STATE OF MICHIGAN

COURT OF APPEALS

RUAA ABED,

Plaintiff-Appellee,

v

JOSHUA MICHAEL MASALKO,

Defendant,

and

ALLSTATE PROPERTY AND CASUALTY INSURANCE COMPANY,

Defendant-Appellant.

UNPUBLISHED
February 21, 2019

No. 341786
Macomb Circuit Court
LC No. 2016-002739-NI

Before: MURRAY, C.J., and SERVITTO and SHAPIRO, JJ.

PER CURIAM.

Defendant Allstate Property and Casualty Insurance Company appeals by leave granted an order denying in part its motion for partial summary disposition in this no-fault action.[1] For the reasons discussed below, we affirm.

This case arises from an automobile accident involving plaintiff Ruaa Abed and defendant Joshua Masalko. It is undisputed that, at the time of the accident, plaintiff was covered by an Allstate no-fault insurance policy and a health insurance benefit plan through her employer. It is further undisputed that plaintiff's health insurance coverage, administrated by

[1] See *Abed v Masalko*, unpublished order of the Court of Appeals, entered February 7, 2018 (Docket No. 341786).

Aetna Insurance Company (Aetna), was provided through a self-funded ERISA[2] plan.[3] Both policies contain a "coordination of benefits" (COB) provision.

> The Aetna policy's "Coordination of Benefits" section provides, in relevant part:
>
> **Primary Plan/Secondary Plan.** The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person.
>
> When This Plan is a primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.
>
> When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.
>
> When there are more than two Plans covering the person, this Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.
>
> **Which Plan Pays First**
>
> When two or more **plans** pay benefits, the rules for determining the order of payment are as follows:
>
> - The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.
>
> - A plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan **hospital** and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.
>
> - A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.

[2] Employee Retirement Income Security Act, 29 USC 1001 *et seq.*

[3] Consistent with the parties and the trial court, we will refer to plaintiff's health insurance plan as the "Aetna policy."

- The first of the following rules that describes which plan pays its benefits before another plan is the rule to use:

    1. Non-Dependent or Dependent. The plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the plan that covers the person as a dependent is secondary. However, if the person is a **Medicare** beneficiary and, as a result of federal law, **Medicare** is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.

    2. Child Covered Under More than One Plan. The order of benefits when a child is covered by more than one **plan** is:

        A. The primary plan is the plan of the parent whose birthday is earlier in the year if:

            i. The parents are married or living together whether or not married;

            ii. A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage or if the decree states that both parents are responsible for health coverage. If both parents have the same birthday, the plan that covered either of the parents longer is primary.

        B. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health coverage for the dependent child's health care expenses, but that parent's spouse does, the plan of the parent's spouse is the primary plan.

        C. If the parents are separated or divorced or are not living together whether or not they have ever been married and there is no court decree allocating responsibility for health coverage, the order of benefits is:

            – The plan of the **custodial parent**;

- The plan of the spouse of the **custodial parent**;
- The plan of the non**custodial parent**; and then
- The plan of the spouse of the non**custodial parent**.

For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits should be determined as outlined above as if the individuals were the parents.

3. Active Employee or Retired or Laid off Employee. The plan that covers a person as an employee who is neither laid off nor retired or as a dependent of an active employee, is the primary plan. The plan covering that same person as a retired or laid off employee or as a dependent of a retired or laid off employee is the secondary plan. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule will not apply if the Non-Dependent or Dependent rules above determine the order of benefits.

4. Continuation Coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another plan**,** the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule will not apply if the Non-Dependent or Dependent rules above determine the order of benefits.

5. Longer or Shorter Length of Coverage. The plan that covered the person as an employee, member, subscriber longer is primary.

6. If the preceding rules do not determine the primary plan, the allowable expenses shall be shared equally between the plans meeting the definition of plan under this provision. In addition, this plan will not pay more than it would have paid had it been primary.

