STATE OF MICHIGAN

COURT OF APPEALS

CHRISTINE BOOTH,

Plaintiff-Appellant,

v

AUTO OWNERS INSURANCE CO,

Defendant-Appellee.

FOR PUBLICATION
July 25, 1997
9:35 a.m.

No. 192527
Monroe Circuit Court
LC No. 95-003272

Before: Cavanagh, P.J., and Reilly and White, JJ

PER CURIAM..

In this insurance dispute, plaintiff appeals as of right the trial court's decision granting summary disposition in favor of defendant. We reverse.

Defendant is plaintiff's no-fault insurance carrier. In 1989, plaintiff was involved in a serious automobile accident while making a delivery for her employer. As a result, she suffered a severe closed head injury and was in a coma for several months. After her discharge from the hospital in 1989, plaintiff went to live with her parents, Dawn and Thomas Booth. Since that date, Dawn has allegedly provided attendant care for her daughter twenty-four hours a day, seven days a week. Thomas also cares for plaintiff when he is home.

Plaintiff's workers' compensation carrier agreed to compensate Dawn and Thomas for their services at a rate of $8.00 per hour. Pursuant to § 315 of the Worker's Disability Compensation Act (WDCA), MCL 418.315(1); MSA 17.237(301)(1), this compensation was limited to fifty-six hours per week. After defendant refused to pay Dawn for the remaining 112 hours of care per week, plaintiff filed this suit. In granting summary disposition in favor of defendant, the trial court held that plaintiff failed to submit evidence establishing that she had incurred expenses relating to the attendant care services provided by her parents because she was not charged for these services. The court also held that plaintiff could not seek no-fault benefits from defendant for her parent's services in excess of fifty-six hours because plaintiff could have obtained payment from her worker's compensation carrier if the care was provided by a commercial agency instead of her parents. We disagree with both rationales for granting summary disposition in favor of defendant, and therefore, reverse.

Section 3107 of the no-fault act, MCL 500.3107; MSA 24.13107, provides that personal protection insurance (PIP) benefits are payable for "[a]llowable expenses consisting of all reasonable charges incurred for reasonably necessary products, services and accommodations for an injured person's care, recovery, or rehabilitation." There are three requirements which must be satisfied in order for a no-fault insurer to be responsible for PIP benefits: (1) the expense must have been incurred; (2) the expense must have been for a product, service or accommodation reasonably necessary for the injured person's care, recovery or rehabilitation; and (3) the amount of the expense must have been reasonable. *Moghis v Citizens Ins Co*, 187 Mich App 245, 247; 466 NW2d 290 (1991).

This Court has previously considered compensation for care provided by family members in *Visconti v DAIIE*, 90 Mich App 477; 282 NW2d 360 (1979) and *Van Marter v American Fidelity Fire Ins Co*, 114 Mich App 171; 318 NW2d 679 (1982).

In *Visconti*, the plaintiff sought to recover the value of his wife's services at a rate of twenty dollars per day for the 132 days of care she provided while the plaintiff's leg was in a cast. The Court held that the services were compensable under the no-fault act and cited subsections (a) and (b) of the version of MCL 500.3107; MSA 24.13107 in effect at that time, the pertinent parts of which are unchanged in the current version of MCL 500.3107(1); MSA 24.13107(1).

Similarly, in *Van Marter*, the father of the insured (who was also the guardian of the insured's estate) sought to recover no-fault benefits for the value of services rendered by the insured's step-mother. The defendant recognized that it was obligated to pay for the value of the services under *Visconti*, but claimed that the three-year limitation period for replacement services was applicable. This Court agreed with the trial court that the services were compensable under MCL 500.3107(a); MSA 24.13107(a) (now MCL 500.3107(1)(a); MSA 24.13107(1)(a)) and the three-year limitation period did not apply to the services the step-mother was rendering to the insured.

This Court has extended the principles of *Visconti* and *Van Marter* in *Reed v Citizens Ins Co*, 198 Mich App 443; 499 NW2d 22 (1993) and *Botsford General Hosp v Citizens Ins Co*, 195 Mich App 127; NW2d (1992).

In *Reed*, the issue was whether room and board is an allowable expense "when the insured who could be institutionalized is cared for at home." *Id.* at 450. The Court noted, "family members may be compensated for the services they provide at home to an injured person in need of care," and cited *Van Marter*. The Court then extended the reasoning of those cases to hold that "where an injured person is unable to care for himself and would be institutionalized were a family member not willing to provide home care, a no-fault insurer is liable to pay the cost of maintenance in the home." *Reed, supra* at 453.

In *Botsford General Hospital*, the defendant argued that the plaintiff did not prove that he incurred any expenses for replacement services. See MCL 500.3107(1)(c); MSA 24.13107(1)(c). The plaintiff's wife testified that she mowed the grass, took out the trash, shoveled the sidewalk, and went to the store when the plaintiff would normally have done so. This Court stated that case law "permits the recipient of no-fault PIP benefits to recover for replacement services provided by

family members" *id.* at 142, and affirmed the jury award for these services. According to the Court, whether the plaintiff was entitled to collect the value of the replacement services and the determination of the value were properly left for the jury to decide. *Id.* at 143.

