STATE OF MICHIGAN

IN THE SUPREME COURT

(ON APPEAL FROM THE MICHIGAN COURT OF APPEALS)

MACOMB COUNTY, MACOMB COUNTY ROAD COMMISSION, & 16TH JUDICIAL CIRCUIT COURT,	Sup Ct No. 144303
Respondents-Appellants,	Ct of App No. 296416
v	MERC L/C Nos. C07-D-083 C07-D-086 C07-D-087 C07-E-115
AFSCME COUNCIL 25 AND ITS AFFILIATED LOCALS 411 AND 893; INTERNATIONAL UNION, UAW AND ITS LOCALS 412 AND 889; and MICHIGAN NURSES ASSOCIATION,	
Charging Parties-Appellees. /	

BRIEF OF AMICUS CURIAE MICHIGAN MUNICIPAL LEAGUE, MICHIGAN TOWNSHIPS ASSOCIATION, MICHIGAN ASSOCIATION OF COUNTIES AND THE PUBLIC CORPORATION LAW SECTION IN SUPPORT OF MACOMB COUNTY, MACOMB COUNTY ROAD COMMISSION & 16TH JUDICIAL CIRCUIT COURT

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INDEX TO AUTHORITIES

Pages

Michigan Cases:

Out-of-State Cases:

Federal Cases:

Court Rules:

Statute(s):

Miscellaneous:

STATEMENT OF APPELLATE JURISDICTION

On May 9, 2012, this Court granted Respondents-Appellants' (Macomb County, Macomb County Road Commission, and the 16th Judicial Circuit Court, collectively, "respondents") application for leave to appeal a September 20, 2011, decision from the Court of Appeals (Docket. No. 296496). The Court of Appeals decision affirmed the Michigan Employment Relations Commission's ("MERC") January 25, 2010, decision and order. Accordingly, this Court has jurisdiction pursuant to MCR 7.301(A)(2) and MCR 7.302(H)(3).

STATEMENT OF THE QUESTION PRESENTED

I.

Did the Court of Appeals properly apply the holding of *Port Huron Ed Ass'n v Port Huron Area School Dist*, 452 Mich 309; 550 NW2d 228 (1996), when it concluded that the parties intended to modify the collective bargaining agreement by use of the 100% female / 0% male mortality tables?

Charging Parties-Appellees answer: "Yes."

Respondents-Appellants answer: "No."

Amici answer: "No."

The Court of Appeals answered: "Yes."

The Michigan Employment Relations Commission answered: "Yes."

STATEMENT OF INTEREST

The Michigan Municipal League, the Michigan Townships Association, the Michigan Association of Counties, and the Public Corporation Law Section of the State Bar of Michigan are amici in this case.

The Michigan Municipal League is a non-profit Michigan corporation whose purpose is the improvement of municipal government and administration through cooperative effort. Its membership is comprised of hundreds of Michigan cities and villages, many of which are also members of the Michigan Municipal League Legal Defense Fund. The Michigan Municipal League operates the Legal Defense Fund through a board of directors[1], which is broadly representative of its members. The purpose of the Legal Defense Fund is to represent the member cities and villages in litigation of statewide significance.

The Michigan Townships Association is a Michigan non-profit corporation whose membership consists of in excess of 1,230 townships within the State of Michigan

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[1] The 2012-2013 Board of Directors of the Legal Defense Fund are: Randall L. Brown, Chair, City Attorney, Portage; Lori Grigg Bluhm, Vice-Chair, City Attorney, Troy; Stephen P. Postema, Immediate Past-Chair, City Attorney, Ann Arbor; Eric D. Williams, City Attorney, Big Rapids; Clyde J. Robinson, City Attorney, Kalamazoo; James O. Branson, City Attorney, Midland; James J. Murray, City Attorney, Boyne City and Petoskey; Robert J. Jamo, City Attorney, Menominee; John C. Schrier, City Attorney, Muskegon; Thomas R. Schultz, City Attorney, Farmington and Novi; Karen Majewski, Mayor, Hamtramck, Michigan Municipal League President; Daniel P. Gilmartin, Executive Director and CEO of Michigan Municipal League; and William C. Mathewson, General Counsel, Michigan Municipal League, and Fund Administrator.

(including both general law and charter townships) joined together for the purpose of providing education, exchange of information, and guidance to and among township officials to enhance the more efficient and knowledgeable administration of township government services under the laws and statutes of the State of Michigan.

The Michigan Association of Counties was formed in 1898 to advocate for the interests of Michigan's county governments. MAC is a non-partisan, non-profit organization which advances education, communication, and cooperation among county government officials in the state of Michigan. MAC is the counties' voice at the State Capitol, providing legislative support on key issues affecting counties. MAC also provides the full spectrum of association services that distribute important public information to its members. MAC offers members educational programs, legislative representation, local workshops, conferences, and weekly legislative communications to keep members up to date on the latest events that affect county governments. MAC's 16-member board is the association's decision-making body, which acts on recommendations of MAC committees. The committees are charged with recommending policy for the association on legislative issues and developing political platforms that explain MAC's positions on important legislative issues.

The Public Corporation Law Section of the State Bar of Michigan studies laws and procedures relating to public law as they affect the activities of government corporations, agencies, departments and boards, including townships, counties,

villages, cities, schools, and charter or special authorities. The PCLS also seeks to promote the fair and just administration of public law; study, report upon, and recommend necessary legislation; and promote the legal education of members of the bar and the public concerning public law. To this end, the PCLS sponsors meetings and conferences, and distributes pamphlets and brochures. The PCLS also prepares, sponsors, and publishes legal writings in the field; and files amicus curiae briefs in cases involving issues significant to public corporations in Michigan.[2]

Amici's interest in this case is two-fold. Amici first seek to ensure the integrity of contracts negotiated with public employee unions and urge this Court to affirm the analysis set forth in *Port Huron* for dealing with claims of unfair labor practices. *Port Huron* instructs that an employer has fulfilled its statutory duty to bargain when a subject is covered in a collective bargaining agreement. Any disputes with respect to such covered subjects are dealt with through the grievance system and arbitration. If a

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[2] The Public Corporation Law Section is not the State Bar of Michigan itself, but rather a Section which members of the State Bar choose voluntarily to join, based on common professional interest. The position expressed is that of the Public Corporation Law Section only and is not the position of the State Bar of Michigan. To date, the State Bar of Michigan does not have a position on this matter. The total membership for the Public Corporation Law Section is 637. The Section Council of the State Bar of Michigan Public Corporation Law Section consists of 21 elected members. The Public Corporation Law Section adopted the position after discussion and vote. Sixteen members of the Section Council were present at the June 22, 2012, meeting at which this item was presented for consideration. The number who voted in favor of this position was 15. The number who voted opposed to this position was 0. The number who abstained from vote was 1.

claim is made that a past practice has somehow altered express contract language, the party challenging the language must meet a high burden of proof and show that the parties knowingly, voluntarily, and mutually agreed to new obligations. "Once the employer has fulfilled its duty to bargain, it has a right to rely on the agreement . . . ." *Port Huron Ed Ass'n v Port Huron Area School Dist*, 452 Mich 309, 327; 550 NW2d 228 (1996).

Amici are also interested in the specific outcome of this case. Here, the Court of Appeals found ambiguous several collective bargaining agreements that expressly provide for an independent retirement commission to determine the actuarial assumptions used to calculate optional retirement benefits that are required to be the actuarial equivalent of straight life benefits. The Court of Appeals rested its decision on the dubious conclusions that "actuarial equivalent" does not mean equal, and that the parties herein intended to give one group of retirees a greater benefit than a similarly situated group.

Several state statutes that address public employee retirement systems, and undoubtedly, countless collective bargaining agreements, use the term "actuarial equivalent" with the goal of treating retirees equitably. The Court of Appeals ruling will have a destabilizing effect on retiree benefits and will make it difficult for public employers to efficiently maintain retirement systems and ensure their solvency.

STATEMENT OF FACTS

Amici curiae rely upon the statement of facts set forth in respondents' brief on appeal.

STANDARD OF REVIEW

The MERC's factual findings are conclusive if supported by competent, material, and substantial evidence on the record considered as a whole. *Quinn v Police Officers Labor Council*, 456 Mich 478, 481; 572 NW2d 641 (1998), quoting *Port Huron Ed Ass'n v Port Huron Area School Dist*, 452 Mich 309, 322; 550 NW2d 228 (1996). Review of factual findings of the commission must be undertaken with sensitivity and due deference must be accorded to administrative expertise. *Gogebic Cmty Coll Michigan Ed Support Pers Ass'n v Gogebic Cmty Coll*, 246 Mich App 342, 348-49; 632 NW2d 517 (2001). Reviewing courts should not invade the exclusive fact-finding province of administrative agencies by displacing an agency's choice between two reasonably differing views of the evidence. (*Id.* at 349). Regarding questions of law, however, an appellate court will set aside a legal ruling by the MERC if it violates the constitution or a statute, or if the ruling is affected by a substantial and material error of law. (*Id.*).

ARGUMENT I

The Court Of Appeals Did Not Properly Apply The Holding Of *Port Huron* When It Concluded That The Parties Intended To Modify The Collective Bargaining Agreements By Use Of The 100% Female / 0% Male Mortality Tables Because The Agreements Expressly Stated That Optional Retirement Benefits Were To Be The Actuarial Equivalent Of A Straight Life Benefit And, By Incorporating The Macomb County Retirement Ordinance, The Agreements Allowed For The Commission To Change Actuarial Assumptions When Needed.

A. *Port Huron* does not require a party to bargain over a subject covered by a collective bargaining agreement.

Port Huron addressed a situation analogous to the one presented in this case and articulated a framework for addressing claims of unfair labor practices that is designed to protect the collective bargaining process and ensure the sanctity of contract. In *Port Huron*, the Port Huron Education Association and the Port Huron Area School District entered into a collective bargaining agreement which provided that health insurance benefits would be prorated for teachers who work less than a full year. *Port Huron*, 452 Mich at 312. Despite this provision, from the 1983-1984 school year on, the district failed to prorate insurance benefits for midyear hires. (*Id.* at p 313).

During the 1987-88 school year, the district hired an "unusually large" number of midyear hires, which caused the district "to reexamine the agreement and notice the proration provision." *Port Huron*, 452 Mich at 313. The district subsequently notified the new teachers that, in accordance with the agreement, benefits would be prorated.

(*Id.*). As in this case, the association demanded that the district bargain before enforcing the proration provision, but unlike the unions here, also filed a grievance. (*Id.* at 313.) When the association was unsuccessful in the first two stages of the grievance process, it withdrew the grievance before arbitration and then filed an unfair labor practice charge, alleging that the district refused to bargain in violation of MCL 423.210(1)(e)[3] of the Public Employees Relations Act (PERA). (*Id.* at 313-314).

The first time the MERC heard the case it concluded that payment of insurance benefits for an entire summer before reexamining the agreement created a term of employment and that "the district had a duty to bargain because the proration language in the agreement was ambiguous and therefore did not amount to a waiver by the association of its right to bargain." *Port Huron,* 452 at 315. The Court of Appeals affirmed the MERC's ruling but this Court vacated that decision and remanded to the MERC for further consideration of the proration language in light of another paragraph of the agreement which addressed proration. (*Id.* at 316). The MERC then concluded that this paragraph removed any ambiguity in the collective bargaining agreement. (*Id.*).