The Allstate policy's "Coordination of Benefits" section provides, in relevant part:

1. If Allowable Expenses are identified as excess on the Policy Declaration, Allowable Expenses benefits will be reduced by any amount paid or payable under the provisions of any:

    a) individual, blanket or group accident disability or hospitalization insurance.

b) medical or surgical reimbursement plan.

c) automobile no-fault benefits or medical expense benefits, or premises insurance affording medical expense benefits.

This reduction applies only to amounts that are duplication of payment for the same items of loss or expense. This reduction applies only to you or a resident relative.

If Allowable Expenses are identified as excess on the Policy Declarations, the injured person must seek treatment afforded for, or payable by his other coverage before we will be liable for any excess not paid for by such other coverage. You have a duty to mitigate your damages.

Plaintiff brought this suit against Masalko and Allstate, seeking personal protection insurance (PIP) benefits from Allstate. Allstate eventually filed a motion for partial summary disposition pursuant to MCR 2.116(C)(10). Allstate argued that Aetna was primarily responsible for the payment of plaintiff's medical expenses because the Aetna policy does not contain unambiguous language elevating no-fault insurance to primary. In a response, plaintiff argued that Allstate was the primary insurer for her allowable expenses incurred after August 22, 2016, when the Aetna policy terminated. She stated that "[t]he issue of medical expenses up until August 22, 2016 are not in dispute, but all expenses after said date are." Allstate filed a reply, arguing that there was no question that Aetna was primarily liable for plaintiff's allowable expenses, at least through August 22, 2016, and the trial court should summarily rule that Aetna was primarily liable for all medical expenses incurred through that date. While Allstate conceded that Aetna might not be primarily responsible for payment of expenses after August 22, 2016, it argued that there was no basis for the trial court to summarily rule that Allstate was primarily responsible for expenses incurred after that date.

The trial court issued an opinion and order granting Allstate's motion in part. With regard to the priority issue, the court ruled that "a plain reading of the COB provision in the AETNA policy demonstrates that there is a conflict with the general rule that the health insurer is primarily liable for the insured's medical expenses." The trial court found that "although not declaring its coverage as secondary, the AETNA policy has expressly disavowed responsibility for 50% of allowable expenses when the insured has other coverage." The court, therefore, concluded that Allstate was required to pay 50% of plaintiff's allowable expenses through August 22, 2016. Accordingly, the court granted Allstate's motion in part, ruling that plaintiff's claim "for allowable expenses through August 22, 2016 shall be set off by 50%."

Allstate subsequently filed a motion for partial reconsideration pursuant to MCR 2.119(F), arguing that it was legal error for the trial court to conclude that the language of the Aetna policy apportioning payments equally between Aetna and Allstate was in conflict with the coordination language in the Allstate policy. Because the Aetna policy does not expressly subordinate its coverage to other coverage, there was no direct conflict. Allstate argued that the Aetna provision does not subordinate its coverage to Allstate, but attempts to place its coverage into an equal position with Allstate. Therefore, the trial court committed palpable error by concluding that the policies conflict.

The trial court denied the motion for reconsideration, ruling that Allstate raised "substantially the same arguments" in its motion for reconsideration that were raised in its original motion for summary disposition, which were already ruled upon by the trial court. This appeal followed.

I. MOTION FOR SUMMARY DISPOSITION

Allstate first argues that the trial court erred by denying its motion for summary disposition because Aetna was the primary insurer responsible for plaintiff's medical expenses.

This Court reviews "de novo a trial court's decision on a motion for summary disposition." *Sanders v McLaren-Macomb*, 323 Mich App 254, 264; 916 NW2d 305 (2018). Under MCR 2.116(C)(10),

> [s]ummary disposition is appropriate if there is no genuine issue regarding any material fact and the moving party is entitled to judgment as a matter of law. In deciding a motion under MCR 2.116(C)(10), a court reviews the pleadings, admissions, and other evidence submitted by the parties in the light most favorable to the nonmoving party. [*Id.* (quotation marks and citations omitted).]

This Court also reviews the interpretation of insurance policies de novo. *Wells Fargo Bank, NA v Null*, 304 Mich App 508, 518; 847 NW2d 657 (2014).