In this case, defendant argued and the trial court agreed that the value of the care provided to plaintiff was not an allowable expense because plaintiff was not charged by her parents for those services. Pursuant to MCL 500.3107(1)(a); MSA 24.13107(1)(a), allowable expenses consist "of all reasonable charges incurred for reasonably necessary products, services and accommodations for an injured person's care, recovery or rehabilitation." According to defendant's argument, no charges for the service provided by plaintiff's parents have been "incurred." Although this Court has not addressed this precise argument in any published opinion that we have located, accepting such an argument would be inconsistent with the holdings in *Visconti, Van Marter, Reed, and Botsford General Hospital.* In each of those cases, this Court implicitly held that "charges" or "expenses" had been "incurred" without requiring that the insured was actually billed by the family.[1] We decline to create such a requirement in this case. As in *Botsford General Hospital, supra,* whether the plaintiff was entitled to collect the value of the services and the determination of the value are matters properly left for the jury to decide. *Id.* at 143. Defendant was not entitled to summary disposition on this basis.

Next, we consider whether defendant was entitled to summary disposition because, by choosing her parents to provide services, plaintiff failed to make a reasonable effort to obtain benefits available under the WDCA, and thus was precluded from recovering from defendant for those services.

Because of the limitation in § 315(1) of the WDCA, plaintiff could not receive worker's disability compensation for more than fifty-six hours of "attendant or nursing care" provided by her parents. However, no such time limitation applies when the care is provided by someone other than the "employee's spouse, brother, sister, parent or any combination of these persons." Thus, if plaintiff agreed to be cared for by someone from a commercial agency for 112 hours per week, for example, the entire cost of the care would be compensable under the WDCA.

A no-fault insurer is entitled to set off worker's compensation benefits under § 3109(1) of the no-fault act. *Root v Insurance Co of North America*, 214 Mich App 106, 108; 542 NW2d 318 (1995). Defendant, relying on *Perez v State Farm Mutual Ins Co*, 418 Mich 634; 344 NW2d 773 (1984), argues that if an injured person does not exercise a reasonable effort to obtain available worker's compensation benefits, the worker's compensation benefits that were available but not collected are required to be subtracted from any no-fault benefits. According to defendant, plaintiff failed to make reasonable efforts to obtain the full amount of worker's compensation benefits that were available for nursing or attendant care because the entire cost of her care would be compensable under the WDCA if plaintiff used a commercial agency to provide care in excess of the fifty-six hour a week limit imposed by § 315(1) on care provided by plaintiff's parents. Thus, defendant argues, plaintiff's unwillingness to agree to such an arrangement amounts to a failure to use reasonable efforts to obtain benefits available under the WDCA and entitles defendant to set off the cost of her parent's services.

Contrary to defendant's argument, defendant is not entitled to set off the cost of the services provided by her parents unless those services are duplicative of benefits required to be paid by the government.

In *Morgan v Citizens Ins Co of America*, 432 Mich 640; 442 NW2d 626 (1989), the plaintiff was injured in an automobile accident on his way to National Guard training. Because he was on military service at the time, the plaintiff's initial medical expenses were paid by the federal government. Later, the plaintiff underwent surgery at a nonmilitary hospital for a herniated disc. The plaintiff's no-fault insurer refused to pay for the additional expense, and the plaintiff filed suit. The trial court granted summary disposition pursuant to § 3109(1) of the no-fault act in favor of the defendant no-fault insurer. The court held that the plaintiff did not have the option of obtaining non-emergency medical care in a nonmilitary hospital when the federal government was required by law to provide the medical service at a military hospital. This Court affirmed the trial court's decision, finding that the plaintiff elected not to receive benefits offered by the federal government. *Morgan v Citizens Ins Co of America*, 163 Mich App 115; 413 NW2d 747 (1987).

The Supreme Court reversed and held that the plaintiff was entitled to receive payment from his no-fault carrier. According to the Court, § 3109(1) did not preclude the plaintiff from seeking payment of expenses incurred in a nonmilitary hospital simply because he could have had the procedure performed in a military hospital:

> A person injured in an automobile accident is not required under § 3109(1) to avail himself of whatever medical service in kind a governmental source may provide. Governmental 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. Hospitals and doctors are not fungible. There are good hospitals and some that are not, good doctors and some that are not. The Legislature did not intend that however legitimate the injured person's concern regarding the quality of the governmental service in kind -- even if the medicine practiced at the hospital or the doctor is questionable, debatable, or notoriously bad -- it is nevertheless a benefit as a matter of law within the meaning of § 3109(1).
>
> The no-fault act preserves to injured persons a reasonable choice of hospitals and physicians although this may add to the premium cost of no-fault insurance. The no-fault insurer cannot, in the name of reducing the premium cost, require an injured person to obtain medical service from a particular provider.
>
> Section 3109(1) does not mandate the offset of all governmentally provided benefits, only duplicative benefits:
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> * * *
>
> A surgical procedure performed in a military hospital may not, because of differences in quality and service, be duplicative of the medical service that an injured person could obtain and pay for with the no-fault medical expense benefit

through the exercise of the choice in medical service providers preserved to injured persons under the no-fault act. [*Morgan*, 432 Mich at 647-648.]