In hearing the district's subsequent appeal, this Court explained that the statutory duty to bargain over "wages, hours, and other terms and conditions of

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[3] MCL 423.210 provides that (1) It shall be unlawful for a public employer or an officer or agent of a public employer ... (e) to refuse to bargain collectively with the representatives of its public employees, subject to the provisions of section 11.

employment....' pursuant to MCL 423.215(1), may be fulfilled by 'negotiating for a provision in the collective bargaining agreement that fixes the parties' rights and forecloses further mandatory bargaining....'" (*Id.* at 318, quoting *Local Union No 47, Int'l Brotherhood of Electrical Workers v NLRB*, 927 F2d 635 (DCCA 1991)). In such a situation, "the matter is 'covered by' the agreement." (*Id.*).

This Court went on to explain that, "[a]lternately, the employer may be freed from its duty to bargain if the union has waived its right to demand bargaining." *Port Huron*, 452 Mich at 318. Thus, a "two step analysis" exists for determining "whether an employer must bargain before altering a mandatory subject of bargaining." (*Id.*). The analysis entails asking whether the issue the union seeks to negotiate is "covered by" or "contained in" the collective bargaining agreement; and, if not, did the union somehow relinquish its right to bargain? (*Id.* at 318-319, citing *Dep't of Navy v Federal Labor Relations Authority*, 247, 962 F.2d 48 (DCCA 1992)). In *Port Huron*, this Court plainly stated that, "[i]f the term or condition in dispute is 'covered' by the agreement, the details and enforceability of the provision are left to arbitration." (*Id.* at 321). Accordingly, when a term is covered by the collective bargaining agreement, the analysis stops and the MERC should not go on to consider whether there was a waiver. "[W]here the matter is covered by the collective bargaining agreement, the union has exercised its bargaining right and the question of waiver is irrelevant." (*Id.* at 319).

In *Port Huron*, this Court affirmed the MERC's finding that the proration language at issue was unambiguous as a matter of law. (*Id.* at 323). In this case, as explained in respondents' brief, each collective bargaining agreement ("CBA") contains an express formula for calculating a straight life retirement benefit, but with respect to the optional benefits at issue here, each agreement provided that it would follow the Macomb County Retirement Ordinance ("retirement ordinance") and the agreements specifically incorporated the ordinance by reference. (Respondents' App 237a (Art 26A); 251a (Art 19A); 258a (Art 29A); 245a, 246a). The retirement ordinance provides that the retiree may choose an optional form of payment which is the "actuarial equivalent" of the straight life retirement allowance. (*Id.* at 65a).

The ordinance further provides that the retirement commission is vested with "the general administration, management and responsibility for the proper operation of the Retirement System, and for construing and making effective the provisions of this Ordinance." (Respondents' App 55a). The commission is the trustee of the retirement system. (*Id.* at 74a). Specifically, "[t]he Retirement Commission shall from time to time adopt such mortality and other tables, and a rate or rates of regular interest, as are necessary in the Retirement System on an actuarial basis." (*Id.* at 59a). Thus, when the retirement commission learned in 2006 that the optional benefits were not actuarially equivalent to the straight life retirement benefit, it had both the power and duty, as provided for in the ordinance and as incorporated into the CBAs, to adjust the mortality

table from the 100% female assumption to the 60% male / 40% female assumption. The CBAs clearly provide that the retirement ordinance controls with respect to actuarial assumptions, and any disagreement with the ordinance's mandate of actuarial equivalence and the methods used to ensure it are subject to the grievance process and arbitration. "The MERC does not involve itself with contract interpretation when the agreement provides a grievance process that culminates in arbitration." *Port Huron,* 452 Mich. at 321.

B. In this case, the Court of Appeals erred in finding that the past practice of using the 100% female table modified the agreements based on the alleged ambiguity of the term "actuarial equivalent."

Port Huron affirmed the general principle that a past practice may create a term or condition of employment that cannot be altered unilaterally absent negotiation. *Port Huron,* 452 Mich at 325. Where the collective bargaining agreement is ambiguous or silent on the subject for which the past practice has developed, there need only be "tacit agreement that the practice would continue." (*Id.*). In such a situation, proof of mutual acceptance may arise by inference from the circumstances. (*Id* at 328). But where unambiguous language in the agreement allegedly conflicts with the past practice of the parties, as in this case, *Port Huron* mandates a higher standard of proof. (*Id.* at 328). "The unambiguous language controls unless the past practice is so widely acknowledged and mutually accepted that it creates an amendment to the contract." (*Id* at 329).

The Court of Appeals erred in this case when, agreeing with the MERC, it found that the term "actuarial equivalent" is ambiguous because it is not defined in the Retirement Ordinance, and therefore, the past practice of the use of the 100 % female / 0% male table became a term or condition of employment under *Port Huron* that could not be altered unilaterally. (Respondents' App 7a). The Court found that testimony from the charging parties' expert on the definition of actuarial equivalence, or lack thereof, constituted competent, material, and substantial evidence for this conclusion. (*Id.*). As pointed out in respondents' brief, however, this expert in fact testified that "actuarially equivalent to me means equal. . . . Identical in value." (*Id.* at 131a). There is thus no support for the Court of Appeals finding that "actuarial equivalent" is an ambiguous term that does "not 'unambiguously' mean 'equal in value.'" (*Id.* at 9a).

Moreover, the failure to define a contractual term does not render a contract ambiguous. *Wells Fargo Bank, NA v Cherryland Mall Ltd Pship*, 295 Mich App 99, 115; 812 NW2d 799 (2011). If a term is not defined in a contract, a reviewing court should interpret such term in accordance with its commonly used meaning. (*Id.*) Additionally, terms in a particular trade are given their natural and ordinary meaning in that trade. (*Id.*) Indeed, in this case, the Court of Appeals acknowledged a Michigan Attorney General opinion from 1981 that was the impetus to changing the previous practice of using gender specific mortality tables in calculating retirement benefits and that addressed the concept of "actuarial equivalent." According to the Court, the attorney

general "issued an opinion that public pension systems must adopt gender-neutral retirement tables." (Appx 2a). In a footnote, the Court briefly mentioned that this momentous opinion "discussed" the definition of actuarial equivalence but "in a different context." (*Id.*). The context, however, involved early retirement benefits, and one of the questions the opinion addressed was: "Under section [1851 PA 156; MCL 46.12a], may a county pension board adopt a unisex early retirement benefit schedule which is derived by use of a formula or approximate actuarial equivalent as opposed to an exact actuarial equivalent method?" (OAG 1981-1982, No. 5846, January 22, 1981).

The attorney general noted that the term "actuarial equivalent" was not defined in the statute. (OAG 1981-1982, No. 5846, January 22, 1981). The opinion then cited *King County Employees' Ass'n v State Employees Retirement Board*, 54 Wash 2d 1; 336 P2d 387, 391 (1959), wherein the Washington Supreme Court considered a statute which defined the term "actuarial equivalent" as any ". . . benefit of equal value when computed upon the basis of such mortality and other tables as may be adopted by the retirement board." (OAG 1981-1982, No. 5846 January 22, 1981). The Washington Court found that "actuarial equivalent" clearly referred to "the mathematical calculations to be made relative to a member's accumulated contributions—calculations made in order to distribute those accumulated contributions on a monthly payment basis over the remainder of his or her life." (*Id.*).

The attorney general found that "[t]he reasoning of the Washington Supreme Court is helpful in determining the meaning of 'actuarially equivalent' in 1851 PA 156, § 12a(1)(b)." (OAG 1981-1982, No. 5846 January 22, 1981). According to the opinion "'Equivalent' may be interpreted as meaning a benefit of equal value based on accumulated contributions, as actuarially determined to be paid eligible early retirants under the statute." (*Id.*). The attorney general went on to explain:

> By employment of the adjective "equivalent" in the actuarial sense, instead of "approximate", it may be concluded that the Legislature intended that early retirement benefits be equivalent to those available to retirants who are not early retirants. Black's Law Dictionary (Rev 4th Ed) defines "equivalent" as "[e]qual in value, force, measure, volume, power, and effect or having equal or corresponding import, meaning or significance; alike, identical." [OAG, 1981-1982, No. 5846].

The attorney general then concluded that "a county's sexually-neutral retirement plan adopted under 1851 PA 156, § 12a(1)(b) . . . must, in the case of early retirement, provide for benefits which are actuarially equivalent and of equal value to those provided for other eligible retirants who do not retire early, based on the accumulated contributions of such early retirant." (*Id.*).

Three years later, the attorney general addressed optional retirement benefits in the Municipal Employees Retirement System, which as in this case, are required to be the actuarial equivalent of straight life benefits. OAG, 1983-1984, No. 6221, April 30, 1984. The opinion noted that "[t]he establishment of optional retirement allowances is not limited to the MERS, and similar provisions are found in the State Employees'

Retirement System, MCLA 38.31 *et seq.*, and the Public School Employees' Retirement System, MCLA 38.1385." The opinion further observed that "the concept of 'actuarial equivalent' was recognized in OAG, No 5846" and repeated the earlier discussion of *King County Employees' Ass'n.* The attorney general again concluded:

> Through the use of the term "actuarial equivalent," the Legislature has indicated that an individual selecting a retirement option, thereby obtaining additional benefits for a beneficiary not otherwise provided under the straight-life retirement, shall receive a benefit of equal value. The computation of such benefit shall be based upon mortality (age) and other sexually neutral tables adopted by the retirement board . . . . The utilization of such mortality tables in computing the actuarial equivalent is a long recognized and accepted practice within the insurance industry . . . [*Id.*].

In addition to the attorney general's pronouncements that "actuarial equivalent" means equal in value, the Michigan Office of Financial and Insurance Services has further explained that "actuarial equivalent" is a "mathematical determination based on the expectation of loss and the benefits to be paid in such an eventuality." *In the Matter of: A Blue Cross Blue Shield of Michigan Capital Contribution to Accident Fund Insurance Company of America,* No. OFIR No. 09-015-M, 2009 WL 1360675 (Fed Cir May 8, 2009) (attached hereto as Exhibit A). Mathematics is not subject to interpretation and finesse.

A journal article explaining the concept of actuarial equivalence illustrates the point:

> Actuarial calculations involve finding the present-day lump-sum value of a stream of payments to be received in the future. Actuarial calculations can be complex in practice, but conceptually are based on just three factors: the length of time until payments begin, standard mortality

> tables, and interest rates. An actuary might calculate, for example, that if a male Participant is 53 today and is entitled to receive $1,200 per month commencing when he reaches age 65 until he dies, that stream of future payments is "actuarially equivalent" to having a lump sum of $73,655.87 on hand today. In other words, if the Participant had $73,655.87 on hand today, he could invest it, collect interest until he was 65, then start drawing out $1,200 per month from age 65, and the money would last until the end of his life, assuming he has an average life expectancy.
>
> Another important point to remember about Actuarial Equivalence is that two streams of future payments may be equivalent to each other. For example, the payments to a 53-year-old male Participant commencing when he is 65 as described above might be Actuarially Equivalent to the payment of $1,053.77 per month to a female Alternate Payee who is 48 years old today with the payments to commence when she is 68. [David Clayton Carrad, QDRO Malpractice 2.0: The Next Generation, 14 No 5 Divorce Litig 77 (May 2002).]

