STATE OF MICHIGAN

COURT OF APPEALS

PERRY MAJOR,

Plaintiff-Appellee,

v

AUTO CLUB INSURANCE ASSOCIATION,

Defendant-Appellant.

September 12, 1990

FOR PUBLICATION

No. 109072

Before: Danhof, C.J., and Cynar and Brennan, JJ.

PER CURIAM.

Defendant appeals by leave granted the denial of its motion for summary disposition. MCR 2.116(C)(10). This action involves a claim by plaintiff against defendant for payment of medical benefits pursuant to the no-fault act, MCL 500.3109; MSA 24.13109. The sole issue before this Court is whether an insured, who pays a reduced premium to the no-fault insurer in exchange for coordinated medical benefits coverage, is required to seek benefits from the primary insurer before seeking payment from the no-fault insurer. We answer in the affirmative and reverse the trial court's decision.

The facts of this case are not in dispute. In 1985, plaintiff was injured in a non-work related automobile accident. At the time of the accident, plaintiff was enrolled in Health Care Network (HCN), a health care program furnished by his employer. Plaintiff was required under that program to be treated by designated approved physicians. Plaintiff also had coordinated medical benefits coverage through defendant, his automobile insurer. Plaintiff did not receive treatment from doctors participating in the HCN plan, but received his treatment from nonparticipating doctors. It is alleged and not disputed that the type of treatment that defendant received was available from doctors who participated in the HCN plan. Plaintiff sought payment from defendant for these medical expenses. Defendant refused to pay for any of the medical treatment rendered by doctors who did not participate in the HCN plan. Defendant cited the coordinated benefits provision of the insurance policy and indicated that the provision required that plaintiff be treated by HCN doctors. Plaintiff filed suit against defendant for payment of medical benefits.

Defendant brought a motion for summary disposition, arguing that defendant was not required to pay benefits for medical expenses incurred outside of the HCN program due to the coordinated benefits provision of the policy.

In denying defendant's motion for summary disposition, the trial court contrasted the language of the medical coordination provision and the absence of any cooperation requirement, with the specific recitation of the insured's various obligations in seeking mandatorily required benefits as set forth in a provision explaining the mandatory coordination features of MCL 500.3109; MSA 24.13109, for an insured seeking government benefits. The trial court concluded:

> The obligation of the insured to seek government benefits and the consequences for failure to pursue them are quite explicit, and yet that language is not used regarding other medical insurance. The difference in treatment carries the natural implication that those provisions do not apply in the latter instance and, accordingly, that the deduction for benefits available but not sought applies only to government benefits. The insurer, presumably, was free to articulate the same explicit duty and penalty regarding other medical insurance but it has simply not done so in this contract.

On appeal, defendant contends that the trial court erred in denying its motion for summary disposition. Defendant argues that by choosing coordinated medical benefits, plaintiff agreed to make HCN the primary insurer and may not choose which insurer will pay benefits. We agree.

A motion for summary disposition under MCR 2.116(C)(10) tests whether there is factual support for a claim. The court must consider the pleadings, affidavits, depositions, admissions and other documentary evidence available to it. Dumas v Auto Club Ins Ass'n, 168 Mich App 619, 626; 425 NW2d 480 (1988).

The moving party must identify by supporting affidavit those facts which it believes cannot be genuinely disputed. Slaughter v Smith, 167 Mich App 400, 403; 421 NW2d 702 (1988). The party opposing the motion has the burden of showing that a genuine issue of disputed fact exists. Dumas, supra. The opposing party may not rest upon mere allegations or denial in the pleadings, but must, by affidavit or other documentary evidence, set forth specific facts showing that there is a genuine issue for trial. MCR 2.116(G)(4); Metropolitan Life Ins Co v Reist, 167 Mich App 112, 118; 421 NW2d 592 (1988), lv den 431 Mich 877 (1988).

The coordination provision of plaintiff's policy states:

> 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. (emphasis in the original).

It is uncontested that plaintiff's declaration certificate showed coordination of medical benefits.

This coordination provision is required to be offered to insureds pursuant to MCL 500.3109a; MSA 24.13109(1), which 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.

Our Supreme Court in Federal Kemper Ins Co, Inc v Health Ins Administration, Inc, 424 Mich 537; 383 NW2d 590 (1986), explained the broad policy rationale behind the coordinated benefits provision of § 3109a:

> [t]o contain both auto insurance costs and health care costs, while eliminating duplicative recovery. Further, this result is consistent with the legislative scheme vesting in insureds, rather than insurers, the option of coordinating of benefits. 424 Mich 551–552.

On these grounds, the Supreme Court declared that an insured's health insurance coverage was to be the primary insurer regardless of policy language which attempted to force the opposite result. The Court based its holding on the Legislature's purpose in enacting § 3109a: reducing insurance costs by lessening the cost of no-fault policies in dual coverage situations. In the face of such strong policy considerations, we do not believe that the statutory scheme allows an insured to simply ignore an existing health care benefit and frustrate the entire coordination program, a program which provided a statutorily mandated reduced insurance premium for plaintiff in this case.

