UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION
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FARM BUREAU GENERAL INSURANCE COMPANY OF MICHIGAN,

Plaintiff,

v.

File No. 5:97-CV-191

MORTON BUILDINGS, INC. EMPLOYEE HEALTH AND WELFARE BENEFIT PLAN,

Hon. Richard Alan Enslen

Defendant.
_____/

OPINION

This matter is before the Court on cross motions for summary judgment. Plaintiff Farm Bureau General Insurance Company of Michigan and Defendant Morton Buildings, Inc. Health and Welfare Benefits Plan both provided insurance to Shawn Morris. Plaintiff seeks a declaratory judgment that Defendant is the primary insurer for injuries sustained by Morris in a 1995 automobile accident. Defendant opposes this motion for summary judgment on the grounds that its insurance provides only secondary or excess coverage in this instance.

FACTS

The facts of this case, as agreed to by the parties, are as follows. Morris entered the employment of Morton Buildings, Inc. on June 2, 1994 and began to participate in the Morton Buildings, Inc. Employee Health and Welfare Benefit Plan ("the Plan"), an

assert third-party claims.[1] However, the insurance issued by Plaintiff provides that "in the event of any payment under this policy, the company shall be subrogated to all the insured's rights of recovery therefor, against any person or organization. . . ." By operation of this provision, Plaintiff has succeeded to Morris' claims against Defendant and has standing to advance these claims. *See, e.g., Transamerica Ins. Co. v. Detroit Carpenters Health and Welfare Fund*, 904 F.2d 708 (6th Cir. 1990) (allowing insurer to advance the claims of its insured under principles of subrogation).

Defendant also argues that Plaintiff's claim is not ripe for review, because neither Plaintiff nor Morris has exhausted the administrative remedies available under the Plan. While the Sixth Circuit generally requires participants in ERISA plans to exhaust administrative remedies before appealing a denial of benefits in federal court, this requirement may be waived if a district court finds that an administrative appeal would be futile or that available administrative remedies would be inadequate. *Constantino v. TRW, Inc.*, 13 F.3d 969, 975-75 (6th Cir. 1994). Defendant asserts in its motion and accompanying affidavits that it has consistently interpreted the Plan to provide only excess

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[1]Defendant does not appear to dispute that Plaintiff meets the constitutional requirements for standing and, in fact, Plaintiff does meet these standards. To assert standing under the Constitution, a plaintiff must allege that he has suffered or will suffer an actual or imminent injury in fact which is causally related to the challenged conduct and is likely to be redressed by a favorable decision. *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560-561, 112 S.Ct. 2130, 2136, 119 L.Ed.2d 351 (1992). In this case, Plaintiff alleges that it has been injured, and will continue to be injured, by paying benefits to Morris that it is not obligated to pay and that this injury is caused by Defendant's wrongful determination that Defendant is only required to provide secondary or excess coverage under the Plan. Plaintiff seeks a declaratory judgment which would, if granted, redress these injuries by instructing Defendant that it is the primary insurer under these circumstances.

coverage for medical expenses related to injuries received from an automobile accident and has always denied primary coverage in such situations in the past. Given Defendant's consistent and longstanding interpretation of the Plan and the undisputed cause of Morris' injuries, this Court believes that Defendant is certain to deny any claims related to these injuries, making further administrative appeals futile. Therefore, any exhaustion requirement should be excused.

II. Plaintiff's and Defendant's Claims

At the heart of these cross-motions for summary judgment is a dispute over whether the Plan or the no fault policy should be considered the primary insurance for injuries and Morris' medical expenses related to his 1995 automobile accident. Because the Plan is governed by ERISA, any conflict between the Plan and the no fault insurance policy must be resolved in favor of the Plan. *Auto Owners Insurance Co.*, 31 F.3d at 374. To determine if there is a conflict, this Court must determine whether each insurer would be considered the primary or secondary insurer under its own policy.

Generally, when asked to interpret an insurance policy, a court will review the policy de novo, applying standard principles of contract interpretation. *Comerica Bank v. Livingston Insurance Co.*, 3 F.3d 939, 942 (6th Cir. 1995). This standard will apply to the interpretation of the no fault policy. However, because of the underlying purposes of ERISA, policies issued under that law are sometimes treated differently.