Again, "[t]wo modes of payment are actuarially equivalent when their present values are equal under a given set of actuarial assumptions." *Stephens v US Airways Group, Inc*, 644 F3d 437, 440 (DC Cir 2011), cert den 132 S Ct 1857 (2012).

As alluded to in the later attorney general opinion discussed above, several provisions of various Michigan statutes use the term "actuarial equivalent" when addressing retirement options and similar subjects: the Public School Employees Retirement Act of 1979 (MCL 38.1345, 38.1385, 38.1408, 38.1370); Eligible Domestic Relations Order Act (MCL 38.1705); Michigan Legislative Retirement System Act (MCL 38.1059a, 38.1058a); Judges Retirement Act of 1992 (MCL 38.2604, MCL 38.2602, MCL 38.2506); State Employees' Retirement Act (MCL 38.31, 38.49, 38.41); Fire Fighters and Police Officers Retirement Act (MCL 38.556); State Police Retirement Act (MCL

38.1613a); County Boards of Commissioners (MCL 46.12a); Public Employee Retirement Benefits Forfeiture Act (MCL 38.2704); and The Insurance Code of 1956 (MCL 500.4061; MCL 500.603; MCL 500.4060).

Thus, should this Court leave undisturbed the Court of Appeals' pronouncement that "actuarial equivalent" is an ambiguous term that does not necessarily mean "equal value," all of these statutes and corresponding areas of the law will be uncertain and collective bargaining agreements based thereon will be undermined. And in this case, because the term actuarial equivalence is not open to debate, the "[t]he unambiguous language controls unless the past practice is so widely acknowledged and mutually accepted that it creates an amendment to the contract." *Port Huron*, 452 Mich at 329.

C. Parties to the collective bargaining process should be able to rely on the analysis set forth in *Port Huron*, which is designed to maintain the sanctity of contract

The analytical path set forth in *Port Huron* is crucial to protecting the integrity of the collective bargaining process and the sanctity of contract. "Once the employer has fulfilled its duty to bargain, it has a right to rely on the agreement as the statement of its obligations on any topic 'covered by' the agreement." *Port Huron*, 452 Mich at 327.

The *Port Huron* Court recognized that "[t]he heart of labor law," is that "[w]hen parties bargain about a subject and memorialize the results of their negotiation in a collective bargaining agreement, they create a set of enforceable rules—a new code of conduct for themselves—on that subject." *Port Huron*, 452 Mich at 319, quoting *Dep't of*

Navy, 962 F2d at 57. "Because of the fundamental policy of freedom of contract, the parties are generally free to agree to whatever specific rules they like, and in most circumstances it is beyond the competence of [labor boards] or the courts to interfere with the parties' choice." (*Id.*, quoting *Dep't of Navy*, 962 F2d at 57). When this Court articulated a higher standard of proof for claims that a past practice modifies express contract language, as in this case, it emphasized one of amici's main concerns, namely, that "[a] less stringent standard would discourage clarity in bargained terms, destabilize union-management relations, and undermine the employers' incentive to commit to clearly delineated obligations." (*Id.* at 325-26).

This Court further observed that "[a] collective bargaining agreement, like any other contract, is the product of informed understanding and mutual assent," and therefore, *Port Huron* instructs that, "[t]o require a party to bargain anew before enforcing a right set forth in the contract requires proof that the parties knowingly, voluntarily, and mutually agreed to new obligations." *Port Huron*, 452 Mich at 327. There must be proof that the parties "had a meeting of the minds with respect to the new terms or conditions—intentionally choosing to reject the negotiated contract and knowingly act in accordance with the past practice." (*Id.*).

Parties to the collective bargaining process, such as respondents and amici, should be able to rely on this analysis in *Port Huron*. As this Court warned, "[c]ourts, even more than arbitrators, should be wary of raising the parties' past actions to the

664; 798 NW2d 37 (2010), Wayne County moved from a flat-rate-premium structure to an age-related premium structure for its retiree supplemental life insurance (SLI) after learning that the existing SLI premium rate of $2.36 per thousand dollars of insurance coverage was insufficient. (*Id.* at 666-668). This change resulted in higher premiums for older retirees. (*Id.* at 666). Upon receiving notice of the change and choosing to discontinue their coverage, plaintiff retirees filed suit. (*Id.* at 669). The trial court found that the consistent practice of providing SLI at a flat rate premium created a reasonable expectation that the practice would continue, and therefore, the practice was binding on the parties. (*Id.* at 671).

The Court of Appeals observed that the CBA's only explicit reference provided that "'[s]upplemental life insurance is available under a group plan at the option of the employee.' It makes no mention of what the rate is or how it will be calculated . . . ." *Butler*, 289 Mich App at 672. The Court noted however, that, just as the CBA's in this case incorporate the Macomb County Retirement Ordinance, the CBAs in Butler incorporated the Wayne County Health and Welfare Benefit Plan, which specifically stated that "[t]he rate that the employee pays for supplemental life [insurance] will increase as the employee grows older." (*Id.* at 673). The Court of Appeals thus correctly concluded that, "[i]n light of the existence of an express provision in the CBA providing how the SLI rate will be calculated, plaintiffs' allegation of a past practice prohibiting a change from a flat-rate-premium structure is contrary to the express contract language,

making the *Port Huron* standard the applicable standard in this case." (*Id.* at 677). In other words, "the union did have notice of this provision [in the Health Plan], could have bargained to change it and, having not done so, is bound by it unless it can meet the burden of proof for a past practice to the contrary set forth in *Port Huron*." (*Id.* at 680).

The Court explained that the plaintiffs' assertion that a flat-rate premium for SLI was a binding past practice, "required a showing that plaintiffs and the county had a meeting of the minds with respect to the flat-rate premium's existing in perpetuity so that there was an agreement to modify the contract." *Butler*, 289 Mich App at 680-81 (internal citations omitted). As in this case, the plaintiffs pointed to a lengthy time period to show that a past practice was created, because Wayne County waited 16 years to implement the age-rated-premium structure. (*Id.* at 682). The Court characterized this argument as "unavailing in light of the express language in the Plan. [Wayne County's] failure to implement the change to an age-rated-premium structure as permitted by the Plan did not prevent them from doing so in the future." (*Id.* at 682).

In *Southfield Ed Ass'n v Southfield Pub Sch*, No. 240050, 2004 WL 225059 (Mich Ct App February 5, 2004) (unpublished) (attached hereto as Exhibit B), the school employee unions' CBAs "essentially provided that in most circumstances unpaid leaves may be granted or extended" at the school system's discretion. (*Id.* at *1). It was undisputed, however, that the school district granted all leave requests and extensions

from at least 1982 to 1998. (*Id.*). On July 27, 1998, the school district sent a memo to its employees informing them that it was changing its practice with regard to leaves of absence. The district stated that "its permissive leave policy would be discontinued because school enrollment was increasing" whereas in the past, leaves of absence were routinely granted because unpaid leaves helped minimize layoffs. (*Id.*) The letter explained that leaves of absence and extensions would be "granted or denied as determined by the administration." (*Id.*). The unions filed an unfair labor practices charge alleging that the school district unilaterally changed the leave policies. (*Id.*). Both the hearing referee and the MERC rejected this claim and the unions appealed. (*Id.*).

The Court of Appeals determined that the alleged past practice of granting all leave requests did "not conflict with unambiguous contract provisions granting respondent complete discretion regarding most requests." (*Id.* at *2). Moreover the unions "failed to show a voluntary, knowing, and intentional agreement to modify the contract" because "[t]he fact that respondent refrained from denying leaves or enforcing the restrictions placed on leaves does not show that it intended to bind itself to an agreement to approve all future requests." (*Id.*).

Finally, as discussed in respondents' brief, in *Gogebic*, the collective bargaining agreement between the employer and the union provided that a specific insurance carrier would be used for health and vision benefits, but with respect to dental benefits,

the agreement required only that the employer maintain a specific level of benefits. 246 Mich App at 344. For many years, the employer used a specific dental carrier but then changed to a self-insured program during the term of the 1996-98 collective bargaining agreement. (*Id.*). Although the employer maintained the same level of dental benefits, the union contended that the employer "had an obligation to bargain for what the union characterizes as a unilateral, mid-term modification of the collective bargaining agreement." (*Id.*).

The Court of Appeals agreed with the MERC and the employer that "the employer had no duty to bargain regarding this matter, which was clearly and unambiguously covered in the collective bargaining agreement." (*Id* at 345). The Court rejected the union's claim that the past practice of using a specific carrier constituted an amendment of the collective bargaining. (*Id.*). Citing *Port Huron*, the Court observed that the only evidence presented by the union was that its chief negotiator expected that a certain dental plan would continue to be used. The Court concluded that such evidence did not amount to a "meeting of the minds" and fell "far short of demonstrating conduct showing an unequivocal modification with 'definite, certain, and intentional' terms." (*Id.* at 354).

In this case, the Court of Appeals maintained that even if "actuarial equivalent" was not ambiguous and the higher standard of proof was used, the past practice of using the 100% female table modified the CBAs to, apparently, not require actuarial

equivalence. (Respondents' App 10a). In light of the fact that this actuarial assumption provides retirees choosing an optional benefit a greater retirement benefit than the similarly situated retirees who choose a straight-life benefit, however, it strains credulity to believe that the parties knowingly, voluntarily, and mutually agreed to modify the CBAs in this way. Amici will not repeat the thorough discussion of this topic provided in respondents' brief except to point out that the Court of Appeals relies on the fact that respondents were aware, via the 1982 GRS report, that the 100% female assumption would result in "an increased cost to the system," and therefore, according to the Court of Appeals, respondents intended the unequal result. (*Id.* at 10a-11a). An added overall cost to the system, however, does not equate to the intentional provision of a greater benefit to one group of retirees over another.

Neither the Court of Appeals, the MERC, nor any of the unions provided any justification for why it would be acceptable for the group choosing an optional retirement plan to receive more than those choosing the straight life benefit. And as Judge Markey correctly pointed out in her dissent (Respondents' App 18a), the enabling legislation for county retirement plans clearly instructs that "[a] plan adopted for the payment of retirement benefits or a pension shall grant benefits to an employee eligible for pension or retirement benefits according to a uniform scale for all persons in the same general class or classification." MCL 46.12a. Thus, it cannot seriously be argued that the parties here intended to provide unequal benefits to different groups of

similarly situated retirees in violation of express language calling for actuarial equivalence among the various optional retirement benefits.

D. The Court of Appeals' decision endangers the solvency of retirement systems upon which retirees depend.

As discussed above, the analytical path set forth in *Port Huron* ensures the integrity of the collective bargaining process. In this case specifically, proper contract interpretation is crucial to maintaining the solvency of the retirement system for those who depend on it. Amici represent public employers responsible for retirement systems overseen by bodies similar to the commission in this case, which is the trustee of the Macomb County retirement system. (Respondents' App 74a). A trustee's failure to monitor a fund's solvency constitutes a breach of fiduciary duty. *Liss v Smith*, 991 F Supp at 278, 299 (SDNY 1998).

