STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF WAYNE

DANIEL CALHOUN,

Plaintiff-Appellant,

-v-

AUTO CLUB INSURANCE ASSOCIATION,

Defendant-Appellee.
_____/

Hon. Roland L. Olzark
(P18490)

Civil Action
No. 86-623665 AV

Lower Court
No. 85-425804

OPINION AND ORDER REVERSING THE ORDER OF THE TRIAL COURT AND REMANDING THE CASE FOR FURTHER PROCEEDINGS.
_____/

OPINION

The instant case is one for the payment of no fault automobile insurance benefits brought by Daniel Calhoun, the appellant herein, against the Auto Club Insurance Association, the appellee herein. The case is presently before this Court on the appeal of appellant from an order entered in the 36th District Court granting appellee's motion for summary disposition The facts of the case as it pertains to resolution of the issues raised on appeal are as follows:

Appellant was involved in a motor vehicle accident on March 3, 1984. At the time he had a policy of no fault automobile insurance issued by appellee.

Of particular importance to the case at bar is the coordination of benefits clauses contained in the policy.

The Policy, p 7, provided in relevant part that,

> If the Declaration Certificate shows Coordinated Medical Benefits, sums paid or payable to or for you or any relative shall be reduced by any amount paid or payable under any valid and collectible: individual, blanket or group disability or hospitalization insurance; medical, surgical or hospital direct pay or reimbursement health care plan; Workers' Compensation Law, disability law of a similar nature, or any other state or federal law; or car or premises insurance affording medical expense benefits.
>
> . . .
>
> We will subtract benefits provided or required to be provided under the laws of any state or federal government from the benefits otherwise payable under this coverage even though the insured person has failed to apply for them. It is the obligation of the insured person to apply for any benefits provided or required to be provided under the laws of any state or federal government. It is also the obligation of the insured person to reapply, appeal or file suit for those governmental benefits if the initial application is rejected.

(See Exhibit A)

Appellant, as a fringe benefit of his employment also had in force at the time of the accident health insurance coverag

Under the terms of the health insurance policy appellant would only be eligible for benefits if he sought treatment at the Woodland Medical Clinic. (Woodland). Any health care provided by any other facility or physician other than that received at Woodland would not be covered by his health insurance.

After the accident appellant was treated for his injuries at Woodland. However, after a period of time he treated with other physicians not covered by his health insurance.[1/] Appellee initially paid medical benefits to these physicians unde

---

1/ There appears to be some issue of fact as to why appellant sought treatment outside of Woodland. Appellant states he was advised to do so (Appellant's brief, p 2). In contrast, appellee claims that appellant "refused" to be treated at Woodland. (Appellee's brief, p 1). Resolution of this issue of fact, however, is not material to the determination of the issue before the Court.

the no fault automobile insurance policy through November, 1985. In November, 1985, appellant was examined by a physician at appellee's request. Based on the results of this examination appellee determined that appellant was no longer in need of medical treatment and thus would no longer be eligible for benefits. This case followed.

In the complaint, in Count I, appellant asserted that appellee unjustifiably stopped his medical benefit payments. In Count II, appellant asserted that appellee was equitably estopped from denying medical benefit payments on the basis of the statute of limitations.

Some months later appellee filed a motion for summary disposition. Therein, evidently for the first time, appellee argued that it was not liable to appellant for the costs associated with his being treated by doctors not covered by appellant's health insurance. The basis of this argument was the coordinatior of benefits clause in appellant's policy which, in effect, made appellant's health insurance the primary insurance which covered appellant's medical costs. Appellee argued that due to the coordination of benefits clause appellee had a duty to seek treatment within the termsof his health insurance. Because appellant had failed to do so, appellee could not be held liable.

The trial court granted the motion, dismissed the case; this appeal followed.

On appeal, appellant initially argues that appellee was obligated to pay him no fault benefits on the basis of its policy, and that the policy's terms did not mandate that appellant treat with only those physicians that are covered by his health insurance. In response, appellee argues that the public policy behind allowing coordination of benefits clauses in no fault automobile insurance policies supports the decision of the trial court.

