STATE OF MICHIGAN

COURT OF APPEALS

CITIZENS INSURANCE COMPANY, a Michigan Insurance Corporation,

Plaintiff-Appellant,

June 17, 1992

v

No. 130551

MICHIGAN PRECISION INDUSTRIES and MASCO CORPORATION,

UNPUBLISHED

Defendants-Appellees.

Before: Sawyer, P.J., and Neff and Fitzgerald, JJ.

PER CURIAM.

Plaintiff appeals as of right coordination of benefits issues that resulted from an automobile accident. The facts of this case are undisputed. On February 16, 1986, Thomas Coles was killed instantly and his wife and children were injured in a car accident. At the time of the accident, Thomas Coles was insured for personal injury protection (PIP) benefits under a no-fault automobile insurance policy issued by plaintiff. Coles elected to coordinate these no-fault PIP benefits with his health insurance, and received a reduced premium rate. Mr. and Mrs. Coles were both covered by employee health and welfare benefit plans within the meaning of the Employment Retirement Income Security Act (ERISA), 29 USC 1002(1). Mr. Coles was covered by defendant MPI insurance, and Mrs. Coles was covered by defendant MASCO insurance. The MPI plan administrator determined that Mr. Coles' employment terminated in February of 1986, with the plan coverage ending on February 28, 1986. After the accident Citizens paid nearly $400,000 in accident-related medical expenses and sought recoupment from MASCO and MPI.

The trial court held that MPI was obligated to provide benefits until coverage ceased on February 28, 1986. The court also ruled that the MASCO plan's $10,000 limitation on benefits constituted an exclusion, was enforceable, and limited MASCO's liability to $10,000 per covered individual. In accordance with these rulings, judgment was entered on June 11, 1990, in favor of Citizens and against MPI in the amount of $36,877.20 and MASCO in the amount of $19,337.00. MASCO was awarded mediation sanctions in the amount of $5,713.00, reducing Citizens' recovery against MASCO to $13,624.00. We affirm.

I

In Michigan, when a no-fault insurance policy and a health insurance policy contain coordinated benefits clauses, the intent of the no-fault insurance act, expressed in MCL 500.3109a; MSA 24.3109(1), mandates that the health insurance carrier will be primarily liable for the insured's medical expenses resulting from injuries suffered in a motor vehicle accident. Federal Kemper Ins Co v Health Ins Admin, 424 Mich 537; 383 NW2d 590 (1986). However, because the MASCO insurance plan in this case is an uninsured self-funded ERISA plan, it is not subject to direct Michigan insurance regulation. FMC Corp v Holliday, 498 US ___; 111 S Ct 403, 407, 409; 112 L Ed 2d 356 (1990); Auto Club Ins Assoc v Frederick & Herrud, Inc (On Remand), 191 Mich App 471; ___ NW2d ___ (1991). See also State Farm v CA Muer Corp, 154 Mich App 330, 337-338; 397 NW2d 299 (1986). Frederick, supra initially relied on Northern Group Services, Inc v Auto Owners Ins Co, 833 F2d 85 (CA 6, 1987), cert den 486 US 1017 (1988), which held that ERISA did not preempt the application of Federal Kemper to ERISA plans. Northern was effectively overruled by the United States Supreme Court decision in FMC. Frederick, supra at 474. This firmly established a federal preemption clause in state insurance regulation of ERISA noninsured plans. The issues raised in the case at

bar involve the application of the federal preemption to a conflict between the self-funded MASCO ERISA plan, the partially commercially insured MPI ERISA plan, and the no-fault carrier, Citizens.

II

On appeal Citizens argues that in spite of the FMC ruling, the no-fault insurer's coordination of benefits clause is not invalid because of further Sixth Circuit interpretation of FMC. We disagree. By its terms, ERISA preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." Auto Club Ins Assoc v Health and Welfare Plans, Ins, 1992 WL 69815 (CA 6 (Mich)) [Health and Welfare], quoting 29 USC § 1144(a) (pre-emption clause). The deemer clause of 29 USC § 1144(b)(2)(B) provides:

> Neither an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks trust companies, or investment companies.