It is beyond dispute that public employee pension systems are, in the best case scenario, under stress. "[U]nfunded state and local government pension liabilities are one of the major contributors to the fiscal crisis." R. Theodore Clark, Jr., Public Sector Collective Bargaining at the Crossroads, 44 Urb Law 185, 210 (2012). As is of concern to amici, "[t]he nation's largest municipal pension plans are underfunded by $574 billion, or $14,000 per household in each respective town or city. Public employee health care benefits face a similar problem" and as a result "[t]he ability of local governments, particularly cities, to provide levels of service they do now is threatened by this liability." Richard W. Trotter, Running on Empty: Municipal Insolvency and Rejection

of Collective Bargaining Agreements in Chapter 9 Bankruptcy, 36 S Ill.U LJ 45, 50-51 (2011). At the state level, it is widely recognized that many "public employee pension systems are severely underfunded." Gavin Reinke, When A Promise Isn't A Promise: Public Employers' Ability to Alter Pension Plans of Retired Employees, 64 Vand L Rev 1673, 1675 (2011). Although the causes of the current pension crisis are complex, a recent report from the Pew Center on the States identified structural problems with retirement plans as one of the four major causes. (*Id.*).

It is also worth noting that "retirees are not bargaining-unit members and, therefore, fall outside the labor-management relationship." *Butler v Wayne Co*, 289 Mich App 664, 675; 798 NW2d 37 (2010), app den 488 Mich 1054 (2011). However, a retiree's contractual rights vest at the time of retirement. Should an actuarial assumption need to be negotiated, a retiree's interest would not be represented. In this case, the contractual rights of the Macomb County retirees at the time of retirement provided for actuarially equivalent benefits to be determined by an independent retirement commission. Requiring negotiation of the actuarial assumptions when the need arises – as opposed to giving such authority to an independent commission – subjects retirees to the whims of the bargaining process. "[W]hile local governments and employee unions often have a mutual incentive to work together towards a financially viable plan of compensation, concessions on either side are often very difficult to come by given that negotiations are driven not only by fiscal, but political considerations as well." Richard

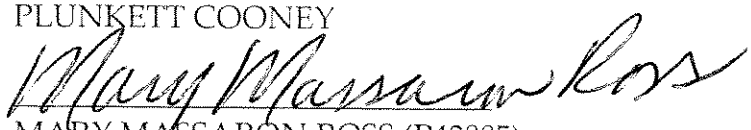
W. Trotter, Running on Empty: Municipal Insolvency and Rejection of Collective Bargaining Agreements in Chapter 9 Bankruptcy, 36 S. Ill. U. L.J. 45, 49 (2011).

The United States Supreme Court has articulated the public policy objective underlying the furnishing of retirement benefits, which is "to provide assistance to aged individuals who, having rendered long and valuable employment service, are no longer able to labor productively." *Adrian Sch Dist v Michigan Pub Sch Employees Ret Sys*, 458 Mich 326, 333; 582 NW2d 767 (1998), citing *Helvering v Davis*, 301 US 619; 57 S Ct 904; 81 L Ed 1307 (1937). "If employees are permitted to collect benefits from a fund to which insufficient contributions have been made on their behalf, the actuarial soundness of the plan could be threatened. Such claims may not be considered alone: the rights and interests of the other pensioners must also be taken into account." *McMartin v Cent States, Se & Sw Areas Pension Fund*, 159 Mich App 1, 5; 406 NW2d 219 (1987), citing *Phillips v Kennedy*, 542 F2d 52, 58 (CA 8, 1976). Therefore, amici urge this Court to reaffirm the analysis in *Port Huron* because this analysis protects properly bargained agreements such as the CBAs at issue in this case. These agreements give an independent retirement commission the power to adjust actuarial assumptions, thus ensuring efficiency and enabling the commission to maintain the retirement plan's solvency.

RELIEF

WHEREFORE, Michigan Municipal League, Michigan Townships Association, Michigan Association of Counties and the Public Corporation Law Section, respectfully request this Court to reverse the decision of the Court of Appeals and grant such other relief as is proper in law and equity.

PLUNKETT COONEY

By: 

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Dated: August 27, 2012

STATE OF MICHIGAN

IN THE SUPREME COURT

(ON APPEAL FROM THE MICHIGAN COURT OF APPEALS)

MACOMB COUNTY, MACOMB COUNTY ROAD COMMISSION, & 16TH JUDICIAL CIRCUIT COURT,	Sup Ct No. 144303
Respondents-Appellants,	Ct of App No. 296416
v	MERC L/C Nos. C07-D-083 C07-D-086 C07-D-087 C07-E-115
AFSCME COUNCIL 25 AND ITS AFFILIATED LOCALS 411 AND 893; INTERNATIONAL UNION, UAW AND ITS LOCALS 412 AND 889; and MICHIGAN NURSES ASSOCIATION,	
Charging Parties-Appellees. /	

PROOF OF SERVICE

MARJORIE E. RENAUD, states that on August 27, 2012, two (2) copies of the Brief of Amicus Curiae Michigan Municipal League, Michigan Townships Association, Michigan Association of Counties and the Public Corporation Law Section in Support of Macomb County, Macomb County Road Commission & 16th Judicial Circuit Court, together with Proof of Service, was served on:

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by depositing same in the United States Mail with postage fully prepaid.

MARJORIE E. RENAUD

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EXHIBIT A

2009 WL 1360675 (Mich.Off.Fin.Insur.Serv.)

Office of Financial and Insurance Services

Department of Labor and Economic Growth

State of Michigan

IN THE MATTER OF:
A BLUE CROSS BLUE SHIELD OF MICHIGAN CAPITAL CONTRIBUTION TOACCIDENT FUND INSURANCE COMPANY OF AMERICA

OFIR No. 09-015-M
Circuit Court Case No. 08-917-CZ
May 8, 2009

***1 Before the Commissioner of Financial and Insurance Regulation**

Issued and entered this 8th day of May 2009

By Ken Ross

Commissioner

ORDER

I

BACKGROUND

This matter comes before the Commissioner of Financial and Insurance Regulation (Commissioner) by referral from the Ingham County Circuit Court (Case No. 08-917-CZ). In the circuit court case, the Attorney General asserted that Blue Cross Blue Shield of Michigan (BCBSM) violated the Nonprofit Health Care Corporation Reform Act (Act 350) with respect to transactions with its subsidiary, the Accident Fund Insurance Company of America (Accident Fund). Judge Paula Manderfield, in orders issued October 6, 2008 and January 13, 2009, dismissed all three counts of the Attorney General's complaint.

Count II of the complaint was dismissed without prejudice and referred to the Commissioner for resolution. In Count II, the Attorney General alleged that a $125 million capital contribution from BCBSM to the Accident Fund in November 2007 was an unlawful subsidy that violated MCL

550.1207(1)(x)(vi), which is Section 207(1)(x)(vi) of Act 350. The Attorney General sought an order to have the funds returned to BCBSM.

On November 26, 2008, the Commissioner met with attorneys representing the Attorney General and BCBSM to discuss the issues presented by Judge Manderfield's order. Since the parties were in apparent agreement on key facts, the Commissioner encouraged them to submit stipulated facts.

Since the Accident Fund is a directly affected corporation, the Commissioner invited it to join in the informal proceedings. It accepted and participated in negotiations as to stipulated facts. The three parties did not submit an agreed-upon statement of facts, but did submit briefs arguing their positions with respect to Count II. The Attorney General submitted a request for a stay of the proceedings but, with no sufficient reason or authority presented, and with the Commissioner wanting to fully implement the referral, the Commissioner denied the request.

The Attorney General also requested a contested case hearing if the Commissioner relied on disputed facts. (AG Brief, p 15-18) None of the facts relied upon in this order are disputed facts. While the Attorney General may view the $125 million capital contribution as funds for the purchase by the Accident Fund, there were not facts presented to offset the BCBSM position that it made the capital contribution to strengthen the surplus of the Accident Fund in light of the purchase.

Thus, BCBSM's characterization of the transfer in paragraph 11 of its Opening Brief is accepted as true:

11. On or about August 4, 2007, the BCBSM Board of Directors approved a capital contribution from BCBSM to Accident Fund "in an amount sufficient to insure the collective workers' compensation companies are able to maintain an 'A' insurance rating."

***2** This means that the capital contribution was for the purpose of strengthening surplus, and thereby bolstering its investment in a performing asset, and not for the purpose of subsidizing the Accident Fund rates or providing operating funds.

Even if there were some range of dispute as to how the transfer should be characterized, there is no authoritative source in the Insurance Code of 1956, as amended, MCL 500.100 *et seq.* (Code) or Act 350 requiring an evidentiary hearing in connection with this decision.

The Commissioner has considered the briefs of the parties, the record of the circuit court proceedings, the records of this agency, and the specialized knowledge of this agency in transactions between a parent company and its insurance company subsidiary. This order ensues.

II

THE CIRCUIT COURT REFERRAL TO THE COMMISSIONER WAS BASED UPON THE EXPERTISE OF THE AGENCY

Public Act 201 of 1993 authorized BCBSM to purchase the State Accident Fund, a workers compensation insurer which, at that time, was wholly owned by the State of Michigan. In June 1994, BCBSM created the Accident Fund as a privately held stock insurance company to assume the business of the State Accident Fund.

In November 2007, BCBSM made a capital contribution of $125 million to the Accident Fund. Shortly thereafter, the Accident Fund acquired a California workers compensation insurer, CompWest Insurance Company (CompWest), by purchasing 100% of the outstanding shares of CWI, Inc., a Delaware holding company that owns 100% of the shares of CompWest. The purchase price was $127.4 million. The Accident Fund's purchase was completed on December 28, 2007. It is this transaction that is the subject of the Attorney General's circuit court complaint.

In her order of October 6, 2008, Judge Manderfield determined that Count II of the Attorney General's complaint would be best resolved by the Commissioner. In making this decision, Judge Manderfield relied on the doctrine of primary jurisdiction under which a court may refer a matter, initiated as civil litigation, to an administrative agency for resolution.

Primary jurisdiction is "a flexible doctrine whose invocation is largely discretionary with the trial judge." *Attorney General v Raguckas*, 84 Mich App 618, 667 (1978). Such a referral may be made where (1) the agency has specialized expertise that makes it a preferable forum for resolving the issue; (2) there is a need for uniform resolution of the issue; and (3) there is a potential for an adverse impact on the agency's ability to perform its regulatory duties should the matter be resolved by the court. *Rinaldo's Construction Co v Michigan Bell Telephone Co*, 454 Mich 65, 71 (1997).

In applying the doctrine of primary jurisdiction to the present case, Judge Manderfield stated:

> [T]he Insurance Commissioner's specialized expertise makes [OFIR] a preferable forum for resolving the issue. It is further a situation where judicial resolution of the issue may well have an adverse impact on the Commissioner's performance of his regulatory responsibilities. [Opinion and Order of October 6, 2008, p 9.]

*3 OFIR is the only state agency with regulatory authority over nonprofit health care corporations such as BCBSM; workers compensation insurers such as the Accident Fund; and, insurance company holding systems like the BCBSM-Accident Fund arrangement. It is appropriate that a circuit court judge refer to the Commissioner civil litigation which requires extensive knowledge of these three regulatory subjects.

Judge Manderfield indicated in her order that she would likely have resolved the issue against BCBSM. However, there are at least two reasons why Judge Manderfield's discussion of Count II in her October 6 ruling was not binding on the Commissioner.