An administrator's decision to deny benefits under an ERISA plan is reviewed de novo, unless the Plan itself contains an explicit grant of discretion to the Administrator. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115, 109 S.Ct. 948, 956-57, 103

L.Ed.2d 80, 95 (1989); *Anderson v. Great West Life Assurance Co.*, 942 F.2d 392, 394-95 (6th Cir. 1991). If the Plan grants the Administrator discretion in interpreting its provisions, this Court must review such interpretations under an arbitrary and capricious standard. *Firestone*, 489 U.S. at 115, 109 S.Ct at 956-57; *Anderson*, 942 F.2d at 394-95. Although Plaintiff is not directly appealing a denial of benefits under 29 U.S.C. § 1132, its claim stems from a denial of benefits. Because Plaintiff's standing is premised on its subrogation of Morris' claims against Defendant, this Court will apply the same standard of review to Plaintiff's claim that it would have applied to claims presented by Morris.

Under an arbitrary and capricious standard, the Plan administrator's construction will be upheld if reasonable. *Johnson v. Eaton Corp.*, 970 F.2d 1569, 1574 (6th Cir. 1992). An interpretation may be considered unreasonable if it renders language in the plan meaningless or internally inconsistent. *Davis v. Kentucky Finance Companies Retirement Plan*, 887 F.2d 689, 695 (6th Cir. 1989); *Moench v. Robertson*, 62 F.3d 553, 566 (3rd Cir. 1995), *Finley v. Special Agents Mut. Benefits Ass'n*, 957 F.2d 617, 621 (8th Cir. 1992). Other factors that may be considered in determining reasonableness include (1) whether the interpretation is consistent with the goals of the plan, (2) whether the interpretation conflicts with the *226 substantive or procedural requirements of ERISA, (3) whether the interpretation is consistent, and (4) whether the interpretation is contrary to the clear language of the plan. *Moench*, 62 F.3d at 566; *Finley*, 957 F.2d at 621.

In this case, the Plan includes a provision called "Interpretation of Plan," which grants the Employer discretion to interpret the Plan. This section provides, in relevant part, that "[f]inal authority for interpretation of the terms and provisions of the Plan is vested in

the Employer. . . . The Employer shall have discretionary authority to determine eligibility for benefits or to construe the terms of the Plan." Thus, this Court must review Defendant's interpretation of the Plan under an arbitrary and capricious standard.

The no fault policy contains a single provision related to other insurance. That provision, labeled "Coordination of Benefits," explicitly precludes coverage to the extent that benefits are available "under any individual, blanket or group accident, disability, health maintenance organization, hospitalization or similar insurance or health plan " when the insured opts for excess medical coverage only. Because Morris opted for excess coverage only, the no fault policy would be considered secondary under its own terms.

The Plan contains two potentially relevant provisions. First, the Plan contains an "Excess Insurance Provision" which states:

> If at the time of Injury or Sickness there is available to the Covered Person . . . any other insurance, or other form of indemnification, . . . the benefits under this Plan shall apply only as excess insurance coverage over such other sources of indemnification; by way of illustration, but not in limitation, this provision shall be applicable to those Expenses Incurred as the result of Sickness or Injury when:
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> (a) the Covered Person . . . is injured by or in the course of operating a motor vehicle.

The Plan also includes a "Coordination of Benefits" provision, which reads as follows:

> In addition to benefits payable under this Plan, a Covered Person . . . may be entitled to benefits from other plans, payable on account of the same Sickness or Injury. The other plans are those which provide benefits or services for or by reason of medical or dental care or treatment, when such benefits or services are provided on a group basis, whether insured or not; by no-fault automobile insurance; homeowners; by any government or tax-supported program (including Medicare) or any similar plan or program.

* * *

> One of the two or more plans involved is the Primary Plan and the other plans are Secondary Plans. The Primary Plan pays benefits first and without consideration of the other plans. The Secondary Plans then make up the difference up to the total allowable Expenses Incurred. No plan will pay more than it would have paid without this special provision.

The provision then lists several rules for determining which of the plans is primary and which are secondary.

Defendant argues that the Excess Insurance provision constitutes an "express disavowal" of any obligation to pay benefits other than on an excess basis in Morris' case, noting that the injuries sustained in an automobile accident are given as the type of injuries for which the Plan provides excess coverage only. Further, Defendant discounts Plaintiff's argument that the Excess Insurance Provision conflicts with the Plan's Coordination of Benefits provision, arguing that, because the Excess Insurance Provision prevents full coverage of Morris' Incurred Expenses, the total benefits payable would never exceed the "Expenses Incurred" and the Coordination of Benefits provision is never reached. This interpretation is not reasonable in light of the entire policy.

