STATE OF MICHIGAN

COURT OF APPEALS

BRENT HARRIS,

Plaintiff-Appellant,

v

AUTO CLUB INSURANCE ASSOCIATION,

Defendant/Third-Party Plaintiff-Appellee,

and

BLUE CROSS BLUE SHIELD OF MICHIGAN,

Third-Party Defendant/Appellee.

UNPUBLISHED
December 27, 2011

No. 300256
Oakland Circuit Court
LC No. 2009-102219-NF

Before: O'CONNELL, P.J., and MURRAY and DONOFRIO, JJ.

PER CURIAM.

Plaintiff appeals as of right from a circuit court order denying plaintiff's motion for summary disposition and granting summary disposition in favor of Blue Cross Blue Shield of Michigan (BCBSM) with respect to plaintiff's claims and the third-party claims of defendant Auto Club Insurance Association (ACIA).[1] The court also granted ACIA's motion for summary disposition with respect to plaintiff's claims against it, pursuant to MCR 2.116(I)(2). On appeal plaintiff only challenges the trial court's order dismissing his claims against Blue Cross. We reverse the trial court's order insofar that it granted summary disposition to BCBSM, and affirm the denial of plaintiff's motion for summary disposition and the dismissal of ACIA, and remand for further proceedings.[2]

[1] ACIA did not file an appeal in this case, and so does not challenge the trial court's order dismissing its third-party claims against Blue Cross.

[2] From the record presented it is undisputed that ACIA has paid all outstanding medical bills, and continues to do so. Plaintiff's counsel appeared to concede as much at oral argument before this Court.

The pertinent facts are not disputed. On July 1, 2008, plaintiff was injured when the motorcycle he was riding was hit by a vehicle insured by ACIA. Plaintiff also had a health insurance contract (also known as a "certificate") with BCBSM. ACIA acknowledges that its policy is an uncoordinated policy that provides full coverage for plaintiff's medical expenses.[3] ACIA has paid those expenses. The parties dispute whether the BCBSM certificate coordinates with the no-fault policy.

The trial court determined that the BCBSM certificate coordinated benefits with the no-fault policy and, therefore, ACIA was liable for payment of plaintiff's medical expenses. Accordingly, the court granted summary disposition to BCBSM with respect to both plaintiff's and ACIA's claims against BCBSM and denied plaintiff's motion for summary disposition. The court also granted summary disposition to ACIA on plaintiff's claims against it.

Summary disposition may be granted under MCR 2.116(C)(10) when "there is no genuine issue as to any material fact, and the moving party is entitled to judgment . . . as a matter of law." This Court reviews a trial court's decision on a motion for summary disposition de novo. *Maiden v Rozwood*, 461 Mich 109, 118; 597 NW2d 817 (1999). This Court also reviews de novo the proper interpretation of a contract. *Flint v Chrisdom Props, Ltd*, 283 Mich App 494, 498-499; 770 NW2d 888 (2009).

An insurance policy is treated like other contracts. *Smith v Physicians Health Plan, Inc*, 444 Mich 743, 759; 514 NW2d 150 (1994). If contractual language is clear and unambiguous, its meaning is a question of law, and courts must interpret and enforce the contract as written. *Frankenmuth Mut Ins Co v Masters*, 460 Mich 105, 111; 595 NW2d 832 (1999). Although BCBSM contends that plaintiff is seeking a "windfall" by obtaining duplicative payment of his medical expenses from two sources, the availability of double recovery for a person entitled to benefits from two contracts depends on the specific contracts. Both *Shanafelt v Allstate Ins Co*, 217 Mich App 625; 552 NW2d 671 (1996), and *Bombalski v Auto Club Ins Ass'n*, 247 Mich App 536; 637 NW2d 251 (2001), establish that recovery of benefits for medical expenses from two different policies is available and depends on the particular policies. The Supreme Court has recognized this possibility as well, stating, "[i]t is when both the no-fault automobile insurance and the health insurance are uncoordinated policies that multiple recovery is possible for the insured." *Smith*, 444 Mich at 752.

The trial court was persuaded by BCBSM's argument that it was not liable to pay plaintiff's medical expenses because of certain provisions in its policy. Two of these provisions are similar in referring to benefits paid by other plans. The contract states:

> **PHYSICIAN AND OTHER PROFESSIONAL SERVICES THAT ARE NOT PAYABLE**

[3] An "uncoordinated" no-fault policy means that "the no-fault automobile insurance would pay benefits regardless of whatever other insurance the insured may have." *Smith v Physicians Health Plan, Inc*, 444 Mich 743, 747; 514 NW2d 150 (1994).

> The following services are not payable:
>
> • Services covered under any other Blue Cross or Blue Shield contract or under any other health care benefits plan.

The contract also states:

> **Coordination of Benefits**
>
> We will coordinate the benefits payable under this certificate pursuant to the Coordination of Benefits Act, Public Act No. 64 of 1984 (starting at MCLA 550.251). To the extent that the services covered under this certificate are also covered and payable under another group health care plan, we will combine our payment with that of the other plan to pay the maximum amount we would routinely pay for the covered services.