First, the ruling was made only in the context of denying BCBSM's summary motion. Her order does not contain a fully developed analysis of the issue. Second, if Judge Manderfield had intended her analysis to be dispositive of Count II, she would not have referred that matter to the Commissioner. Instead, she indicated that as to Count II she wanted the Commissioner to bring the specialized knowledge of this agency to bear on the issues.

Acting pursuant to Judge Manderfield's ruling, the Commissioner is charged with applying OFIR knowledge and expertise to determine whether the $125 million capital contribution violated Section 207(1)(x)(vi) and, if so, whether BCBSM must require the Accident Fund to return the $125 million.

III.

AGENCY EXPERTISE IN REGULATING THE INSURANCE INDUSTRY

This agency has been regulating the business of insurance since the middle of the 19th Century. The first Commissioner of Insurance, Samuel H. Row, assumed his duties in 1871. Financial solidity was the order of the day, then as now. There has always been a need for the professional assessment of the assets, liabilities, and financial transactions of insurers.

As relates to this matter, in 1912 the Legislature created, and placed under the Commissioner's supervision, the State Accident Fund. Many businesses in need of workers compensation insurance were unable to secure that coverage in the private market. The State Accident Fund, as a state owned entity, initially served as the insurer of last resort.

As things evolved in the last half of the 20th century, the State Accident Fund insured companies that could secure coverage elsewhere, but chose to buy their insurance from the State Accident Fund. Greater competition from private insurers diminished the need for the State Accident Fund to serve as the insurer of last resort. Increasingly, the book of business of the State Accident Fund resembled the book of business of an ordinary insurer. It was ripe for conversion to a private insurer under the authority of the 1993 Public Acts.

BCBSM was a child of the Great Depression. Doctors and hospitals looked for a reliable bill payer in those difficult financial times and they were influential in the creation of BCBSM, which was initially two corporations that were later put together by Act 350 in 1981. The Commissioner has always regulated BCBSM.

*4 In what would have undoubtedly been a great surprise to the lawmakers that set the stage for BCBSM, the corporation became the dominant health insurer in Michigan in the last half of the 20th century. Through its group insurance, individual insurance, and administrative service work for self-insured groups, it writes or manages more than 60% of the health care market.

In a variety of ways, BCBSM has sought to broaden its insurance horizons in the last three decades. It was poised and ready to enter the workers compensation market with its purchase of the State Accident Fund in 1994.

In a separate development in the 1960s, insurance regulators came to understand that there was every reason to carefully oversee companies buying insurance companies and the ensuing financial transactions between the companies. Most importantly, some companies had bought insurers and stripped their assets to an extent that the acquired insurers could not meet their financial obligations to policyholders.

These concerns led to the creation of model holding company laws that were enacted in Michigan in 1970. The model laws, developed through the National Association of Insurance Commissioners, were crafted in part by Michigan Insurance Commissioner David J. Dykhouse. The model laws, which regulate acquisitions of insurers and transactions between affiliated insurers, became Chapter 13 of the Code, MCL 500.1301 *et seq.*

Thus, this agency has been intensively regulating transactions between affiliated insurers since 1970. Most pertinent to this matter is MCL 500.1341, which provides:

(1) Transactions within a holding company system to which an insurer domiciled in this state or any foreign insurer whose written insurance premium in this state for each of the most recent 3 years exceeds the premiums written in its state of domicile and whose written premium in this state was 20% or more of its total written premium in each of the most recent 3 years is a party or with respect to which the assets or liabilities of these insurers are affected are subject to all of the following standards:

(a) The terms shall be fair and reasonable.

* * *

(2) The commissioner's prior approval shall be required for sales, purchases, exchanges, loans, extensions of credit, or investments, involving 5% or more of the insurer's assets at the immediately preceding year's end, between a domestic controlled insurer and any person in its holding company system.

(3) A domestic insurer and any person in its holding company system shall not enter into the following transactions with each other unless the insurer has notified the commissioner in writing of its intention to enter into the transaction at least 30 days, or a shorter period as the commissioner allows, prior to entering into the transaction and the commissioner has not disapproved it within that period:

(a) Sales, purchases, exchanges, loans, extensions of credit, or investments, provided the transaction is equal to or greater than the lesser of 3% of the insurer's assets or 25% of capital and surplus as of December 31 of the immediately preceding year.

*5 (b) Loans or extensions of credit to any person who is not an affiliate, where the insurer makes loans or extensions of credit with the agreement or understanding that the proceeds of the transactions, in whole or in substantial part, are to be used to make loans or extensions of credit to, to purchase assets of, or to make investments in, any affiliate of the insurer making the loans or extensions of credit provided the transaction is equal to or greater than the lesser of 3% of the insurer's assets or 25% of capital and surplus as of December 31 of the immediately preceding year.

(c) Reinsurance treaties or agreements.

(d) Rendering of services on a regular systematic basis.

(e) Any material transactions, specified by regulation, that the commissioner determines may adversely affect the interests of the insurer's policyholders.

* * *

BCBSM, regulated by Act 350, is not directly governed by Section 1341. Thus, while the $125 million capital contribution from BCBSM was not subject to the approval of the Commissioner, the Accident Fund, which is subject to Section 1341, reported it to the agency as well as its acquisition of CompWest The Accident Fund was required to seek prior approval of the CompWest purchase from the California Commissioner of Insurance under California's similar holding company laws.

While the $125 million capital contribution from BCBSM was not subject to agency approval, what is critical is that the agency reviews this sort of transaction with regularity. It has 17 accountants that spend time each year reviewing inter-company capital contributions. The agency reviewed over 50 capital contributions in the past three years.

This agency, through its regular scrutiny of capital contributions, is in an excellent position to assess whether the $125 million capital contribution at issue amounted to a subsidy, a transfer for operating expenses, or another form of financial transaction for the purposes of Section 207(1)(x)(vi).

IV

ANALYSIS

A. The Principal Allegations of the Attorney General

The allegations brought by the Attorney General in Count II are stated in paragraphs 45 and 46 of the Attorney General's circuit court complaint:

45. Blue Cross made the $125 million capital contribution to the Accident Fund (with the express approval of Blue Cross' Board of Directors) for the purpose of funding the Accident Fund's acquisition of CWI/CompWest. As such, Blue Cross used company funds to operate the Accident Fund in violation of MCL 550.1207(1)(x)(vi) by, among other ways: (a) performing the funding function; (b) exerting the power or influence necessary to secure the acquisition of CWI/CompWest; and (c) producing the desired outcome or effect, i.e., ensuring the Accident Fund's successful acquisition of CWI/CompWest.

46. Blue Cross is not authorized to use (and is in fact expressly prohibited from using) company or subscriber funds to operate or subsidize the Accident Fund in any way, including but not limited to making capital contributions to the Accident Fund to enable it to acquire CWI/CompWest or any other insurance company.

***6** Section 207(1)(x)(vi), which lies at the center of this dispute, provides:

(1) A health care corporation, subject to any limitation provided in this act, in any other statute of this state, or in its articles of incorporation, may do any or all of the following:

* * *

(x) Notwithstanding subdivision (o) or any other provision of this act, establish, own, and operate a domestic stock insurance company only for the purpose of acquiring, owning, and operating the state accident fund pursuant to chapter 51 of the insurance code of 1956, 1956 PA 218, MCL 500.5100 to 500.5114, so long as all of the following are met:

* * *

(vi) Health care corporation and subscriber funds are not used to operate or subsidize in any way the insurer including the use of such funds to subsidize contracts for goods and services. This subparagraph does not prohibit joint undertakings between the health care corporation and the

insurer to take advantage of economies of scale or arm's-length loans or other financial transactions between the health care corporation and the insurer.

The central issue of this case is whether the November 2007 capital contribution constitutes BCBSM operating or subsidizing the Accident Fund as proscribed by Section 207(1)(x)(vi) or whether the capital contribution is an "other financial transaction" permitted by that section.

B. Three Public Acts Underlying the Dispute

Section 207(1)(x)(vi) appears in one of three Public Acts passed in 1993 under which BCBSM acquired the State Accident Fund. The 1993 Acts amended the Workers Disability Compensation Act, the BCBSM Act, and the Insurance Code. These Acts are germane to this matter:

· PA 198 (SB 51) — Amended the Workers Disability Compensation Act, authorizing the sale of the State Accident Fund.

· PA 200 (SB 346) — Amended parts of the Insurance Code and created Chapter 51 of the Insurance Code ("Organization of an Acquiring Insurer or Transaction of Certain Types of Insurance"). This Act contains detailed requirements for establishing and approving workers compensation rates, in the event that the insurer acquiring the State Accident Fund was controlled by BCBSM.

· PA 201 (SB 568) — Amended Section 207 of Act 350 to permit a nonprofit health care corporation to own a domestic stock insurance company to acquire the State Accident Fund. Enactment of this statute was conditioned on the passage of PA 200, above. It is Section 207(1)(x) of this Act which the AG alleges was violated by the November 2007 fund capital contribution.

The Attorney General asserts that any movement of BCBSM funds to the Accident Fund not explicitly authorized by Section 207(1)(x)(vi) is prohibited. BCBSM argues that it may make a capital contribution to the Accident Fund so long as the funds are not used to reduce the Accident Fund's workers compensation rates to the detriment of other workers compensation insurers. For the reasons set forth belows the Commissioner concludes that the November 2007 capital contribution did not violate Section 207(1)(x)(vi).

C. The Definitions of the Key Terms Used in Section 207(1)(x)(vi) Show that the Capital Contribution was Authorized Under that Section.

*7 In order to determine whether Section 207(1)(x)(vi) has been violated, it is necessary to understand several terms used in that section: "subsidize," "operate," and "other financial transactions." The legislature did not provide definitions for these terms when it created Section 207(1)(x)(vi).

The lynchpin of the Attorney General's position is that the $125 million capital contribution was a subsidy to the Accident Fund. The Attorney General argues that, in the absence of statutory definitions, the *Merriam-Webster Collegiate Dictionary* definition of "subsidize" and "operate" must be employed. In contrast, BCBSM argues that these terms have special definitions derived from the fact that they are employed in the statute in the context of workers compensation rate setting. The Attorney General further argues that the meaning of "other financial transactions" is limited. BCBSM, of course, would give a broad reading to this phrase.

1. "Subsidize" is a technical term in the business of insurance and its technical definition governs this dispute.

What "subsidize" means lies at the heart of the Attorney General's contentions.

Subsidize has an insurance industry-specific meaning. The term is defined in Barron's *Dictionary of Insurance Terms* as the "difference between the ACTUARIAL EQUIVALENT (rate) and the often lower rate actually charged to insure a risk." ("Actuarial equivalent" is a "mathematical determination based on the expectation of loss and the benefits to be paid in such an eventuality. The premium charged will vary directly with the probability of loss.") Thus, "subsidy" in the insurance industry refers to the relationship between premiums and expected losses.

While the Attorney General argues for a broad dictionary definition of "subsidize," statutory and judicial standards for the construction of statutes mandate that technical terms shall be construed in their technical sense. MCL 8.3a provides:

> All words and phrases shall be construed and understood according to the common and approved usage of the language; but technical words and phrases, and such as may have acquired a peculiar and appropriate meaning in the law, shall be construed and understood according to such peculiar and appropriate meaning.