Because the Excess Insurance Provision applies to any other insurance, this provision subordinates the Plan to all other insurance held by the Covered Person and the Plan would never provide more than excess coverage. In that case, the Coordination of Benefits provision would never be reached and would be rendered superfluous. Even if the Excess Insurance Provision is understood to render the Plan subordinate only to no fault insurance, this interpretation still renders a portion of the Coordination of Benefits provision superfluous, because the Coordination of Benefits provision is explicitly made

applicable to no fault insurance. Thus, regardless of the consistency with which Defendant has interpreted the Plan to provide only excess coverage for medical expenses related to injuries from an automobile accident, this interpretation must be considered arbitrary and capricious. *See Davis*, 887 F.2d at 695; *Moench*, 62 F.3d at 566; *Finley*, 957 F.2d at 621.

Having rejected Defendant's interpretation of the Plan as unreasonable, this Court must determine whether the Plan otherwise categorizes Defendant as the primary or secondary insurer. Because this involves interpreting Plan provisions not considered by Defendant in denying benefits to Morris, this Court will review such provisions de novo using standard principles of contract interpretation. *See Regents of the Univ. of Mich. v. Employees of Agency Rent-A-Car Hosp. Ass'n*, 122 F.3d 336, 339-40 (6th Cir. 1997). By interpreting the Plan's language in an ordinary and common sense fashion and resolving ambiguities against Defendant, as drafter of the Plan, *id.*; *Citizens Insurance Company of America v. Northstar Print Group, Inc.*, No. 2:97-CV-144, slip op. at 7 (W.D. Mich. filed Feb. 24, 1998), a reasonable and consistent interpretation of the Plan's provisions is possible. Reading the Excess Insurance and the Coordination of Benefits provisions together, the Excess Insurance Provision must be understood to indicate that the Plan provides only excess coverage to an insured when, after processing the insured's claim, Defendant determines, under the Coordination of Benefits provision, that it is not the primary insurer. In addition, the Excess Insurance provision provides that, where Defendant opts to provide immediate coverage in such circumstances, it has the right to recover the amounts improperly paid. *See NorthStar,* slip op. at 9, 11 (interpreting similar provisions and reaching similar result). Thus, this Court cannot rely on the Excess Insurance provision

alone to determine whether Defendant should provide primary or secondary liability to Morris, but must also consider the Plan's Coordination of Benefits provision.

The first rule in the Coordination of Benefits provision states that: "[i]f one plan has no coordination of benefits plan, it is automatically primary." Defendant argues that, if the Coordination of Benefits provision is reached, Plaintiff is primary under this provision. Although the no fault policy includes a provision labeled "Coordination of Benefits," Defendant asserts that this provision simply subordinates the no fault policy to all other policies and, therefore, does not meet the Plan's criteria for a Coordination of Benefits provision. However, the Plan does not contain a specific definition of the term "Coordination of Benefits provision" nor does it require that the Coordination of Benefits provision in the other insurance be similar to the Plan's Coordination of Benefits provision.

Under the generally recognized definition of a Coordination of Benefits clause, a provision need only be conditioned on the existence of other insurance and establish an order of payment between the plans. *Allstate Insurance Co. v. Michigan Carpenter's Council Health & Welfare Fund*, 750 F. Supp. 827, 831 (W.D. Mich. 1990). The provision can establish rules by which the insurer is sometimes primary, declare itself to be always excess or establish a pro rata system for sharing costs incurred by a mutual insured. *Allstate Insurance Co.*, 750 F. Supp. at 831; *NorthStar*, slip. op. at 14; *United Benefit Life Ins. Co. v. U.S. Life Ins. Co.*, 36 F.3d 1063, 1064 (11th Cir. 1994). The Coordination of Benefits provision in the no fault policy meets these criteria by making itself secondary to other insurance which provided benefits for the same loss.

The second rule in the Plan's Coordination of Benefits provision states that an insurance plan "will be Primary if it covers the individual as an employee and Secondary if it covers the individual as a dependent." Plaintiff argues that, under this rule, Defendant must be considered primary, since it covered Morris as an employee. However, if this rule is read in context, it merely determines the order of coverage between a policy covering an individual as an employee and a policy covering an individual as a dependent; it does not make a policy covering an individual as an employee primary with respect to any other insurance. This interpretation is reinforced by a subsequent rule, which provides the order of coverage between a policy that covers an individual as a current employee and a policy that covers an individual as a former employee, retiree, or a person who has otherwise chosen to continue benefits under the plan after coverage would otherwise have ended.[2] Because Plaintiff did not cover Morris as either an employee or as a dependent, this rule is inapplicable to the present situation.