In FMC Corp, supra at 407, 409, the Supreme Court explained that the pre-emption clause:

> [I]s conspicuous for its breadth. It establishes as an area of exclusive federal concern the subject of every state law that "relate[s] to" an employee benefit plan governed by ERISA. The saving clause [29 USC § 1144(b)(2)(A)] returns to the States the power to enforce those state laws that "regulat[e] insurance" except as provided in the deemer clause. Under the deemer clause, an employee benefit plan governed by ERISA shall not be "deemed" an insurance company, an insurer, or engaged in the business of insurance for purposes of state laws "purporting to regulate" insurance companies or insurance contracts.
>
> * * *
>
> We read the deemer clause to exempt self-funded ERISA plans from state laws that "regulat[e] insurance" within the meaning of the savings clause. By forbidding States to deem employee benefit plans "to be an insurance company or other insurer . . . or to be engaged in the business of insurance," the deemer clause relieves plans from state laws "purporting to regulate insurance." As a result, self-funded ERISA plans are exempt from state regulation insofar as that regulation "relate[s] to" the plans. State laws directed toward the plans are pre-empted because they relate to an employee benefit plan but are not "saved" because they do not regulate insurance. State laws that directly regulate insurance are "saved" but do not reach self-funded employee benefit plans because the plans may not be deemed to be insurance companies, other insurers, or engaged in the business of insurance for purposes of such state laws. On the other hand, employee benefit plans that are insured are subject to indirect state insurance regulation. An insurance company that insures a plan remains an insurer for purposes of state laws "purporting to regulate insurance" after application of the deemer clause. The insurance company is therefore not relieved from state insurance regulation. The ERISA plan is consequently bound by state insurance regulations insofar as they apply to the plan's insurer.

Based on FMC, the Sixth Circuit concluded that self-insured ERISA plans, including self-insured ERISA plans containing coordination of benefits clauses, are not reached by MCL 500.3109a; MSA 24.13109(1). Health and Welfare, supra at 4. However, the court in Health and Welfare also concluded that even though § 3109a cannot mandate priority for coordination of benefits, the no fault auto carrier's coordination of benefits clause is not rendered ipso facto void. Id at 5. The fact that there was a preemption was not dispositive in that case because there still existed the issue of which of two apparently valid insurance policies containing what appeared to be irreconcilable "other insurance" clauses is liable for payment of medical expenses. Id at 4. The court remanded for the lower court to first decide whether the trustees of the

self-insured ERISA plan acted within their discretion in denying benefits. If the court found that discretion properly exercised and the decision regarding benefits reasonable, then the court must resolve the conflict between the coordination of benefits clauses. Id at 5-6.

III

Given the Health and Welfare interpretation of FMC, the present case might initially be viewed as involving a reconciliation of coordination clause issue. However, the facts in this case differ from those in Health and Welfare. There is a preemption, but there are no irreconcilable "other insurance clauses." MASCO's plan contained a $10,000 coverage limitation, which was clearly intended to be secondary to any no-fault automobile coverage. The applicable portions of that policy provided:

> **Coordination with No-Fault Automobile Coverage**
>
> Coverage provided by this plan is not intended to reduce the level of coverage that would normally be available through a no-fault automobile insurance policy, nor does this coverage intend to provide benefits as **primary** in order to reduce any premium cost for no-fault automobile coverage. Coverage under this plan will be **secondary** to any no-fault automobile coverage.
>
> In the event you lose income or you or a **covered dependent** incur medical expenses as a result of an automobile accident (either as an operator of the vehicle, a passenger or a pedestrian), this plan will pay for covered services limited to:
>
> -- any deductible under the automobile coverage,
> -- any copayment under the automobile coverage, and
> -- any expenses excluded by the automobile coverage that are covered by this plan's benefits.
>
> * * *
>
> This plan's benefits for all covered services and wage loss replacement are limited to an aggregate maximum of $10,000 for each **covered individual** for each automobile accident.
>
> Failure to maintain no-fault automobile coverage that is legally required by your state will not entitle you or your **dependents** to any benefits that would not otherwise be payable.
>
> * * *
>
> **Coordination With Financial Responsibility**
>
> If your state has a 'financial responsibility law' or 'financial responsibility act' which does not allow this plan to pay benefits as **secondary** or advance payment with the intent of subrogating, or recovering an overpayment, this plan will not cover any services related to an automobile accident for you or your **dependents**.
>
> **Coordination With Other Automobile Liability Insurance**
>
> If your state has neither a no-fault automobile requirement nor a 'financial responsibility law', this plan will be considered **secondary** and will coordinate payment for covered services with your automobile insurance coverage or with any other party who may have liability for medical expenses. [Emphasis in original.]