As expected, there has been an abundance of appellate court cases drawing upon and adhering to this statutory standard, one recent example being *People v. Blunt*, 282 Mich App 81, 83 (2009).

The commonness and soundness of this principle is underscored by the Michigan Supreme Court applying it to constitutional interpretations, *Michigan Coalition of State Employee Unions v. Michigan Civil Service Commission*, 465 Mich. 212, 222 (2001), and the United State Supreme Court applying it in the construction of federal statutes, *Corning Glass Works v. Brennan*, 417 U.S. 188, 201 (1974).

***8 2. From the inception of the unified BCBSM, the Legislature recognized and utilized "subsidy" in its rate-related technical sense in Act 350.**

Act 350, passed in 1980, became law in 1981. In the original act, the Legislature made a significant use of the term "subsidy." The Legislature used the term in the context of setting rates. MCL 550.1436 provides:

> There may be created within each health care corporation a Michigan caring program for children. The program shall provide primary health care coverage for children as set forth in section 438 and shall be administered by the health care corporation. Each program shall be described in a certificate that sets forth the benefits provided. A certificate and the contribution to be charged shall be subject to the commissioner's approval. Contribution requirements shall be established in accordance with rating methodologies approved by the commissioner which, over time, shall not result in either gain or loss to the corporation. *The rating methodology for a program shall not include any factors otherwise includable pursuant to other sections of this act that are intended to provide for subsidies, surcharges, or administrative costs.* Any other provisions of this act that would otherwise apply to a program but which are inconsistent with the provisions of this section and sections 437 to 439 are superseded. [Emphasis added.]

This has reference to MCL 550.1609(5), where, as an exception to the requirement that rates for each line of business must be self-sustaining— meaning no subsidy—BCBSM was authorized to use its funds to subsidize certain rates through capital contributions:

> Except for identified cost capital contributions, each line of business, over time, shall be self-sustaining. However, there may be cost capital contributions for the benefit of senior citizens and group conversion subscribers. Cost capital contributions for the benefit of senior citizens, in the aggregate, annually shall not exceed 1% of the earned subscription income of the health care corporation as reported in the most recent annual statement of the corporation. Group conversion subscribers are those who have maintained coverage with the health care corporation on an individual basis after leaving a subscriber group.

Thus, the Legislature has been mindful of, and carefully controlled, subsidies in rates, as it did in the original act in 1980 and later in Section 207(1)(x)(vi) in 1993 by prohibiting BCBSM from using its resources to subsidize the Accident Fund rates.

3. Legislative history shows a major concern was that BCBSM, after acquiring the Accident Fund, could use its resources to subsidize Accident Fund rates, thereby driving out competition. The $125 million capital contribution was a transfer to strengthen surplus, not a transfer to subsidize Accident Fund rates.

The influence that BCBSM might exert on the Accident Fund premium rates was a significant legislative concern when the Accident Fund privatization statutes were being drafted. The Legislature in Public Act 200 of 1993 detailed how rates were to be established and regulated should BCBSM become the purchaser of the State Accident Fund. See MCL 500.2403, 500.2406, and 500.2420.

***9** There are no similar restrictions in those Acts which would apply if some other insurer purchased the State Accident Fund. The Acts demonstrate that the Legislature believed there were circumstances unique to BCBSM as a potential purchaser that warranted additional restrictions on BCBSM when acting as the Accident Fund's parent.

A September 15, 1993, analysis prepared by the House Legislative Analysis Section summarized the arguments supporting and opposing the privatization bills. The pertinent section of that analysis (pages 9-10) is set forth in full below, with emphasis added:

Against:

While privatizing the fund may be a good idea, allowing [BCBSM] to enter the bidding process with the possible goal of buying the fund, as Senate Bill 568 would permit, goes against the whole idea of privatization. Simply put, BCBSM is not a private company. It was created by the legislature under Public Act 350 of 1980 and is subject to political manipulation of its rates and business activities just as is the accident fund now. *If BCBSM were allowed to bid on the fund, it probably would offer the highest bid. And if it were to buy the fund, it could — by virtue of its current dominance in the health care market — leverage its buying power with health care providers to effectively undercut private worker's compensation carriers. Assuming it owned the fund, BCBSM could artificially reduce the rates charged for worker's compensation insurance, subsidized via its health care operations, in order to put other carriers out of business and eventually monopolize the market; rates, of course, eventually would rise as fewer carriers wrote policies*. On the other hand, allowing BCBSM to venture into another insurance market could harm its primary mission of acting as a quasi-governmental health care insurance carrier. It seems odd that the state would create an agency like BCBSM and strictly limits its scope of operations, and then reverse itself by allowing the Blues to act as a private worker's compensation insurance carrier. Also, what assets would BCBSM use to purchase the fund? It's supposed to be a nonprofit corporation, and any reserves it has are statutorily required to be at a level appropriate solely to pay its claims and other expenses. If BCBSM now believes it has enough "extra money" in reserves or elsewhere to purchase the accident fund, does that not suggest that it may have been and still is overcharging its subscribers?

Response:

A number of provisions were added to the House committee substitute for Senate Bill 568 that would prevent BCBSM from acting unscrupulously if it were to buy the fund. Language was added that specifically would prohibit BCBSM from subsidizing its worker's compensation rates, and that would require it to submit certain information about its rates to the insurance commissioner. In addition, the substitute would allow other insurance carriers to bring a contested case hearing against BCBSM if they felt its rates were too low. With these protections added to Senate Bill 568, the state could be assured that proper oversight of BCBSM would exist if it were to purchase the fund. More importantly, however, it would be certain to receive hundreds of millions of dollars more from selling the fund that it otherwise might if BCSBM were not allowed to bid.

***10** The language of Section 207(1)(x)(vi) and the analysis quoted above demonstrate that the Legislature was careful to ensure that the economic power of BCBSM would not be wielded to enhance the Accident Fund's influence in the workers compensation marketplace. The Attorney General's complaint and subsequent briefs have not established a different rationale for the restrictions of Section 207(1)(x)(vi).

In the 15 years since privatization, no complaint has been filed with the Commissioner by a workers compensation insurer claiming that the Accident Fund rates have been too low, even though MCL 500.2420(3) created a process for receiving and adjudicating such complaints. This shows that the special rate provisions of Public Act 200 have been successful in preventing the use of BCBSM's economic power to improperly influence workers compensation rates.

4. The Business Plan submitted by BCBSM to the State of Michigan in 1994 demonstrates that all parties, including the Attorney General who represented the State, understood that capital contributions of BCBSM funds to strengthen the surplus of the Accident Fund were an obligation where needed. This establishes that capital contributions to strengthen surplus would not be understood to be subsidies or operating expenses prohibited by Section 207(1)(x)(vi).

In connection with its bid to purchase the State Accident Fund, BCBSM submitted a five-year Business Plan to the State of Michigan. See Complaint, Exhibit A. On page two of the Business Plan, BCBSM represented to the State of Michigan that:

> [BSBSM] plans to keep the Accident Fund financially strong by allowing earnings to accumulate in the [Accident] Fund until statutory surplus is adequate to obtain an A rating by A.M. Best and [BCBSM] is prepared to make capital contributions to the Accident Fund from its general assets in the form of surplus notes in the early years to maintain an acceptable writing to surplus ratio.

On page 6 of the Business Plan, BCBSM similarly represented to the State of Michigan that BCBSM would make contributions to the Accident Fund in the form of surplus notes in order to

maintain adequate surplus, the Accident Fund's A.M. Best rating, and a net premiums written to surplus ratio of 1.5 to 1.

5. The Asset Purchase Agreement entered into by BCBSM in its acquisition of the Accident Fund obligated BCBSM for a period of seven years to use its funds to strengthen the surplus of the Accident Fund if needed. The Attorney General, representing the State, reviewed this agreement This shows that capital contributions to strengthen surplus were not understood to be subsidies or operating expenses prohibited by Section 207(1)(x)(vi).

To complete the sale of the State Accident Fund, BCBSM, as the Bidder, the State of Michigan, as the Seller, and the Accident Fund, as the Buyer, entered into an Asset Purchase Agreement dated June 15, 1994 (Agreement), and a First Amendment to the Agreement dated December 28, 1994. See Complaint at Exhibit B. Section 8(o) of the Agreement provided that:

> ***11** [S]o long as [BCBSM] is Controlling Affiliate of [Accident Fund], [BCBSM] shall make contributions to [Accident Fund] from [BCBSM]'s general assets in the form of surplus notes, to the extent permitted by law and with the prior approval of the Michigan Commissioner of Insurance, sufficient to create and maintain, at all times, [Accident Fund]'s ratio of net written premium to surplus at a level less than or equal to one and one-half to one (1.5: 1). [See Complaint at Exhibit B.]

It was a condition of the sale that BCBSM would for a period of seven years make capital contributions to the Accident Fund as needed to strengthen surplus. This was the commitment that BCBSM made to the State of Michigan.

6. Expert agency analysis of capital contributions between insurers in general confirms that the $125 million capital contribution was not a subsidy or a transfer for operating expenses under Section 207(1)(x)(vi). It was, instead, an investment that falls under "other financial transaction" in Section 207(1)(x)(vi).

This agency has devoted substantial resources to evaluate inter-company financial transactions under Section 1341, quoted above. It has a workforce of 17 accountants that analyze a variety of transactions, including extraordinary dividends, service contracts, land sales, and capital contributions. These accountants, after joining OFIR, mentor for years with more experienced staff members. This careful training builds a specialized knowledge in insurance accounting.

This specialized knowledge is necessary because the business of insurance has many unique facets and because, while most businesses are regulated under General Accounting Accepted Principles (GAAP), the insurance industry, for most purposes, is governed by the Statutory Accounting Principles (SAP). Overall, SAP is more conservative than GAAP as to assets and liabilities given that the primary mission of insurance regulation is keeping insurers financially sound so that they can meet their duty to pay claims, many of which arise years after a policy is purchased.

The staff has reviewed over 50 capital contributions reported under Section 1341 in the past three years. It has a deep working knowledge of subsidies, operating expenses, and financial transactions in general, especially capital contributions. As noted, the BCBSM capital contribution was not subject to approval since this transaction was regulated under Section 207(1)(x)(vi), but the staff's insight on key terms used in that section is invaluable.

Rather than a subsidy, OFIR views the November 2007 capital contribution as a shifting back of funds or capital that was previously paid to BCBSM by the Accident Fund. BCBSM returning capital back to the Accident Fund is an efficient and effective use of capital within the holding company. In holding company systems, capital is often shifted among member companies in order to maximize the return on equity. This capital movement is preferable to obtaining a loan from an outside lender because interest charges can be minimized and retained within the holding company system rather than being paid to an outside entity.

***12** The $125 million capital contribution allowed the Accident Fund to maintain a favorable rating with outside rating agencies. The Accident Fund could have made the purchase of CompWest without the capital contribution of funds from BCBSM and the purchase would have likely been approved by California insurance regulators. The decision to have the additional capital is typical of insurers who prefer to maintain a high rating in order to afford agents and policyholders an additional comfort level.

As to operating funds, in accounting, they are different than capital funds. Operating funds flow out of an insurer to meet its business obligations. Capital funds are retained as a reserve for dividend distribution, to satisfy regulatory requirements, or to maintain a favorable rating with rating agencies in order to be viewed favorably by investors and policyholders.