Of the remaining rules, the only provision which has any application to the situation at hand states that "[i]f none of the above rules apply, a plan will be Primary if it has covered the individual for the longer period of time and Secondary if it has covered the individual for the shorter period of time." In this case, Defendant has provided coverage for Morris since June 2, 1994; Plaintiff has provided coverage for Morris since June 13, 1994, at the earliest. Thus, under the terms of the Plan itself, Defendant must be

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[2]This provision states that a plan "will be considered Primary if it covers the individual as an employee and Secondary if it covers the individual (i) as a former employee, (ii) as a retiree, or (iii) as an individual who has elected to continue benefits under the Plan pursuant to Article VIII therein."

considered the primary insurer with respect to Morris' medical expenses and there is no conflict between the two policies.

In its request for relief, Plaintiff asked this Court to enter a declaratory judgment, stating that Plaintiff is entitled to recoup from Defendant all amounts which Plaintiff has paid for medical benefits under its no fault policy for injuries to Morris arising from his 1995 automobile accident, which amounts are not in excess of the coverage afforded by Defendant's plan relative to this loss and that, as to any future medical benefits to which Morris might become entitled as a result of the automobile accident, Defendant shall be considered the primary insurer and Plaintiff shall be considered the secondary insurer. Although this Court will grant this relief, this Order should not be construed to make Defendant liable for all medical expenses arising from Morris' injuries. Rather, Defendant is liable to the extent that the Plan, by its terms, provides coverage. This Court can offer no opinion on the extent of coverage available under the Plan for past or future medical expenses.

Plaintiff also asks this Court to award it costs, interest and attorney's fees incurred in bringing this litigation and the instant Motion. However, to apply for costs, Plaintiff must file a bill of costs in accordance with Local Civil Rule 54.1. Therefore, Plaintiff's motion for costs and interest is denied at this time. Further, Plaintiff provides no basis for the award of attorney's fees. Because this action was not brought directly under 29 U.S.C. § 1132, this Court finds that an award of attorney's fees under that statute is inappropriate. Further, this Court can find no other basis for an award of attorney's fees. Therefore, Plaintiff's request for attorney's fees is denied.

CONCLUSION

For the foregoing reasons, Plaintiff's motion for summary judgment on its declaratory judgment motion is granted and Defendant's motion for summary judgment is denied. Plaintiff's motion for costs is denied at this time and Plaintiff is instructed to file a bill of costs, as required under Local Civ. R. 54.1 to recover its costs. There being no statutory or other basis for awarding attorney's fees in this case, Plaintiff's motion for attorney's fees is denied.

Dated in Kalamazoo, MI:

E. 28-98

RICHARD ALAN ENSLEN
Chief Judge

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION
****

FARM BUREAU GENERAL INSURANCE COMPANY OF MICHIGAN,

Plaintiff,

v.

File No. 5:97-CV-191

MORTON BUILDINGS, INC. EMPLOYEE HEALTH AND WELFARE BENEFIT PLAN,

Hon. Richard Alan Enslen

Defendant.
_____/

JUDGMENT

In accordance with the Opinion issued this date;

IT IS HEREBY ORDERED that plaintiff's motion for summary judgment, filed May 15, 1998 (dkt. # 15), is **GRANTED**;

IT IS FURTHER ORDERED that defendant's motion for summary judgment, filed May 15, 1998 (dkt. #14) is **DENIED**;

IT IS FURTHER ORDERED that declaratory judgment is **GRANTED** in favor of plaintiff, as follows:

(1) Plaintiff, Farm Bureau General Insurance Company of Michigan, is entitled to recoup from Defendant, Morton Buildings, Inc. Employee Health & Welfare Benefit Plan, all amounts which plaintiff has paid for medical benefits under the no fault

policy which are not in excess of the coverage provided by Defendant's plan for these expenses.

(2) As to any future medical benefits to which the insured may become entitled as a result of his 1995 automobile accident and as between Defendant and Plaintiff only, Defendant shall be considered the primary health care benefit provider and shall be liable to the extent of its coverage for future medical expenses incurred by the insured and Plaintiff shall be considered the secondary provider and shall be responsible to the extent of its coverage for any amounts in excess of the coverage afforded by Defendant for these expenses.

IT IS FURTHER ORDERED that Plaintiff's requests for costs, interest and attorney's fees is **DENIED**.

Dated in Kalamazoo, MI:
8.28.98

RICHARD ALAN ENSLEN
Chief Judge