained from Wirick after it filed the complaint was sufficient to confer standing to HCHC. Empire argues that standing in an ERISA action, which it claims is a jurisdictional issue, must be determined at the time the complaint is filed. Therefore, according to Empire, the assignment that HCHC obtained from Wirick after it filed the complaint was insufficient to confer standing to HCHC. HCHC claims that the assignment was sufficient to confer standing because it is the real party in interest and because the assignment was obtained before trial. We need not address these specific arguments because we believe that the assignment HCHC obtained when Wirick was admitted for treatment, an assignment which the parties only address in passing, was sufficient to confer standing to HCHC.

The assignment that HCHC obtained when Wirick was admitted for treatment provides in pertinent part:

1. If I, or the patient for whom I am signing, have insurance through Michigan Blue Cross/Blue Shield, Medicare, Medicaid or any other third party, or automobile no-fault carrier, I agree to the following terms:

* * *

- c. *I assign to HCHC all rights to benefits, insurance proceeds, settlement payments or judgments to which I may be entitled for the services rendered to me by HCHC or any physicians or other persons employed by HCHC. I also give HCHC the right to intervene in any lawsuit or other action brought to me, or on my behalf, to collect amounts due to HCHC for services rendered to me. [Emphasis added.]*

The first sentence of paragraph 1(c) is clearly an assignment of benefits to HCHC for the benefits that Wirick was entitled to receive under the PBG Plan. The sentence assigns to HCHC all rights to benefits and insurance proceeds to which Wirick is entitled for the services rendered by HCHC. Accordingly, HCHC, at the time it filed the complaint, had a valid assignment of benefits from Wirick. HCHC had standing to bring this ERISA action. *Cromwell, supra*.⁴

C. Denial of the Claims

Empire claims that the trial court erred in determining that its decisions to deny HCHC's claims for payment were arbitrary and capricious. Accordingly to Empire, the denials were rational because the PBG Plan unambiguously required precertification for physical therapy after the 20th visit and for outpatient therapy after the tenth visit and it was undisputed that Wirick did not obtain precertification in the manner required by the Plan.

⁴ We acknowledge that the assignment HCHC obtained when Wirick was admitted for treatment was signed by Charland. However, Empire makes no argument that a parent does not have authority to assign the rights of his or her child.

A denial of benefits under 29 USC 1132(a)(1)(B) is reviewed de novo by the trial court and an appellate court, unless the benefit plan gives the plan administrator discretionary authority to determine eligibility for benefits or to construe the terms of the plan. *Firestone Tire & Rubber Co v Bruch*, 489 US 101, 115; 109 S Ct 948; 103 L Ed 2d 80 (1989); *Bennett v Kemper Nat'l Services, Inc*, 514 F3d 547, 552 (CA 6, 2008). If the benefit plan has given the administrator discretionary authority, the administrator's decision will be reversed only if it was arbitrary and capricious. *Bennett, supra* at 522. Under this standard, an administrator's decision will be upheld if it is the result of a deliberate and principled reasoning process. *Id.* A decision is not arbitrary and capricious if it was rational in light of the benefit plan's provisions. *Jones v Metro Life Ins Co*, 385 F3d 654, 661 (CA 6, 2004). A review of a plan administrator's decision to deny benefits is limited to the administrative record. *Miller v United Welfare Fund*, 72 F3d 1066, 1071 (CA 2, 1995).

HCHC does not dispute that the PBG Plan has given Empire, the administrator of the Plan, discretionary authority to determine eligibility for benefits or to construe the terms of the Plan. Accordingly, we review Empire's denials of the claims for payment under the arbitrary and capricious standard.⁵

The PBG Plan contained the following precertification provision:

Some covered services require precertification in order for you to receive the highest level of coverage allowed by your medical option. Although you or a family member can call SHPS for precertification, your doctor will be able to provide the most complete clinical information needed to review the recommended procedure. Requests for precertification must be made at least two weeks before any non-emergency service, or within 48 hours after an emergency service. SHPS will let you know if the service has been certified, and if applicable, for how long.

* * *

Be sure to get precertification for the following services:

* * *

⁵ We reject HCHC's contention that we should review Empire's denials de novo. First, a conflict of interest, such as where the same party funds the benefit plan and evaluates the claims, does not change the standard of review; rather, it is a factor to be weighed in determining whether there was an abuse of discretion. *Metro Life Ins Co v Glenn*, 554 US __; 128 S Ct 2343, 2350; 171 L Ed 2d 299 (2008). Second, 29 CFR 2560.503-1(h)(3)(ii), (iii), the federal regulations on which HCHC relies to argue that Empire was required to give its claims a "fresh look" are not applicable to the present case. The regulations state the procedures a benefit plan must provide to a claimant for a review of a denial of benefits. Wirick did not seek a review of Empire's denials through the procedures set forth in the PBG Plan.