In summary, in the staff's expert opinion, the transfer was not used to "operate" or "subsidize" the Accident Fund. It was, instead, a "financial transaction" designed to achieve, and achieving, the strengthening of the Accident Fund's surplus. This strengthening was correctly reflected in the quarterly and annual statements of the Accident Fund.

Capital contributions from a parent to its insurance subsidiary to strengthen surplus, and thus enhance its investment in the subsidiary, are commonplace. The transfer at issue here, had it been subject to Section 1341, would not even had required the Commissioner's approval, given the commanding assets of BCBSM and its capital and surplus as of December 31, 1993.

7. The history of transfers of funds between BCBSM and the Accident Fund from 1994 through 2007 establishes that the Accident Fund, up to the transfer at issue, had transferred $144.8 million more in funds to BCBSM than BCBSM transferred to it Even taking into account the $125 million capital contribution in November 2007, the Accident Fund remained ahead in transfers by $19.8 million. This makes it clear that, collectively, over the

duration of their affiliation, BCBSM has not subsidized the Accident Fund as proscribed by Section 207(1)(x)(vi).

The Attorney General has taken a single movement of funds from BCBSM to the Accident Fund and claimed that it was a gift of funds. However, over the lifetime of the BCBSM-Accident Fund relationship, there have been numerous monetary transactions between the two entities. Ten transactions occurred before the $125 million transaction:

1.	1994	BC to AF	$10,000,000	stock purchase
2.	1995	BC to AF	$40,000,000	surplus contribution [1]
3.	1999	AF to BC	$100,000,000	shareholder dividend
4.	2000	AF to BC	$35,000,000	shareholder dividend
5.	2000	BC to AF	$200,000	capital contribution [2]
6.	2001	AF to BC	$33,000,000	shareholder dividend
7.	2002	AF to BC	$1,800,000	shareholder dividend
8.	2002	BC to AF	$1,800,000	capital contribution [2]
9.	2006	AF to BC	$15,000,000	shareholder dividend
10.	2007	AF to BC	$12,000,000	shareholder dividend
11.	2007	BC to AF	$125,000,000	capital contribution

***13** The net effect of these transactions is that, since the initial purchase, the Accident Fund had furnished to BCBSM $19.8 million more than the Accident Fund had received from BCBSM. Moreover, before the $125 million transaction, the Accident Fund had sent to BCBSM $144.8 million more than BCBSM had transferred to the Accident Fund.

The Attorney General's preferred definition of subsidy as a "non-repayable gift" (AG Brief, p 6) does not reflect the reality of the BCBSM-Accident Fund relationship. BCBSM has always had the expectation of a return on its investment in the Accident Fund. This expectation has been realized, as shown above. BCBSM has received dividends from the Accident Fund which are well in excess of the money BCBSM has invested in the Accident Fund. An investment is not a gift or subsidy, under any definition.

IV

FINDINGS OF FACT

The Parties

1. BCBSM is a nonprofit health care corporation governed by the Nonprofit Health Care Corporation Reform Act, MCL 550.1101, *et seq*, referred to as Act 350

2. The Accident Fund is a Michigan domestic insurer, formed pursuant to chapter 51 of the Michigan Insurance Code.

3. The Attorney General is broadly authorized by the Michigan Constitution of 1963 to initiate litigation on behalf of the public to secure the enforcement of state laws.

The Circuit Court Case and the Referral

4. This matter comes before the Commissioner by referral from the Ingham County Circuit Court (Case No. 08-917-CZ).

5. In the circuit court case, the Attorney General asserted that BCBSM violated Act 350 with respect to transactions with its subsidiary, the Accident Fund.

6. Count II of the complaint was dismissed without prejudice and referred to the Commissioner for resolution. In Count II, the Attorney General alleged that a $125 million capital contribution from BCBSM to the Accident Fund in November 2007 was an unlawful subsidy that violated MCL 550.1207(1)(x)(vi), which is Section 207(1)(x)(vi) of Act 350. The Attorney General sought an order to have the funds returned to BCBSM.

7. In her order of October 6, 2008, Judge Manderfield determined that Count II of the Attorney General's complaint would be best resolved by the Commissioner. In making this decision, Judge Manderfield relied on the doctrine of primary jurisdiction under which a court may refer a matter, initiated as civil litigation, to an administrative agency for resolution.

8. In applying the doctrine of primary jurisdiction to the present case, Judge Manderfield stated:

> [T]he Insurance Commissioner's specialized expertise makes [OFIR] a preferable forum for resolving the issue. It is further a situation where judicial resolution of the issue may well have an adverse impact on the Commissioner's performance of his regulatory responsibilities. [Opinion and Order of October 6, 2008, p 9.]

9. Since the Accident Fund is a directly affected corporation, the Commissioner invited it to join in the informal proceedings. It accepted and participated in negotiations as to stipulated facts and submitted a brief.

Statutes Leading to the Acquisition

***14** 10. Public Act 198 of 1993 amended the Workers Disability Compensation Act and authorized the sale of the State Accident Fund.

11. Public Act 200 of 1993 created chapter 51 of the Michigan Insurance Code which established procedures for setting workers compensation rates in the event that the State Accident Fund was purchased by BCBSM.

12. Public Act 201 of 1993 made additions to Section 207 of Act 350 to permit BCBSM to create, own, and operate a domestic stock insurance company to acquire the State Accident Fund. Section 207 additions also described the authority of BCBSM in acting as the parent of the insurer which acquired the State Accident Fund.

Expertise of the Agency

13. This agency has been regulating the business of insurance since the middle of the 19th Century.

14. In 1912, the Legislature created, and placed under the Commissioner's supervision, the State Accident Fund.

15. BCBSM was initially two corporations that were later put together by Act 350 in 1981. The Commissioner has always regulated BCBSM.

16. Model holding company laws were enacted in Michigan in 1970. The model laws, developed through the National Association of Insurance Commissioners, were crafted in part by Michigan Insurance Commissioner David J. Dykhouse. These model laws regulate the acquisitions of insurers and transactions between affiliated insurers.

17. This agency has been intensively regulating transactions between affiliated insurers since 1970, principally through its enforcement of MCL 500.1341.

18. BCBSM, regulated by Act 350, is not directly governed by Section 1341.

19. While the $125 million capital contribution from BCBSM was not subject to agency approval, what is critical is that the agency reviews this sort of transaction with regularity. It has 17 accountants that spend time each year reviewing inter-company capital contributions. The agency reviewed over 50 capital contributions in the past three years.

20. This agency, through its regular scrutiny of capital contributions, is in an excellent position to assess whether the $125 million capital contribution at issue amounted to a subsidy, a transfer for operating expenses, or another form of financial transaction for the purposes of Section 207(1)(x)(vi).

Steps in the Acquisition

21. Following passage of Public Act 201 of 1993, BCBSM created a wholly-owned subsidiary stock insurance company, the Accident Fund Company, to acquire the State Accident Fund. The Accident Fund Company was later renamed the Accident Fund Insurance Company of America.

22. On June 15, 1994, the State of Michigan, BCBSM, and the Accident Fund executed an Asset Purchase Agreement under which the Accident Fund would acquire the State Accident Fund. This Agreement was amended December 28, 1994. A business plan was part of the agreement.

23. On November 13, 2007, BCBSM made a capital contribution of $125 million to the Accident Fund.

*15 24. On November 20, 2007, the Accident Fund acquired 100% of the outstanding shares of CWI Holdings, Inc., a Delaware insurance holding company that owns 100% of the shares of CompWest Insurance Company, a California property and casualty insurance company writing workers compensation insurance, primarily in California. The Accident Fund paid $127.4 million for CWI Holdings.

25. On December 28, 1994, the Accident Fund completed its purchase of the State Accident Fund.

Principal Findings

26. The definitions of the key terms used in Section 207(1)(x)(vi) show that the capital contribution was authorized under that section.

27. "Subsidize" is a technical term in the business of insurance and its technical definition governs this dispute.

28. Subsidize has an insurance industry-specific meaning. The term is defined in Barron's *Dictionary of Insurance Terms* as the "difference between the ACTUARIAL EQUIVALENT (rate) and the often lower rate actually charged to insure a risk." ("Actuarial equivalent" is a "mathematical determination based on the expectation of loss and the benefits to be paid in such an eventuality. The premium charged will vary directly with the probability of loss.") Thus, "subsidy" in the insurance industry refers to the relationship between premiums and expected losses.

29. From the inception of the unified BCBSM, the Legislature recognized and utilized "subsidy" in its rate-related technical sense in Act 350.

30. Act 350, passed in 1980, became law in 1981. In the original act, the Legislature made a significant use of the term "subsidy." The Legislature used the term in the context of setting rates.

31. Legislative history shows a major concern was that BCBSM, after acquiring the Accident Fund, could use its resources to subsidize Accident Fund rates, thereby driving out competition. The $125 million capital contribution was a transfer to strengthen surplus, not a transfer to subsidize Accident Fund rates.

32. In the 15 years since privatization, no complaint has been filed with the Commissioner by a workers compensation insurer claiming that Accident Fund rates have been too low, even though MCL 500.2420(3) created a process for receiving and adjudicating such complaints. This shows that the special rate provisions of Public Act 200 have been successful in preventing the use of BCBSM's economic power to improperly influence workers compensation rates.

33. The Business Plan submitted by BCBSM to the State of Michigan in 1994 demonstrates that all parties, including the Attorney General who represented the State, understood that capital contributions of BCBSM funds to strengthen the surplus of the Accident Fund were an obligation where needed. This establishes that capital contributions to strengthen surplus would not be understood to be subsidies or operating expenses prohibited by Section 207(1)(x)(vi).

***16** 34. On page 6 of the Business Plan, BCBSM similarly represented to the State of Michigan that BCBSM would make contributions to the Accident Fund in the form of surplus notes in order to maintain adequate surplus, Accidents Fund's A.M. Best rating, and a net premiums written to surplus ratio of 1.5 to 1.

35. The Asset Purchase Agreement entered into by BCBSM in its acquisition of the Accident Fund obligated BCBSM for a period of seven years to use its funds to strengthen the surplus of the Accident Fund if needed. The Attorney General, representing the State, reviewed this agreement. This shows that capital contributions to strengthen surplus were not understood to be subsidies or operating expenses prohibited by Section 207(1)(x)(vi).

36. In November 2007, the Accident Fund had access to assets sufficient to purchase CompWest without obtaining any funds from BCBSM.

37. Expert agency analysis of capital contributions between insurers in general confirms that the $125 million capital contribution was not a subsidy or a transfer for operating expenses under Section 207(1)(x)(vi). It was, instead, an investment that falls under "other financial transaction" in Section 207(1)(x)(vi).

38. The $125 million capital contribution allowed the Accident Fund to maintain a favorable rating with outside rating agencies.

39. Operating funds, in accounting, are different than capital funds. Operating funds flow out of an insurer to meet its business obligations. Capital funds are retained as a reserve for dividend distribution, to satisfy regulatory requirements, or to maintain a favorable rating with rating agencies in order to be viewed favorably by investors and policyholders.

40. Capital contributions from a parent to its insurance subsidiary to strengthen surplus, and thus enhance its investment in the subsidiary, are commonplace.