In Federal Kemper Insurance Co Inc v Health Insurance

Administration Inc, 424 Mich 537, 544 (1986), the Court stated that "PIP (i.e., no fault) benefits are not paid directly by reason of the operation of the statute, rather, the statutory scheme contemplates that PIP benefits will be paid under the required insurance." Thus in the first instance in determining the issue on appeal, the Court looks to the terms of the policy given appellant by appellee. In construing the policy, the Court is mindful of the usual rules of construing insurance contracts. These were summarized in United States Fidelity & Guaranty Co v Group Health Plan of Southwest Michigan, 131 Mich App 268, 274 (1983).

> Ambiguities in an insurance contract are liberally construed in the insured's favor. Herring v Golden State Mutual Life Ins Co, 114 Mich App 148; 318 NW2d 641 (1982); Interstate Fire & Casualty Co v Hartford Fire Ins Co, 548 F Supp 1185, 1187 (ED Mich, 1982). In fact, "[i]nsurance policies must be construed in accord with the ordinary and popular sense of the language used therein. To be given full effect, an insurer has a duty to clearly express the limitations in its policy. A technical construction of policy language which would defeat a reasonable expectation of coverage is not favored." State Farm Mutual Automobile Ins Co v Ruuska, 90 Mich App 767, 777-778; 282 NW2d 472 (1979), aff'd 412 Mich 321; 314 NW2d 184 (1982).

In the case at bar, the coordination of benefits clause indicates, in essence, that appellee was to first look to his health insurer for payment of benefits for "amounts paid or payable under any valid and collectible: . . . group disabili or hospitalization insurance; . . ." It is undisputed by appellant that the health insurance coverage provided by his employer constituted valid and collectible group hospitalization insuranc and that therefore appellee would not be liable to pay him benefits for "amounts paid or payable" under his health insurance.

Under the literal terms of appellant's policy of insurance, whether the coordination of benefits clause would

have provided a defense to the action would be dependent upon whether the costs of appellant's medical treatment which forms the basis of his claim were amounts "paid or payable" under his health insurance.

As noted earlier appellant's health insurance provided coverage only if appellant treated with certain institution and physicians designated by the health insurer. It is undisputed that the physicians by whom appellant was treated were not among those designated. Accordingly, the amounts paid by appellant for treatment with these physicians were not amounts paid or payable under the terms of his health insurance. This being so, it follows that, under the terms of the appellant's no fault automobile policy the coordination of benefits clause would not provide a defense to appellee in the case at bar.

With respect to the contention of appellee, THAT its coordination of benefits clause imposed a duty an appellant to seek treatment with only those physicians included within coverage of appellant's health insurance, again, looking at the terms of the policy, the fact is that there is nothing expressly stated in the coordination of benefits clause, or elsewhere in the policy which would suggest such a duty, or otherwise give notice to the appellant that he was under such a duty. Had the appellee meant to impose such a duty on appellant, and thereby limit the policy' coverage it should have clearly expressed its intent in the policy.[2/] The fact that appellee chose not to do so prevents

---

2/ It should be noted that the policy's coordination of benefits clause, as quoted earlier, expressly notifies the insured that he is under some duty to pursue any benefits that he may be entitled to under state or federal law, and that his failure to do so would not otherwise make appellee liable for amounts that t insured could have received. There is no similar warning with respect to the alleged duty of the insured to seek medical treatment which is covered by his health insurance.

this Court, under the above noted rules of insurance contract construction from giving effect to the limitation that appellee now seeks to impose on coverage.

Accordingly, looking at the words used by appellee in drafting this portion of the coordination of benefits clause, the Court finds that there is no duty imposed by the policy on an insured to seek medical treatment which is covered by his health insurance, and the coordination of benefits clause would not appear to prevent appellant's recovery in the instant case.