- Outpatient therapy (such as occupational therapy, speech therapy, and vision therapy) after the 10th visit[.]
- Physical therapy after the 20th visit[.]

In addition, when explaining the limits of coverage for physical therapy, the PBG Plan stated that “[p]recertification and a review for medical necessity are required after the 20th visit.” The Plan contained a similar statement when explaining the coverage limits for outpatient therapy: “Precertification and a review for medical necessity are required after the 10th visit.” Thus, as claimed by Empire, the PBG Plan unambiguously set forth the precertification requirement. Also, as claimed by Empire, the administrative record shows that Wirick did not obtain precertification from SHPS. Focusing exclusively on the precertification requirement and the undisputed fact that Wirick did not obtain precertification in the manner required by the Plan, Empire argues that its denials of the claims were not arbitrary and capricious. However, Empire’s myopic reliance on Wirick’s failure to obtain precertification fails to acknowledge and account for the other facts and circumstances established by the administrative record.

In addition to establishing that Wirick did not obtain precertification, the administrative record establishes that at the same time Empire was arguing in *Wirick I* that Pioneer had primary coverage, Empire’s employees were acknowledging in internal memos that primary coverage rested with Empire. For example, in a June 15, 2006 internal memo, an Empire employee wrote, “WE ARE PRIMARY,” and in a June 19, 2006 memo, an Empire employee wrote, “SINCE HE [sic] HAS COODINATED MEDICAL INS WE ARE PRIMARY FOR HIM [sic].” The administrative record further establishes that Empire offered a myriad of reasons for denying the claims for payment for Wirick’s physical and outpatient therapy. According to the Explanations of Benefits (EOBs) that it sent to Wirick, Empire denied some claims because “medical necessity has not been provided,” but it denied other claims because the “patient is not covered under your policy,” the “policy ended prior to the time care was provided,” or the “auto insurance carrier is primary for any treatment due to an auto accident.” Also, according to the forms sent to HCHC, the claims were denied either because the service rendered was “not a benefit” or because Wirick was “not a member.” Further, even though Empire claims that, as required by the terms of the PBG Plan, it paid the claims it received for Wirick’s first 20 physical therapy visits and first ten occupational therapy visits for each calendar year, Empire has not presented any evidence which details the payments it asserts that it made. Under these circumstances, it cannot be said that Empire’s denials of the claims for benefits were the result of a deliberate and principled reasoning process. *Bennett, supra*. Rather, we are persuaded that Empire’s denials of the claims were done with a willful and deliberate intent of avoiding its contractual obligation, regardless of whether the claims were meritorious under the Plan’s provisions. No other conclusion can be entertained when Empire fought priority, even though its internal memos show that its employees knew that Empire had primary coverage, it used a shotgun approach to deny the claims and the majority of the reasons for the denials were completely without merit,⁶ and

⁶ In *Wirick I*, Empire was declared to be the primary insurer, and Empire has never asserted in this litigation or in *Wirick I* that Wirick was not a covered beneficiary of the PBG Plan, that the PBG Plan had ended before March 2007, or that the therapy provided by HCHC was not a
(continued...)

Empire has not established that, in fact, it paid the claims for the therapy sessions for which precertification was not required. Accordingly, the trial court did not err in concluding that Empire's denials of the claims were arbitrary and capricious.

D. Administrative Appeals

For essentially the same reasons, we reject Empire's claim that the trial court erred in denying its motion for summary disposition because HCHC failed to exhaust the administrative remedies set forth in the PBG Plan. "The application of the administrative exhaustion requirement in an ERISA case is committed to the sound discretion of the district court and thus can be disturbed on appeal only if there has been an abuse of discretion." *Fallick v Nationwide Mut Ins Co*, 162 F3d 410, 418 (CA 6, 1998).

The PBG Plan contained an administrative appeal procedure, which involved two levels: (1) the claimant must submit a "first level appeal" within 180 days after receiving a claim denial; and (2) if the first level appeal is denied, the claimant must submit "a second level appeal" within 60 days of receiving the decision on the first level appeal. It is undisputed that neither Wirick nor HCHC sought an administrative appeal.

ERISA does not contain a requirement for exhaustion of administrative remedies. *Fallick, supra* at 418. However, because ERISA does require that a benefit plan provide an administrative appeal process, see 29 USC 1133, the federal courts have read into ERISA a requirement to exhaust administrative remedies. *Fallick, supra* at 418; *Miller v Metro Life Ins Co*, 925 F2d 979, 986 (CA 6, 1991). However, "a court is obliged to exercise its discretion to excuse nonexhaustion where resorting to the plan's administrative procedure would simply be futile or the remedy inadequate." *Fallick, supra* at 419. "The standard for adjudging the futility of resorting to the administrative remedies provided by a plan is whether a clear and positive indication of futility can be made. A plaintiff must show that it is certain that his claim will be denied on appeal, not merely that he doubts that an appeal will result in a different decision." *Id.* (internal citations and quotation omitted).

