STATE OF MICHIGAN

COURT OF APPEALS

ALLSTATE INSURANCE COMPANY,

Plaintiff-Appellant,

v

No. 114200

HEALTH ALLIANCE PLAN,

Defendant-Appellee,

and

STEPHEN GRUBER,

Defendant.

Before: Holbrook, Jr., P.J., and McDonald and Jansen, JJ.

PER CURIAM.

Stephen Gruber and his wife, now deceased, were seriously injured in a May, 1988, automobile accident. Plaintiff was their no-fault insurance carrier and defendant Health Alliance Plan (HAP) was their health maintenance organization. As the Grubers were eligible for Medicare, their contract with HAP provided supplementary coverage encompassing deductibles, excess payments, coinsurance payments and the like. Citing Michigan law, plaintiff sought secondary liability after HAP. Pursuant to federal law, however, Medicare is afforded secondary status. The trial court awarded HAP summary disposition on its liability status pursuant to MCR 2.116(C)(10), finding that HAP payments constituted Medicare payments within the meaning of federal statutory language, and that federal law preempted otherwise applicable state law. Plaintiff now appeals as of right. We reverse.

Following the accident, plaintiff paid for all necessary costs, for the Grubers' convenience, with the intention of seeking reimbursement from whatever source might be obligated to pay. The coordination of benefits (COB) clause of the no-fault policy provided that plaintiff would not be liable to the extent that medical expenses were paid or payable under any

individual or group accident, disability or hospitalization insurance or under any medical or surgical reimbursement plan, or under any state or federal government laws. The Grubers' contract with HAP, "Senior Plus -- Option III", also contained a COB clause which specifically cited automobile-related injury and insurance, thus making the two insurance policies mutually contradictory.

Plaintiff first argues that where Michigan law resolves the conflicting COB clauses in favor of the no-fault insurer, and where federal law does not preempt such law as it applies to HAP, HAP is primarily liable for the medical expenses. We agree.

Where a no-fault insurance policy and a health care policy both contain COB clauses, it is the intent of the Legislature that primary liability be imputed to the health insurance carrier. Federal Kemper Ins Co, Inc v Health Ins Administration, Inc, 424 Mich 537, 550-552; 383 NW2d 590 (1986). This holding is equally applicable to HMO's. Spencer v Hartford Accident & Indemnity Co, 179 Mich App 389, 398; 445 NW2d 520 (1989).

At one point it was held that Medicare benefits were "other health and accident coverage" within the meaning of MCL 500.3109a; MSA 24.13109(1), and could therefore be set off by the no-fault carrier. LeBlanc v State Farm Mutual Automobile Ins Co, 410 Mich 173, 205-206; 301 NW2d 775 (1981). This result was changed, however, when Congress enacted certain new sections of Subchapter XVIII of the Social Security Act, 42 USC 1395, et seq., and related regulations. Section 1395y(b)(1) provided that payment could not be made under the subchapter to the extent that payment has been made or can reasonably be expected to be made under an automobile or liability insurance policy or plan or under no-fault insurance. Section 1395mm(e)(4) provided that in the event an eligible organization provides services to a member enrolled under this section for an injury for which the member is entitled to no-fault benefits, the eligible organization can charge either the insurance carrier or its member, if the carrier

has already paid the member, thereby preventing double recovery by making Medicare benefits secondary.

The determinative question before us, then, is whether or not the benefits payable by HAP are entitled to the protection accorded Medicare payments by the federal statute.

The lower court's ruling seems to infer that plaintiff is arguing that what were once Medicare benefits cease to be such when provided through an HMO. What plaintiff is really arguing, both here and below, is that supplemental benefits, over and above the obvious Medicare benefits under parts A and B of Subchapter XVIII, were never Medicare benefits, and are therefore not covered by the statute.

HAP was a party to a risk-sharing contract with the Department of Health and Human Services, under the terms of which HAP received a per capita monthly fee for every Medicare-eligible insured. As plaintiff quite correctly notes, the most significant feature of this contract is that HAP receives reimbursement only to the extent the benefits are payable under parts A and B of the subchapter. Section 1395mm(a)(4) clearly specifies that the basis for the amount payable to the HMO is the amount that "would be payable [if furnished by a non-eligible organization] in any contract year for services covered under parts A and B of this subchapter, or part B of the subchapter only, and types of expenses otherwise reimbursable under parts A and B of the subchapter, or part B of the subchapter only . . . ."

The risks and costs inherent in a no-fault coverage, which go beyond parts A and B of the subchapter are not taken into account in this calculation and plaintiff therefore correctly asserts that it is improper to refer to this type of benefit as "Medicare benefits".

Thus we conclude that the trial court erred in its inference that all benefits paid by HAP were "Medicare benefits". Pursuant to federal law, Medicare benefits constitute secondary coverage and to the extent HAP provides such benefits, plaintiff

is not entitled to reimbursement. This abbrogation of our state law imputing primary liability to the health insurance carrier applies only to Medicare benefits. Therefore, to the extent HAP provides non-Medicare coverage, plaintiff is entitled to reimbursement. On remand, judgment for plaintiff is to be entered and a determination made of the amount it does owe.

Reversed and remanded. We do not retain jurisdiction.

/s/ Donald E. Holbrook, Jr.
/s/ Gary R. McDonald
/s/ Kathleen Jansen