Appellee, however, argues that the foregoing result cannot obtain since the public policy behind the coordination of benefits clauses in no fault insurance policies mandates that an insured must take advantage of the benefits of his health insurance, and thus only treat with those physicians covered by his insurance plan. Reliance is placed on those cases arising under MCL 500.3109(1)[3/] which indicate that an insured has the duty to seek state or governmental benefits - such as workers' compensation - that he may be entitled to and that the failure of an insured to do so will not prevent the no fault insurer from reducing no fault benefits by amounts that otherwise the insured would have received had he applied for the state and federal government benefits. Perez v State Farm Mutual Automobile Insurance Co, 418 Mich 634 (1984); Gregory v Transamerica Insurance Co 425 Mich 625 (1986).

In Gregory, supra, 631-632, the Court explained the operation and legislative intent behind application of MCL 500.3109(1) in a situation where the insured is eligible for workers' compensation benefits:

> The offset statute, and this Court's application of it, reflect a determination that the workers' compensation system should be the primary insurer with respect to disabilities arising from an automobile accident at work.

3/ MCL 500.3109(1) states:

> Benefits provided or required to be provided under the laws of any state or the federal government shall be subtracted from the personal protection insurance benefits otherwise payable for the injury.

> The responsibility for workers' compensation benefits rests first on the employer or workers' compensation insurer, and the amount of that payment is to be deducted from the liability of the personal protection insurance carrier. [408 Mich 183.]

The decision to make the no-fault insurer only secondarily liable is premised on a belief that

> [b]ecause the first-party insurance proposed by the [no-fault] act was to be compulsory, it was important that the premiums to be charged by the insurance companies be maintained as low as possible. [O'Donnell v State Farm Mutual Automobile Ins Co, 404 Mich 524, 547; 273 NW2d 829 (1979).]

One way to ensure lower premiums is "'through the elimination of duplicative benefits recovery.'" 404 Mich 545 (quoting from the dissent of Williams, J.) See also Tebo v Havlik, 418 Mich 350, 367; 343 NW2d 181 (1984) ("In effect, the Legislature made a trade-off. Those who were required to participate in the no-fault scheme gave up the possibility of redundant recoveries, but they were intended to receive the benefit of lower insurance rates.").

Also see Perez, supra, 641. In Perez, supra, 645-646, the Court explained the significance of the "required to be provided" language of MCL 500.3109(1) in the situation where a person has failed to apply for workers' compensation benefits notwithstanding he was eligible to receive them:

> By declaring that workers' compensation payments "provided or required to be provided" are to be subtracted from a no-fault recovery, the Legislature appears to have set forth a straightforward answer to the question it was addressing: an injured worker must pursue available workers' compensation payments because they are deductible simply by virtue of their availability.
>
> . . .
>
> The "required to be provided" clause of § 3109 (1) means that the injured person is obliged to use reasonable efforts to obtain payments that are available from a workers' compensation insurer. If workers' compensation payments are available to him, he does not have a choice of seeking workers' compensation or no-fault benefits; the no-fault insurer is entitled to subtract the available workers' compensation payments even if they are not in person to use reasonable efforts to obtain them. (footnote omitted).

The Court is of the opinion, however, that the above noted authorities, cited by appellee, do not mandate that appellee, in order to be eligible for no fault benefits, was required to seek only medical treatment that was covered by his health insurance.

The Court would initially note that the legislative authority for the coordination of benefits clause at issue herein is not MCL 500.3109(1), but rather MCL 500.3109a.[4/] Unlike section 3109(1), section 3109a does not contain the clause "required to be provided." Nor is that phrase contained in the policy. Since the statutory phrase "required to be provided" appears to be the basis for the finding in Perez and Gregory, that an insured must pursue his federal and state statutory benefits, its absence from section 3109a or the policy would appear to indicate that the above noted rule of law found in Perez would not have application to the case at bar.