41. The history of transfers of funds between BCBSM and the Accident Fund from 1994 through 2007 establishes that the Accident Fund, up to the transfer at issue, had transferred $144.8 million more in funds to BCBSM than BCBSM transferred to it. Even taking into account the $125 million capital contribution in November 2007, the Accident Fund remained ahead in transfers by $19.8 million. This makes it clear that, collectively, over the duration of their affiliation, BCBSM has not subsidized the Accident Fund as proscribed by Section 207(1)(x)(vi).

42. The capital contribution was for the purpose of strengthening surplus, and thereby bolstering its investment in a performing asset, and not for the purpose of subsidizing Accident Fund rates or providing operating funds.

V

CONCLUSIONS OF LAW

Based upon the foregoing analysis, the Commissioner concludes that:

1. There is no authority in Act 350 providing for a formal hearing in deciding this matter. The parties have had a fair and ample opportunity to present facts and argue laws in their briefs.

2. This dispute is governed by Section 207(1)(x)(vi).

***17** 3. Technical terms used in statutes are to be construed and applied in their technical sense according to MCL 8.3a. That includes "subsidy," "operate," and "other financial transactions," used in Section 207(1)(x)(vi).

4. BCBSM did not violate Section 207(1)(x)(vi) in its November 2007 capital contribution to the Accident Fund.

VI

ORDER

Therefore, it is ORDERED that:

1. The November 2007, capital contribution is not set aside; and

2. BCBSM is not required to direct the Accident Fund to repay BCBSM's November 2007 capital contribution.

Ken Ross

Commissioner

Footnotes

1 Repaid with interest in 1996 and 1997.

2 Required by non-Michigan regulators.

2009 WL 1360675 (Mich.Off.Fin.Insur.Serv.)

EXHIBIT B

2004 WL 225059
Only the Westlaw citation
is currently available.

Court of Appeals of Michigan.

SOUTHFIELD EDUCATION ASSOCIATION, Southfield Public Schools Michigan Education Support Personnel Association, and Educational Secretaries of Southfield, Charging-Parties-Appellants,
v.
SOUTHFIELD PUBLIC SCHOOLS, Respondent-Appellee.

No. 240050. | Feb. 5, 2004.

Before: WILDER, P.J., and GRIFFIN and COOPER, JJ.

Opinion

[UNPUBLISHED]

PER CURIAM.

***1** Charging parties Southfield Education Association, Southfield Public Schools Michigan Education Support Personnel Association, and Educational Secretaries of Southfield appeal as of right from an order entered by the Michigan Employment Relations Commission (MERC) dismissing their unfair labor practice charge against respondent Southfield Public Schools. We affirm.

We are asked to determine whether the MERC properly concluded that respondent did not violate its duty to bargain in good faith by deciding to enforce the leave policies contained in the parties' collective bargaining agreements (CBAs); thereby deviating from the permissive leave policy it had employed in the past. Because the CBAs unambiguously grant respondent discretion in granting leaves of absence, charging parties have failed to show that respondent acted contrary to the contract terms by choosing to grant all leaves. To the extent respondent may not have enforced some of its rights under the agreements, charging parties have failed to show an actual agreement to alter the agreements. For this reason, we also find that the MERC properly rejected the charging parties' claim of direct dealing.

The MERC's factual findings are conclusive when "supported by competent, material, and substantial evidence on the record considered as a whole."[1] Due deference is also afforded to the MERC's administrative expertise.[2] The MERC's legal determinations will only be set aside if they violate the constitution or a statute, or "are based on a substantial and material error of law."[3]

The parties' leave policies in this case were originally defined in June 1990 during negotiations for a CBA. Charging parties subsequently entered into CBAs with respondent in 1996. For purposes of this appeal, the 1996 agreements essentially provided that in most circumstances unpaid leaves *may* be granted or extended at respondent's discretion. It is undisputed, however, that defendant

granted all leave requests and extensions from at least 1982 to 1998.

The instant controversy began when respondent sent a memorandum to its employees on July 27, 1998, informing them that it was changing its practice with regard to leaves of absence. Rather than routinely granting leaves and leave extensions, respondent stated that its permissive leave policy would be discontinued because school enrollment was increasing. The memorandum explained that leaves of absence were routinely granted in the past because school enrollment was declining and unpaid leaves helped minimize layoffs. It further stated that leaves of absence and extensions would be "granted or denied as determined by the administration." Charging parties filed an unfair labor practices charge alleging that respondent unilaterally changed the leave policies. Both the hearing referee and the MERC rejected this claim and the instant appeal followed.

Public employers are required to bargain in good faith over "wages, hours, and other terms and conditions of employment...."[4] As such, once an agreement is reached between labor and management, neither may unilaterally modify its terms without the other party's consent.[5] However, it has been commonly accepted that " '[a] past practice which does not derive from the parties' collective bargaining agreement may become a term or condition of employment which is binding on the parties." ,6

***2** Our Supreme Court provided the following guidance regarding the ability of past practices to modify the terms of an agreement:

> In order to create a term or condition of employment through past practice, the practice must be mutually accepted by both parties. *Where the collective bargaining agreement is ambiguous or silent on the subject for which the past practice has developed, there need only be "tacit agreement that the practice would continue." However, where the agreement unambiguously covers a term of employment that conflicts with a parties' past behavior, requiring a higher standard of proof facilitates the primary goal of the [Public Employment Relations Act]-to promote collective bargaining to reduce labor-management strife.* A less stringent standard would discourage clarity in bargained terms, destabilize union-management relations, and undermine the employers' incentive to commit to clearly delineated obligations.
>
> Requiring a higher standard of proof when there is express contract language to the contrary comports with previous Michigan cases regarding modification. Generally, parties are free to take from, add to, or modify an existing contract. However, in the same way a meeting of the minds is necessary to create a binding contract, so also is *a meeting of the minds necessary to modify the contract after it has been made.* A collective bargaining agreement, like any other contract, is the product of informed understanding and mutual assent. To require a party to bargain anew before enforcing a right set forth in the contract requires proof that the parties knowingly, voluntarily, and mutually agreed to new obligations.[7]

It is insufficient to merely show that a party knew or should have known that its past practices conflicted with express contract language.[8] Rather, to establish that a past practice modified the contract, a party must show that both contracting parties had a "meeting of the minds" with respect to the changes and specifically intended that the practice would replace the agreed upon term.[9] As noted in *Port Huron,* "it is the underlying agreement to modify the contract that alters the parties' obligations, not the past practice."[10]

Here, the past practice charging parties allege-approval of all leave requests-does not conflict with unambiguous contract provisions granting respondent complete discretion regarding most requests. And to the extent respondent's actions could be viewed as conflicting with these contract provisions, by the fact it ignored certain leave restrictions or created a practice of mandatory approval, we agree with the MERC that charging parties have failed to show a voluntary, knowing, and intentional agreement to modify the contract.[11] The fact that respondent refrained from denying leaves or enforcing the restrictions placed on leaves does not show that it intended to bind itself to an agreement to approve all future requests.[12]

***3** As the MERC observed, this case is clearly distinguishable from *Detroit Police Officers Ass'n,* where our Supreme Court concluded that the charging party presented substantial evidence to show that the parties adopted their past practices as an amendment.[13] In that case the charter provided the board of trustees with the authority to determine whether an individual's disability was duty-related for retirement purposes.[14] However, the charging parties in that case presented evidence showing that the board of trustees had accepted over one hundred decisions from the medical board of review on the issue of duty-relatedness as binding.[15] The charging parties in that case also presented several forms the board of trustees created asking the medical board of review to make duty-related findings and emphasizing that these findings were final .[16]

Conversely, charging parties in this case have failed to provide any evidence showing that respondent acknowledged or intended to implement a new mandatory approval policy. Even in the July 1998 memorandum to its employees, respondent referred to the leave policy as a permissive practice and not mandatory. As noted by the MERC, and perhaps more indicative of the parties' intent, is the fact that despite a history of liberally granting leave requests, the 1990 agreement respondent negotiated with charging parties provided it with complete discretion regarding leaves and stated the responsibilities of employees on leave. These provisions were referred to in the ensuing CBAs.

We further reject charging parties' argument on appeal that the MERC applied an improper standard by adding a "tangible affirmative steps" element to their burden of proof. A review of the record shows that the MERC was merely noting a factual difference between the present case and *Detroit Police Officers Ass'n.*[17] Accordingly, we find that the MERC correctly held that charging parties failed to meet their burden of showing that respondent intended to modify the contract through its past practices.

We also find no merit to charging parties' claim that respondent engaged in direct dealing. Direct dealing with employees constitutes an unfair labor practice.[18] But an employer is permitted to "communicate with employees in a noncoercive manner as long as he does not engage in individual bargaining on mandatory subjects."[19] Absent the duty to negotiate, information regarding policy changes falls within the general communication permitted between employers and employees.[20] Because respondent did not have a duty to bargain over the matters contained in the July 1998 memorandum, the MERC properly rejected this claim.[21]

Affirmed.

Footnotes

1 *Grandville Mun Executive Ass'n v City of Grandville*, 453 Mich. 428, 436; 553 NW2d 917 (1996).

2 *Gogebic Community College Michigan Ed Support Personnel Ass'n v Gogebic Community College*, 246 Mich.App 342, 348-349; 632 NW2d 517 (2001).

3 *Grandville, supra* at 436.

4 MCL 423.215(1); *Gogebic, supra* at 349.

5 *St Clair Intermediate School Dist v Intermediate Ed Ass'n*, 458 Mich. 540, 566-567; 581 NW2d 707 (1998).

6 *Port Huron Ed Ass'n v Port Huron Area School Dist*, 452 Mich. 309, 311-312; 550 NW2d 228 (1996), quoting *Amalgamated Transit Union v Southeastern Michigan Transp Authority*, 437 Mich. 441, 454; 473 NW2d 249 (1991).

7 *Port Huron, supra* at 325-327 (citations omitted, emphasis added).

8 See *id.* at 332.

9 *Id.* at 329.

10 *Id.* at 329-330; see also *Gogebic, supra* at 354.

11 See *Detroit Police Officers Ass'n v Detroit*, 452 Mich. 339, 348-349; 551 NW2d 349 (1996).

12 While charging parties challenge the MERC's factual finding that respondent's past practice began in 1982, we find no error requiring reversal. Even assuming that respondent had a practice of automatically granting leaves of absence before 1982, the fact remains that the parties negotiated a discretionary leave policy in 1990 and again in 1996.

13 See *Detroit Police Officers Ass'n, supra* at 346-348.

14 *Id.* at 341.

15 *Id.* at 346.

16 *Id.* at 347-348.

17 *Id.* at 339.

18 See MCL 423.211; see also *Nederhood v Cadillac Malleable Iron Co*, 445 Mich. 234, 251; 518 NW2d 390 (1994).

19 *Michigan Ed Ass'n v North Dearborn Heights School Dist*, 169 Mich.App 39, 46; 425 NW2d 503 (1988); see also MCL 423.210(1)(a).

20 See *Michigan Ed Ass'n, supra* at 46.

21 Respondent did not concede this issue on appeal. When a party fails to sufficiently brief an issue *raised by the other party*, we generally attempt to decide the issue. *Wayne Co Prosecutor v. Dep't of Corrections*, 451 Mich. 569, 585; 548 NW2d 900 (1996).

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