While MASCO claims that these clauses describe validly excluded benefits, Citizens characterizes them as a modified version of an escape-type coordination clause. MASCO also argues that the coordination-exclusion dichotomy is no longer valid since state law cannot supercede either coordination or

exclusion clauses in ERISA plans. However, Citizens argues that since defendant opted to provide some coverage for auto accident related injuries, defendant's attempt to limit coverage for expenses arising as a result of injuries suffered in an auto accident constitutes an "other insurance" provision which should be construed as an attempt to coordinate benefits.

The trial court held that the MASCO plan was qualitatively different than the policy considered in Federal Kemper:

> [T]his comes down to the difference between resolving a dispute in priorities and recognizing an exclusion. . . . The critical difference as I perceive it is between a policy which attempts to reduce its liability by the presence of another policy of insurance and one which in all events limits its liability to a specified amount. This is the latter.
>
> The Kemper court -- the Kemper decision was aimed at policies which attempted to limit its liability at the expense of a no fault insurer. This policy limits its liability in all events, whether the no fault insurer [is] around or not. An it's one thing for the court to say that it is inappropriate for an insurer to attempt to limit -- to palm off its liability on another insurer in the face of the policy of this statute. It's quite another thing to declare that an insurer must provide coverage that it never bargained for at all under any circumstance. And no court as far as I know has gone that far.

While we do not fully agree with the trial court's characterization of the MASCO provision as an exception, we find that the result is correct regardless of whether the provisions are characterized as an exception or a form of coordinated benefits. Coordinated benefits provisions appear in three forms: "excess," "pro rata," and "escape" or "other insurance." Transamerica v IBA Health & Life Assurance Co, 190 Mich App 190, 194; 475 NW2d 431 (1991). The excess type provides benefits over the limits of the primary policy. The pro rata type provides benefits in proportion to the amount of total coverage available. Finally, the escape type provides no coverage if other benefits are available. Escape coverage is conditioned on the existence of other insurance. Federal Kemper, supra at 542; IBA, supra. With all three types, benefits are available, but coordinated. IBA, supra.

IBA delineates the parameters of exclusion coverage as follows:

> If an exclusion of coverage is stated absolutely in a health insurance policy without reference to other insurance, then it is not conditioned on the existence or nonexistence of other insurance. Such an exclusion provision qualitatively differs from an "escape" type coordinated benefits provision that is expressly conditioned on the existence of other insurance. Such coverage simply does not exist, regardless of the existence of any no-fault benefit. Peerless, supra [Transamerica Ins Co of North America v Peerless Industries, 698 F Supp 1350 (WD Mich, 1988).
>
> Similarly, where a health insurer opts to pay a specific sum for injuries arising from a motor vehicle accident, regardless of the existence of any no-fault benefits, such limitation of benefits is a valid exclusionary clause when the exclusion is clear, unambiguous, and does not violate public policy. Raska v Farm Bureau Mutual Ins Co of Michigan, 412 Mich 355, 361-362; 314 NW2d 440 (1982); Benike v Scarborough Ins Trust, 150 Mich App 710; 389 NW2d 156 (1986).

In IBA the policy language read: "eligible expenses are the reasonable and customary charges for: . . . (P) injuries sustained in an automobile accident, in an amount not to exceed $5,000.00 per accident." IBA, supra at 192. This Court held that this clear and unambiguous limitations of benefits for injuries related to auto accidents appearing in a health and accident insurance policy, without reference to the existence of other insurance coverage, was a valid exclusionary provision. IBA, supra at 195-196.

The MASCO provisions appear to have two components. The first component is an exclusionary provision that pays a total of $10,000 per covered person in the event of an auto accident, whether the claimant has purchased no-fault auto insurance or not. The second component appears to be an excess-type coordination of benefits section. We find that there was an attempt on the part of MASCO to coordinate a modified exclusion clause. Nevertheless, federal preemption applies.