Plaintiff claims that defendant contractually agreed, under the policy, to pay any expenses not covered by plaintiff's HCN plan irrespective of whether or not plaintiff sought treatment under the HCN plan first. In contrast, defendant claims that plaintiff agreed that HCN would be the primary insurer and therefore plaintiff

had a duty to seek treatment under the HCN plan first. Both parties rely on two cases which had not been decided at the time the trial court denied defendant's motion, Calhoun v Auto Club Ins Ass'n, 177 Mich App 85; 441 NW2d 54 (1989), lv den 434 Mich 894 (1990) and Morgan v Citizens Ins Co of America, 432 Mich 640; 440 NW2d 626 (1989), reh den 433 Mich 1201 (1989).

In Calhoun, a case similar to the instant case[1], a panel of this Court held that an insured who obtained a coordinated benefits clause from the no-fault insurer, was not obligated to "seek all possible health care benefits from his HMO plan prior to making a claim for benefits under his no-fault policy" because the insurer did not include "specific language to that effect in its coordination of benefits clause." Calhoun at 91.

Subsequent to Calhoun, our Supreme Court in Morgan, supra, ruled that an insured may not be required under the mandatory setoff of governmental benefits provided for by MCL 500.3109; MSA 24.13109, "to avail himself of whatever medical service in kind a governmental source may provide," noting that "[g]overnmental medical service may not be comparable in quality and service with the doctor or hospital service that the injured person purchased or may be able to purchase with the no-fault dollar." Id at 647. In a footnote, however, the Court noted:

> We express no opinion whether an injured person who has contracted for a reduced premium under § 3109a (MCL 500.3109a; MSA 24.13109[1]), and thus has voluntarily agreed that other insurance will be primary for medical benefits, may seek recovery from a no-fault insurer unless he was unable to obtain medical care from a facility designated, pursuant to the contract with the primary insurer, by the primary insurer.
>
> Similarly, we express no opinion whether, if Morgan contracted for a reduced premium under § 3109a on the basis of medical benefits available through his employment by the federal government, he voluntarily agreed that such benefits would be primary and may not seek recovery from Citizens unless he was unable to obtain medical care from a facility designated by the federal government which, in that hypothesis, has or may have, in effect, become the primary insurer for the purpose of coordination under § 3109a.

As the Supreme Court recognized in Morgan, a distinction exists between the duties posed upon an insured by §3109 of the no-fault statute and duties imposed upon the insured by his free choice in selecting coordinated medical benefits in exchange for a reduced premium. The insured's choice of treating physicians or facilities in such a situation is limited not by the no-fault insurer, but rather by the terms of the contract with the primary health insurer.

We disagree with the trial court and the Calhoun Court's decision that had defendant intended that plaintiff seek all possible health care benefits from his primary health insurer prior to making a claim for benefits under his no-fault policy, defendant should have included specific language to that effect in his coordination of benefits clause. This Court in United States Fidelity and Guaranty Co v Group Health Plan of Southeast Michigan, 131 Mich App 268, 273; 345 NW2d 683 (1983) interpreted similar language in a no-fault policy as "not easy for a layman to understand, [but] once deciphered, it clearly states that the insurer has only secondary liability." We find that here, the coordination of benefits provision of defendant's insurance policy deems itself an insurer of last resort responsible for expenses uncovered by the insured's primary insurer.

We disagree with the Calhoun Court's holding that an insured who selected coordinated medical benefits coverage in his no-fault policy in exchange for a reduced premium was not required to seek treatment from his primary health insurer, but could seek treatment elsewhere at the expense of the no-fault insurer. We believe that this holding is incorrect, and the Calhoun decision is not persuasive to this Court. To further the purpose of § 3109a, we hold that an insured, who pays a reduced premium in exchange for coordinated medical benefits coverage, is required to seek benefits provided by the primary insurer before seeking payment from the no-fault insurer.

Our decision is made in the factual context in which the insured chose coordinated coverage and the no-fault insurer, accordingly, charged a lower premium rate. We express no view as to what the result would be when the insured does not so elect and the no-fault premium is not correspondingly reduced.

For the foregoing reasons, the order of the trial court denying summary judgment in favor of defendant is reversed.

Reversed.

/s/ Robert J. Danhof
/s/ Walter P. Cynar
/s/ Thomas J. Brennan

[1]The defendant in Calhoun is the same insurer, Auto Club, who is the defendant in the instant case and the coordinated benefits clauses at issue in each case are identical.

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CYNAR, J. (concurring)

I write separately to express my concurrence with the result reached by the majority opinion under the specific facts of this case. While I agree with the majority that an insured who voluntarily elects coordinated coverage in exchange for a reduced premium rate is under some duty to seek out comparable health benefits offered by the primary issuer, I nevertheless envision that there may be any number of fact patterns which may limit the extent of that duty and, consequently, necessitate a different result.

/s/ Walter P. Cynar