Moreover, even if the operative phrase used in the appellee's policy, "paid or payable", could be construed as evinc ing a similar purpose as the phrase "required to be paid", it does not follow that the appellee is barred from seeking no fault benefits because he obtained needed treatment outside the coverage of his health insurance. As noted above, the primary purpose of section 3109(1) is to reduce no fault premiums by eliminating duplicative recovery. In the case at bar, appellant is not

---

4/ MCL 500.3109a provides:

> An insurer providing personal protection insurance benefits shall offer, at appropriately reduced premium rates, deductibles and exclusions reasonably related to other health and accident coverage on the insured. The deductibles and exclusions required to be offered by this section shall be subject to prior approval by the commissioner and shall apply only to benefits payable to the person named in the policy, the spouse of the insured and any relative of either domiciled in the same household.

receiving a duplicative recovery since his medical bills were not in fact, "paid or payable" by his health insurance. In this case therefore, the policy reasons underlying the statement of the Court, quoted above, in Perez simply do not apply. Thus the rule of law noted in Perez similarly cannot be said to obtain.

Appellee additionally notes that under Federal Kemper Insurance Co v Health Insurance Administration Inc, 424 Mich 537 (1986) where, as in the instant case, a no fault automobile insurance policy has a clause which coordinates its coverage for medical expenses with that provided by other insurance carried by the insured, the latter is deemed to be the primary insurer. However, Federal Kemper does not indicate that an insured must seek only that medical treatment which is covered by his health insurance. Moreover, the issue in Kemper Insurance, namely which of two insurance companies was primarily liable to the insured, is not involved in the case at bar. In Kemper, the loss to be paid - namely the insured's medical costs, had already been incurred. The only question was who would pay it. The instant case, however, involves how that loss is created in the first instance.[5/] The principles stated in Kemper Insurance thus have little application to the resolution of the case at bar.

The last argument raised by appellee concerns recognition by the courts that section 3109a has as its purpose eliminating duplicative recovery and containing or reducing medical and insurance costs. See Federal Kemper, supra, 546 (and cases cited therein). Appellee asserts that were the Court to permit recovery against them in this case, it would open the

---

5/ It is undisputed that appellant's health insurance was not legally obligated to pay appellant his medical expenses. Thus this case, unlike Federal Kemper does not involve a dispute between two insurance companies as to who will be primarily liable for the insured's medical costs.

doors to insureds being able to pick and choose which insurance company will bear the cost of medical treatment. However, this case does not involve a plaintiff picking and choosing among his insurers as to who will pay for his medical bills, rather the appellant in this case is merely choosing who will be his doctor. Moreover, contrary to appellee's assertion that it pays for medical costs without limit - and thus presumably encourages higher medical costs - the fact is that appellee by law and contract is only obligated to pay for "reasonably necessary" health care costs. See MCL 500.3107(a); Policy of Insurance, Exhibit A, p 7. Allowing appellant to choose medical services not covered by his health insurance will not open the doors to a flood of unnecessary or unreasonable medical costs. The Court thus is not persuaded that allowing appellant to choose to be treated by physicians who are not covered by his health insuranc will necessarily lead to higher medical and insurance costs.

In conclusion of the foregoing, the Court finds that the coordination of benefits clause does not afford a defense to appellee in the instant case. In particular, the Court is unpersuaded that the policy arguments raised by appellee are such as to defeat the plain language of the insurance contract at issue herein. Accordingly, the Court further finds that the trial court erred in granting appellee's motion for summary disposition; the order granting defendant's motion for summary disposition must therefore be reversed and the case remanded for further proceedings not inconsistent with the foregoing opinion.

Dated: MAR 1 2 1987

Roland E. Olzark

Circuit Judge

STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF WAYNE

DANIEL CALHOUN,

Plaintiff-Appellant,

-v-

AUTO CLUB INSURANCE ASSOCIATION,

Defendant-Appellee.
/

Hon. Roland L. Olzark
(P18490)

Civil Action
No. 86-623665-AV

Lower Court
No. 85-425804

ORDER

At a session of said Court held in the City-County Building, Detroit, Michigan on MAR 12 1987

PRESENT: HON. ROLAND L. OLZARK
Circuit Judge

The Court being fully informed in the premises and in accordance with the foregoing Opinion;

IT IS ORDERED that the order entered in the above encaptioned case granting defendant-appellee's motion for summary disposition be and the same is hereby REVERSED.

IT IS FURTHER ORDERED that said case be and the same is hereby REMANDED for further proceedings not inconsistant with the foregoing Opinion.

Roland L Olzark
Circuit Judge