Under Michigan law defendants could properly have entirely and unconditionally excluded coverage for injuries suffered in a motor vehicle accident. Auto-Owners Ins Co v Autodie Corp Employee Benefit Plan, 185 Mich App 472; 463 NW2d 149 (1990); Transamerica Co of North American v Peerless Industries, 698 F Supp 1350 (WD Mich, 1988). These plans effectively presume the insured is covered under a no-fault insurance policy. However, coverage is not dependent upon the actual purchase of no-fault insurance. The $10,000 limit in the MASCO policy is valid. IBA, supra.

We conclude that there is no conflict in applying the federally preempted Citizens coordination clause and the MASCO quasi-coordination clause. Whatever benefits are not covered under the Citizens policy as the primary payor, which are covered under the MASCO policy, are to be paid by MASCO, to the limit of $10,000 per covered person.

IV

Plaintiff next argues that the death of the claimant should be characterized as an absence from work, as opposed to a termination of employment as the lower court ruled. As against the no-fault carrier, MPI does not dispute that its coverage is primary up to the point when MPI's coverage ceased. MPI claims that its coverage ceased at the end of February, 1986, the month in which the automobile accident occurred. We agree. MASCO and Citizens both argue that the plan's silence related to the event of death requires that MPI's coverage should be resolved in favor of extended coverage through the end of the sixth month following the accident. Under Section 6 of the MPI plan, the event of death is not addressed in the duration of coverage. It is disputed whether subparagraph (e) or subparagraph (h) is most applicable related to termination of coverage:

> The coverage of any Employee covered under this Plan shall terminate on the earliest of the following dates:
>
> * * *
>
> e. the last day of the calendar month in which employment terminates; or
>
> * * *
>
> h. the last day of the sixth calendar month following the commencement of absence from work due to an illness or injury. [Emphasis added.]

We agree with the trial court that the earliest of the above events was at Mr. Coles' death, when his employment terminated. We agree with the reasoning set forth in J.N. Nutt v Members Mutual Ins Co, 474 SW2d 575, 576 (Tex Civ App 1971):

> The general rule, that a personal service contract terminates on death of the employee, applied to the employer's duty to pay as well as the employee's duty to serve. [Citations omitted.] The continued life of the employee is a constructive condition imposed by law in the interest of justice, independent of the intention of the parties, unless the language of the contract indicates a contrary intent. 3A Corbin on Contracts, § 632 (1960). See Restatement, Contracts, §253 (1932).

See also 3A Corbin on Contracts, § 632 (1991 Supp) and Vol 6, § 1334 (1991 Supp). Mr. Coles' unfortunate death destroyed the constructive condition of live employment needed to continue coverage under his medical insurance.

The parties also dispute the standard of review related to MPI's interpretation of its insurance plan language. Under ERISA, absent the express delegation to the plan administrator or trustee, of discretionary authority to determine eligibility for benefits or to construe the terms of the plan, a court should conduct a de novo review of the trustee's benefit determination. Firestone Tire & Rubber Co v Bruch, 489 US 101; 109 S Ct 948, 956; 103 L Ed 2d 80 (1989). But where an ERISA plan expressly affords discretion to trustees to make benefit determinations, the decision to deny benefits should be reviewed for abuse of the trustee's discretion. Id. at 954-956. Under this standard, trustee denial of benefits would be upheld regardless of whether the reviewing court thought it was the correct interpretation of the plan, as long as it was reasonable. Id. at 954. This Court has found Firestone persuasive to the extent that it explicitly rejected the arbitrary and capricious standard of review for ERISA claims. Guiles v U of Mich Bd of Regents, ___ Mich App ___; ___ NW2d ___ (No. 122651, rel'd 2/3/92) slip op p 3.

The MPI plan authorizes the plan administrator to make final decisions promptly. We interpret this as a discretionary delegation. We find that the plan administrator's interpretation was reasonable and he did not abuse his discretionary authority in deciding that MPI coverage ceased on February 28, 1986. See Guiles, supra slip op p 5 n4.

Affirmed.

/s/ David H. Sawyer
/s/ Janet T. Neff
/s/ E. Thomas Fitzgerald