UNITED STATES OF AMERICA
DISTRICT COURT FOR THE WESTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

AUTO OWNERS INSURANCE COMPANY,

Plaintiff,

Case No. G87-712 CA

-vs-

ORDER

STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY,

Defendant.
/

In accordance with the opinion filed this date,

IT IS ORDERED that plaintiff's motion for summary judgment is granted.

IT IS FURTHER ORDERED that defendant's motion for summary judgment is denied. Defendant is ordered to reimburse plaintiff for $21,647.02 of the insured's medical expenses.

IT IS FURTHER ORDERED that the case is dismissed with prejudice.

Douglas W. Hillman
Chief Judge

Dated: JAN -6 1989.

UNITED STATES OF AMERICA
DISTRICT COURT FOR THE WESTERN DISTRICT OF MICHIGAN
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AUTO OWNERS INSURANCE COMPANY,

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OPINION

STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY,

Defendant.
_____/

Factual Background

This action involves a dispute between a no-fault insurance carrier, Auto Owners Insurance Company, and a health insurance carrier, State Farm Mutual Automobile Insurance Company, concerning which insurer is liable for payment of medical expenses arising out of an automobile accident.

On April 12, 1986 James R. Lenon was injured in an automobile accident near Mecosta, Michigan. At the time of his accident, Lenon had in effect both a policy of no-fault automobile insurance issued by plaintiff and a health insurance policy issued by defendant. Lenon purchased his State Farm policy on November 8, 1982. The policy contained a Catastrophic Medical Expense Rider with an exclusion from coverage for any "[i]njury for which the Covered Person is entitled to benefits under mandatory motor vehicle or

automobile insurance, to the extent that benefits are payable without regard to fault under such coverage."

Lenon purchased the Auto Owners no-fault insurance policy on October 3, 1985. The no-fault policy contained a Coordination of Benefits Endorsement which provided that the benefits payable under the policy would be reduced by "any health, disability or automobile medical expense insurance policy; [or] any health care plan. . . ."

Following Lenon's accident, defendant State Farm paid certain medical expenses incurred by the insured, but refused to make additional payments, basing its refusal on the above quoted language contained in its medical expense rider. Consequently, plaintiff paid over $36,000 for medical expenses incurred by Lenon. Plaintiff filed the present action seeking reimbursement from defendant and a declaration that defendant is primarily liable for payment of the medical expenses incurred by Lenon.

The matter is before the court on the parties' cross motions for summary judgment on plaintiff's claim.

Discussion

The issue to be decided in this case is which party is in first priority for payment of the insured's medical expenses. Since the issue is entirely one of law, it must be decided on

summary judgment by the court. Celotex v. Catrett, 477 U.S. 317 (1986).

Plaintiff seeks recovery under M.C.L. § 500.3109a (Section 3109a), the coordinated benefits provision of the Michigan no-fault insurance statute. Under the coordinated benefits provision, no-fault insurers in Michigan must offer, for reduced premiums, insurance policies that coordinate their coverage with other insurance that their insureds may have.

In interpreting Section 3109a, several courts have already grappled with the problem of conflicting coordinated benefits provisions such as those existing in this case. In a decision which I find controlling in the case at hand, the Michigan Supreme Court ruled that a no-fault insurance policy with a coordinated benefits provision is secondarily liable to other health and accident insurance coverage that also has a coordinated benefits provision. Federal Kemper Ins. Co. v. Health Insurance Administration, Inc., 383 N.W.2d 590 (1986). The case of Auto Owners Ins. Co. v. Lacks Industries, 402 N.W.2d 102 (Mich. App. 1986), involved an exclusionary clause similar to that contained in defendant's policy here. Relying on Federal Kemper, the court of appeals held that where an automobile accident victim's health insurance policy and no-fault automobile insurance policy had conflicting "other insurance" provisions, the health insurer's provision was to

be given no effect, and thus the health insurer was primarily liable for payment of the insured's expenses.

Defendant claims first that plaintiff's coordination of benefits provision fails to meet the requirements of Section 3109a since plaintiff failed to investigate the nature and extent of the health insurance already possessed by the insured at the time plaintiff issued its policy. Defendant contends that had plaintiff conducted such an investigation, it would have discovered defendant's exclusion in its Catastrophic Medical Expense Rider and would not have issued a policy with a conflicting provision. Defendant points out that the plain language of the provision states that the no-fault insurer's exclusions must be "reasonably related to other health and accident coverage on the insured" (emphasis added). Defendant also points out that neither of the above Michigan court decisions contains a discussion of the order in which the policies in question were obtained and suggests that consequently they should not be controlling in this case.

I find defendant's argument to be unconvincing. The very fact that prior courts have not addressed the issue of the order in which the policies were acquired suggests that those courts did not consider this issue to be one of importance and would not accept defendant's position. Indeed, it is unlikely that the statute intended to require no-fault insurers to investigate all of a potential insured's other insurance

policies and to interpret other contracts in order to determine whether a conflicting coordinated benefits provision exists. Such a requirement would force no-fault insurers to bear an extremely heavy burden and would undoubtedly raise insurance costs.