"Under Michigan law, where no-fault coverage and health coverage are coordinated, the health insurer is primarily liable for plaintiff's medical expenses." *American Med Security, Inc v Allstate Ins Co*, 235 Mich App 301, 304; 597 NW2d 244 (1999), citing *Fed Kemper Ins Co, Inc v Health Ins Admin, Inc*, 424 Mich 537; 383 NW2d 590 (1986).[4] However, based on federal preemption, in *Auto Club Ins Ass'n v Frederick & Herrud, Inc (After Remand)*, 443 Mich 358, 389-390; 505 NW2d 820 (1993), the Supreme Court held:

> [A]n unambiguous COB clause in an ERISA health and welfare benefit plan must be given its plain meaning despite the existence of a similar clause in a no-fault policy because any conflict created by the requirements of MCL 500.3109a and this Court's interpretation of the statute would have the direct effect of dictating the terms of the ERISA plans. [Citation omitted.]

As this Court further explained:

> In [*Auto Club Ins Ass'n*, 443 Mich at 388-389], and its companion case, the plans at issue were self-funded plans created pursuant to the ERISA, and the Court carved an exception to the rule of law set out in *Federal Kemper*. It held that the unambiguous coordination of benefits clause found in the ERISA plans must be

[4] As explained below, *Fed Kemper* was overruled in part by *Auto Club Ins Ass'n v Frederick & Herrud, Inc (After Remand)*, 443 Mich 358, 389-390; 505 NW2d 820 (1993).

> given their plain meaning despite the clause in the no-fault policy. [*American Med Security, Inc*, 235 Mich App at 304.]

Accordingly, if a self-funded ERISA plan has an unambiguous COB clause, then the no-fault policy will be primary.

The Sixth Circuit ruled consistently with our Supreme Court in *Auto Owners Ins Co v Thorn Apple Valley, Inc*, 31 F3d 371, 374 (CA 6, 1994),[5] where the court held that "when a traditional insurance policy and a qualified ERISA plan contain conflicting coordination of benefits clauses, the terms of the ERISA plan, including its COB clause, must be given full effect." The court stated that "Congress sought to guard qualified benefit plans from claims . . . which have been expressly disavowed by the plans." *Id*. at 375. Therefore, only if the ERISA plan's COB provision "expressly disavows" or subordinates its coverage to a no-fault insurance policy is the no-fault insurance primary. *Dayton Hudson Dep't Store Co v Auto-Owners Ins Co*, 953 F Supp 177, 179-180 (WD Mich, 1995). "However, in instances when the ERISA plan does not expressly disavow coverage for payment of medical benefits otherwise covered under a no-fault policy, the coordination of benefits clauses of each plan are given their full effect, and the ERISA plan is not automatically deemed secondary." *Citizens Ins Co of Am v MidMichigan Health ConnectCare Network Plan*, 449 F3d 688, 696 (CA 6, 2006). Thus, if the ERISA plan does not expressly disavow coverage, there is no conflict between the policies, and the holding of *Thorn Apple Valley* is inapplicable. *Id*.

Here, the trial court ruled that "a plain reading of the COB provision in the AETNA policy demonstrates that there is a conflict with the general rule that the health insurer is primarily liable for the insured's medical expenses." The trial court determined that "although not declaring its coverage as secondary, the AETNA policy has expressly disavowed responsibility for 50% of allowable expenses when the insured has other coverage." Therefore, the trial court concluded that Allstate was required to pay 50% of plaintiff's allowable expenses through August 22, 2016.

Paragraph 6 of the Aetna policy, relied upon by the trial court in denying Allstate's motion, states that "[i]f the preceding rules do not determine the primary plan, the allowable expenses shall be shared equally between the plans meeting the definition of plan under this provision." "Plan" is defined in the policy as "[a]ny Plan providing benefits or services by reason of health care or treatment, which benefits or services are provided by . . . [m]edical benefits coverage in a group, group-type, and individual automobile 'no-fault' and traditional automobile 'fault' type contracts." Thus, as the trial court concluded, the Aetna policy expressly