In this case, the care provided by plaintiff's parents is not duplicative of the care that plaintiff could obtain by hiring a commercial agency. Because the Supreme Court has held, with respect to offsetting benefits under § 3901(1),that a no-fault insurer cannot require an injured person to obtain medical service from a particular provider, defendant in this case cannot require plaintiff to choose a commercial agency to provide nursing and attendant services. The Legislature chose to limit the benefit available under the WDCA for attendant or nursing care provided by certain family members. Because of this limitation, the benefit available under the WDCA is not duplicative of the benefit plaintiff seeks to recover under the no-fault act.

Defendant cites *Tousignant v Allstate Ins Co*, 444 Mich 301; 506 NW2d 844 (1993) and *Owens v Auto Club Ins Association*, 444 Mich 314; 506 NW2d 850 (1993) and argues that "when no-fault insurance is coordinated, a plaintiff agrees to avail himself or herself of the coverage available, which in this case is the by [sic] the workers' [sic] compensation coverage and includes the 56 hour limitation." *Tousignant* and *Owens* are inapposite. Those cases concerned coordination of benefits under § 3109a. See *Tousignant, supra* at 307; *Owens, supra* at 322. The present case concerns § 3109(1), "[b]enefits provided or required to be provided under the laws of any state or the federal government . . . ."

Furthermore, the rationale underlying the Court's decisions in *Tousignant* and *Owens* does not support defendant's position in this case. *Tousignant* and *Owens* are similar to the present case inasmuch as the insureds, like plaintiff, looked to their no-fault insurer for payment of expenses that would have been paid by another source (the worker's compensation carrier in the present case, the HMO in *Tousignant* and the United States Coast Guard and Veteran's Administration in *Owens)* had the injured persons made different choices in their treatment. In *Tousignant* and *Owens*, the Supreme Court held that by choosing to coordinate health care coverage, the insureds agreed in effect to avail themselves of the coverage provided, *Owens, supra* at 321, and relinquish choices of physician and facility, where the coverage is provided by an HMO as in *Tousignant, supra* at 310. Thus, the Supreme Court was unwilling to allow the insured to choose to accept the benefits (e.g. lower premiums) of coordinating coverages and then repudiate the limitations inherent in the health care coverage chosen. In the present case, the limitation in plaintiff's ability to have twenty-four hour care provided by her parents is the result of a decision made by the Legislature when it amended § 315 of WDCA.[2] In contrast to the insureds in *Tousignant* and *Owens,* plaintiff did not agree to accept that limitation when she chose her health care insurer. Nor did she choose to accept the limitations inherent in the benefits provided pursuant to the WDCA in exchange for a reduced premium. The fifty-six-hour limitation exists regardless of plaintiff's choice to coordinate her no-fault and health care insurance. Defendant's attempt to argue that by choosing coordinated coverage, plaintiff agreed to accept the limitations imposed by the WDCA and conform her treatment to the care compensable thereunder, is disingenuous.

Therefore, we conclude that defendant was not entitled to summary disposition because plaintiff did not hire a commercial agency to provide care that was required in excess of fifty-six

hours. Having examined and rejected the two rationales for the court's decision, we reverse the order granting summary disposition in favor of defendant.

Reversed.

/s/ Mark J. Cavanagh
/s/ Maureen Pulte Reilly

[1] The decision in *Moghis, supra* does not require a contrary result. In that case, this Court reduced a judgment that included $280,000 for past care by an aide. This Court concluded that "[a]though there was testimony indicating that plaintiff needed some sort of care by an aide, there is no evidence that this care was actually provided to plaintiff." *Id.* at 247. *Moghis* does not indicate that the insured must be billed. Rather, the defect in the plaintiff's proofs was that "the extent of any aid to plaintiff was not sufficiently established to support a finding that plaintiff incurred semi-dependent care by an aide in the past." *Id.*

[2] 1985 PA 103 added the fifty-six-hour limitation on care provided by certain family members.

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WHITE, J. (concurring).

I agree that the trial court erred in concluding that no expenses had been incurred as a matter of law.

I also agree that under *Morgan v Citizens Ins Co of America*, 432 Mich 640; 442 NW2d 626 (1989), defendant cannot, under section 3109(1), obtain a setoff for compensable services plaintiff could have obtained from an outside provider if those services are not duplicative of the services provided by her parents, because of differences in quality or service.

Lastly, I agree that this case is governed by section 3109(1) (benefits provided or required to be provided under the laws of any state or the federal government) and not section 3109a (other health and accident coverage). See *Profit v Citizens Ins Co* 444 Mich 281, 288 - 300; 506 NW2d 514 (1993)(Boyle, J., concurring in part and dissenting in part).

/s/ Helene N. White