Federal Kemper's extensive discussion of the policy reasons behind its decision further suggests that the order in which the policies were acquired is to be of no consequence. Quoting the language of Auto Club Ins. Ass'n v. Frederick & Herrud, Inc. 377 N.W.2d 902 (Mich. App. 1985), the court stated:

> There is further no evidence that defendant's coordination-of-benefits clause was offered in such a way as to foster consumer savings, a major goal of § 3109a . . . . That is, because no-fault is mandatory and coordination of benefits must be offered at a reduced rate, the insured gains an advantage from such a clause by the required reduction in premium while the insurer's reduced profits reflect a corresponding reduction in its potential liability. No such check necessarily applies to health and accident insurance. It would not be difficult to simply insert a coordination-of-benefits clause in a health and accident policy without a corresponding reduction in premium . . .

Id. at 595 (emphasis in original).

The court additionally stated that another purpose of Section 3109a is controlling health care costs. Quoting Dean v. Auto Club Ins. Ass'n. 362 N.W.2d 247 (Mich. App. 1984), the court explained:

> The skyrocketing hospital and medical costs could be contained to a greater extent with health and accident as the primary coverage since these policies . . . have established limits on their reimbursement of doctor and hospital expenses. A physician who knows his or her patient has unlimited medical coverage has no incentive to keep the doctor bill at a minimum.

Federal Kemper, 383 N.W.2d at 596.

The Federal Kemper decision is backed by compelling policy reasons. Thus the omission of any discussion of which policy was purchased first suggests that this issue was of no consequence in the eyes of the court. In light of the court's opinion, I am satisfied that Section 3109a was not intended to require no-fault insurers to inquire as to the extent of a potential insured's already existing health and accident coverage.

Defendant also argues that since the Michigan decisions addressing the problem of conflicting coordination of benefits provisions were published after defendant's catastrophic medical expense rider went into effect, these decisions should not be applied retroactively to State Farm's policy. In Chevron Oil Co. v. Huson, 404 U.S. 97 (1971), the Supreme Court enunciated a three part test to be used in determining whether or not to apply a decision in a civil case retroactively:

> First, the decision to be applied non-retroactively must establish a new principle of law, either by overruling clear past precedent on which litigants

> may have relied . . ., or by deciding an issue of first impression whose resolution was not clearly foreshadowed . . . . Second, it has been stressed that "we must . . . weigh the merits and demerits in each case by looking to the prior history of the rule in question, its purpose and effect, and whether retrospective operation will further or retard its operation." . . . Finally, we have weighed the inequity imposed by retroactive application, for "[w]here a decision of this Court could produce substantial inequitable results if applied retroactively, there is ample basis in our cases for avoiding the 'injustice or hardship' by a holding of nonretroactivity."

Id. at 106-107 (citations omitted).

The Supreme Court has elaborated upon the first part of this test and elucidated when a "new principle of law" is established, or when a clear break from prior law has occurred.

> In general, the Court has not subsequently read a decision to work a "sharp break in the web of the law," . . . unless that ruling caused "such an abrupt and fundamental shift in doctrine as to constitute an entirely new rule which in effect replaced an older one" . . . . Such a break has been recognized only when a decision explicitly overrules a past precedent of this Court, . . . disapproves a practice this Court arguably has sanctioned in prior cases . . . or overturns a long-standing and widespread practice to which this Court has not spoken, but which a near-unanimous body of lower court authority has expressly approved.

United States v. Johnson, 457 U.S. 537, 551 (1982). The Court has further stated that the "clear break" principle is the

threshold test for determining whether a decision is to be applied nonretroactively and that it is only after it has been determined that a decision established a new principle of law as defined by the Supreme Court, that a court may go on to consider the second and third prongs of the Chevron test. Johnson, 457 U.S. at 550, n.12. In light of the Court's definition of the term in Johnson, I find that no "new principle of law" was established by the Michigan decisions, and thus the Chevron test for nonretroactivity has not been met.

Defendant argues that in establishing the Catastrophic Medical Expense Rider at issue, it relied upon the Michigan Insurance Commissioner's Bulletin AD 74-2, which indicated that where both no-fault and health insurance policies purport to be secondary, the no-fault insurer is primary. The court in Federal Kemper was presented with the identical argument. Acknowledging that in interpreting various statutes, courts generally give weight to the opinion of administrative officials charged with implementing the statutes, the court nevertheless stated: "[w]e are not persuaded that the result suggested by the bulletin should be determinative." Federal Kemper, 383 N.W.2d at 596. The bulletin did not constitute a past precedent of a court, and did not establish a practice which any court sanctioned in prior cases, and thus decisions which contradicted the bulletin did not occasion a clear break

from prior law. Consequently, I find that the Federal Kemper and Lacks Industries decisions can be applied retroactively in this case.

The Court notes that defendant represents that though plaintiff paid approximately $36,000 for the insured's medical expenses, previous payments by defendant and other provisions of defendant's policy not contested by plaintiff reduce defendant's exposure to $21,647.02. Affidavit of Deena Froehele. Since this amount is not disputed by plaintiff, defendant shall be ordered to reimburse plaintiff for $21,647.02 of the insured's medical expenses.

Conclusion

Plaintiff's motion for summary judgment is granted. Defendant's motion for summary judgment is denied. Defendant is ordered to reimburse plaintiff for $21,647.02 of the insured's medical expenses.

Douglas W. Hillman
Chief Judge

Dated: _____.

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Conclusion

Plaintiff's motion for summary judgment is granted. Defendant's motion for summary judgment is denied. Defendant is ordered to reimburse plaintiff for $21,647.02 of the insured's medical expenses. Accordingly, this case is dismissed with prejudice.

Douglas W. Hillman
Chief Judge

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