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[5] Neither plaintiff nor the trial court disputed the applicability of this case. In *Auto Club Ins Ass'n*, 443 Mich at 374, our Supreme Court stated that preemption of state law "creates the void to be filled by the federal common law." See also *Dayton Hudson Dep't Store Co v Auto-Owners Ins Co*, 953 F Supp 177, 179 (WD Mich, 1995) (stating that any conflict between COB provisions should be resolved under federal common law). ERISA presents a situation "where federal common law is expected to develop and address rights and obligations arising under the Act." *Thorn Apple Valley*, 31 F3d at 374.

disavows coverage for 50% of allowable expenses if there is a no-fault policy providing coverage. Accordingly, with regard to half of the allowable expenses, there is a conflict between the Aetna policy and the Allstate policy, and the Aetna policy must be given full effect. See *Thorn Apple Valley*, 31 F3d at 374.

Allstate focuses on the word "subordinate," arguing that the Aetna policy does not subordinate itself to a no-fault policy because it makes the policies equal. As Allstate contends, "subordinate" means "to place in a lower order or rank" or "to make secondary." *Random House Webster's College Dictionary* (1997). However, *Thorn Apple Valley* only used the term "expressly disavow"; the word "subordinate" was added by *Dayton Hudson*. Thus, the dispositive question is whether Aetna's policy "expressly disavows" coverage and, as discussed above, it does so for half of the allowable expenses. Moreover, even if the relevant question is whether Aetna's policy "subordinated" its coverage to no-fault coverage, the plain language of Paragraph 6 shows that Aetna made its coverage secondary with regard to half of the allowable expenses. Thus, the holding of *Thorn Apple Valley* applies.

The unambiguous COB provision in the Aetna plan must be given its plain meaning, which is that Aetna expressly disavows responsibility for 50% of allowable expenses when the insured has no-fault coverage. See *American Med Security, Inc*, 235 Mich App at 304. The trial court properly applied the plain meaning of that provision by ruling that Allstate was required to pay 50% of plaintiff's allowable expenses through August 22, 2016. Accordingly, the trial court did not err by denying Allstate's motion for summary disposition in part.

II. MOTION FOR RECONSIDERATION

Allstate also argues that the trial court abused its discretion by denying its motion for reconsideration.

"This Court reviews for an abuse of discretion a trial court's ruling on a motion for reconsideration. [A]n abuse of discretion occurs only when the trial court's decision is outside the range of reasonable and principled outcomes." *Sanders*, 323 Mich App at 264 (quotation marks and citations omitted).

MCR 2.119(F)(3) provides:

> Generally, and without restricting the discretion of the court, a motion for rehearing or reconsideration which merely presents the same issues ruled on by the court, either expressly or by reasonable implication, will not be granted. The moving party must demonstrate a palpable error by which the court and the parties have been misled and show that a different disposition of the motion must result from correction of the error.

"The trial court has considerable discretion in granting reconsideration to correct mistakes, to preserve judicial economy, and to minimize costs to the parties." *Sanders*, 323 Mich App at 264-265 (quotation marks and citation omitted).

We agree with the trial court that the issue presented in Allstate's motion for reconsideration was the same as that presented in the motion for summary disposition, namely,

which insurer had priority and, in particular, whether the Aetna policy subordinated its coverage to a no-fault policy. In ruling on the motion for summary disposition, the trial court determined that the language of Paragraph 6 of the Aetna policy "expressly disavowed responsibility for 50% of allowable expenses when the insured has other coverage." While Allstate raised new, more nuanced *arguments* regarding that language, the issue before the trial court was the same, and it had already ruled on the language of Paragraph 6. Moreover, even if Allstate presented a new issue in its motion for reconsideration, it did not "demonstrate a palpable error by which the court and the parties have been misled and show that a different disposition of the motion must result from correction of the error," MCR 2.119(F)(3), for the reasons discussed earlier. Therefore, the trial court did not abuse its discretion by denying Allstate's motion for reconsideration.[6]

Affirmed.

/s/ Christopher M. Murray
/s/ Deborah A. Servitto
/s/ Douglas B. Shapiro

[6] To the extent that Allstate argues that the trial court's order is impossible to apply without additional clarification, its argument is premature because plaintiff has not yet been awarded any money for her expenses.