The trial court did not abuse its discretion in determining that exhaustion of the administrative appeal process would have been futile. Empire's decision to litigate whether it was the primary insurer in *Wirick I* despite its employees' knowledge that it was the primary insurer, along with its shifting reasons for denying the claims for payment and its failure to demonstrate that it paid the claims for the therapy sessions for which precertification was not required, establishes that any appeal through the administrative process would have been futile.

III. Docket No. 287126

Empire claims that the trial court erred in granting attorney fees to HCHC. We disagree. A trial court's award of attorney fees under 29 USC 1132(g)(1) is reviewed for an abuse of discretion. *Gaeth v Hartford Life Ins Co*, 538 F3d 524, 528 (CA 6, 2008). "An abuse of discretion exists only when the court has the definite and firm conviction that the district court

(...continued)

covered benefit.

made a clear error of judgment in its conclusion upon weighing relevant factors.” *Id.* at 528-529 (quotation and alteration omitted). We review de novo questions of law that affect the determination of an award of attorney fees. *Hines v Volkswagen of America, Inc*, 265 Mich App 432, 438; 695 NW2d 84 (2005).

A

Empire claims that the trial court erred as a matter of law in granting attorney fees to HCHC because ERISA does not authorize an award of attorney fees to a health care provider. Empire also claims that HCHC was not entitled to attorney fees as a matter of law because HCHC only alleged state causes of action in its complaint.

ERISA authorizes awards of attorney fees. 29 USC 1132(g)(1) provides: “In any action under this title (other than an action described in paragraph 2) by a participant, beneficiary, or fiduciary, the court in its discretion may allow a reasonable attorney’s fee and costs of action to either party.”

Empire did not argue below that HCHC was not entitled to an award of attorney fees because it was a health care provider. Accordingly, we are not obligated to consider the issue. *Michigan Ed Ass’n v Secretary of State*, 280 Mich App 477, 488; 761 NW2d 234 (2008). Regardless, because HCHC, as the assignee of Wirick’s claims, possesses the same rights as Wirick, *Burkhardt v Bailey*, 260 Mich App 636, 652-653; 680 NW2d 453 (2004), HCHC may recover attorney fees.

A state law claim that falls under ERISA’s civil enforcement provision, 29 USC 1132, is subject to “complete preemption.” *Roddy v Grand Truck Western R Inc*, 395 F3d 318, 323 (CA 6, 2005); see also *Metro Life Ins Co v Taylor*, 481 US 58, 63-67; 107 S Ct 1542; 95 L Ed 2d 55 (1987). That is, the preemptive force of ERISA is so extraordinary that the state law claim is considered, from its inception, a federal cause of action. *Roddy, supra* at 323; *Huisjack v Medco Health Solutions, Inc*, 492 F Supp 2d 839, 849 (SD Ohio, 2007). Because HCHC’s state law claims are considered federal causes of action under ERISA, the present case is properly considered “an[] action under” ERISA. 29 USC 1132(g)(1).⁷ The trial court did not err as a matter of law in awarding attorney fees to HCHC.

B

Empire also asserts that, based on the relevant factors to be considered in determining whether a party is entitled to attorney fees under 29 USC 1132(g)(1) the trial court abused its discretion in awarding attorney fees to HCHC. In deciding whether an award of attorney fees is appropriate under 29 USC 1132(g)(1), a court is to consider five factors:

⁷ The case relied upon by Empire, *Davis v Chicago Muni Employees Credit Union*, 891 F2d 182 (CA 7, 1989) is distinguishable. In *Davis*, the state law claim was not preempted by ERISA and it only bore a “tangential vinculum” to the policy behind ERISA.

(1) the degree of the opposing party's culpability or bad faith; (2) the opposing party's ability to satisfy an award of attorney's fees; (3) the deterrent effect of an award on other persons under similar circumstances; (4) whether the party requesting fees sought to confer a common benefit on all participants and beneficiaries of an ERISA plan or resolve significant legal questions regarding ERISA; and (5) the relative merits of the parties' positions. [*Secretary of Dep't of Labor v King*, 775 F2d 666, 669 (CA 6, 1985).]

Empire concedes that it has the ability to pay an award of attorney fees, and HCHC admits that it is not seeking to confer a benefit on participants or beneficiaries of the PBG Plan or to resolve significant legal questions regarding ERISA. We also do not believe that an award of attorney fees in the present case will have a deterrent effect "on other persons." However, under the circumstances of the present case, we agree with the trial court that Empire "clearly acted in bad faith." Based on Empire's bad faith and the resolution on the merits of its denials of the claims in favor of HCHC, we conclude that the trial court did not abuse its discretion in awarding attorney fees to HCHC.

Affirmed.

/s/ Kathleen Jansen
/s/ Joel P. Hoekstra
/s/ Jane E. Markey