We conclude that BCBSM's reliance on these provisions is misplaced. We note that the Coordination of Benefits Act does not include a no-fault insurer among the defined entities with which the health care providers will coordinate or a mechanism for coordination. Although the benefits available under no-fault policies include payment of medical expenses, a no-fault policy is not a "group health care plan," *Haefele v Meijer, Inc*, 165 Mich App 485, 498; 418 NW2d 900 (1987), remanded on other grounds[4] 431 Mich 853 (1988), or a "health care benefits plan." BCBSM relies on *Primax Recoveries v State Farm Mut*, 147 F Supp 2d 775 (ED Mich, 2001), but that decision is not persuasive because the policy at issue there included a specific provision indicating that the coverage was coordinated with no-fault insurance coverage.

A third provision on which BCBSM here relies states:

> **Care and Services That Are Not Payable**
>
> We do not pay for the following care and services:
>
> • Those for which you legally do not have to pay or for which you would not have been charged if you did not have coverage under this certificate[.]

In *Shanafelt*, 217 Mich App at 637-638, and *Bombalski*, 247 Mich App at 542-543, this Court examined the meaning of the term "incurred" in MCL 500.3107(1) and considered the no-fault insurer's contention that the plaintiff did not "incur[]" expenses that were paid by the health care insurer. In *Shanafelt*, this Court explained:

[4] The Supreme Court remanded the case to this Court to consider issues concerning the applicability of the Employee Retirement Income Security Act (ERISA), 29 USC 1144. The parties do not contend that ERISA has any bearing on the issues in the present case.

> The primary definition of the word 'incur' is 'to become liable for.' *Random House Webster's College Dictionary* (1995). Obviously, plaintiff became liable for her medical expenses when she accepted medical treatment. *The fact that plaintiff had contracted with a health insurance company to compensate her for her medical expenses, or to pay directly the health care provider on her behalf, does not alter the fact that she was obligated to pay those expenses.* Therefore, one may not reasonably maintain that plaintiff did not incur expenses. [*Shanafelt,* 217 Mich App at 638 (Emphasis added.).]

In *Bombalski*, this Court further observed that "liable" is defined as "'[r]esponsible or answerable in law; legally obligated.'" *Bombalski*, 247 Mich App at 543, quoting Black's Law Dictionary (7th ed). This Court explained that when providers accept a discounted rate as full payment because of a contractual agreement with the health care insurer, the insured has "incurred" only the discounted amount.[5] See also *Williams v AAA Mich*, 250 Mich App 249, 268-269; 646 NW2d 476 (2002) (the plaintiff did not incur the full amounts billed, but only the lesser amount that the provider accepted as full payment from BCBSM).

BCBSM argues that *Shanafelt* and *Bombalski* are inapposite because they address when charges are "incurred" for purposes of the no-fault act, whereas the present case depends on the language of the BCBSM policy. However, this distinction, while factually accurate, is not legally significant because the Court defined "incurred" as being synonymous with legally obligated to pay. The pertinent phrase in this case is, "We do not pay for . . . care and services . . . for which you legally do not have to pay . . . ." The rationale of *Shanafelt* and *Bombalski*, i.e., that a party receiving services has a legal obligation to pay for them when rendered and incurs the expense even if the expense is paid by an insurer, is applicable here, although the phrase and context are different. When plaintiff received the care and services, he legally had to pay for them. The care and services that are not payable provision refers to health care products and services for which the plaintiff never incurred an obligation to pay. An example of such a situation is the one where the employer requires and pays for a medical product and service for its employee like a preventative medical screening. As this Court observed in *Shanafelt*, 217 Mich App at 638, "[t]he fact that plaintiff had contracted with a health insurance company to compensate [him] for [his] medical expenses, or to pay directly the health care provider on [his] behalf, does not alter the fact that [he] was obligated to pay those expenses." BCBSM's contention that plaintiff was not obligated to pay his medical expenses because ACIA paid them on his behalf is incompatible with *Shanafelt.*

The final provision on which BCBSM relies concerns reimbursement and states:

> **Other Coverage**

[5] Cf. *Duckworth v Continental Nat'l Indemnity Co*, 268 Mich App 129, 134; 706 NW2d 215 (2005) (determining that the plaintiff did not incur medical expenses that were fully paid by Ontario Health Insurance Plan because of the unique features of the plan that distinguished it from ordinary private health insurance).

> In certain cases, we may have paid for health care services for you or your covered dependents that should have been paid by another person, insurance company or organization. In these cases:
>
> • You grant us a lien or right of reimbursement on any money or other valuable consideration you or your covered dependents or representatives receive through a judgment, settlement, or otherwise. . . .
>
> * * *
>
> • You must do whatever is necessary to help us recover the money we paid to treat the injury that caused you to claim damages for personal injury.
>
> * * *
>
> • You agree to cooperate with us in our efforts to recover money we paid on behalf of you or your dependents.

BCBSM argues that "even if BCBSM had paid all of [plaintiff's] medical expenses, BCBSM would have been entitled to reimbursement when [ACIA] paid [plaintiff's] benefits, and [plaintiff] would have been required to cooperate with BCBSM in seeking reimbursement." The provision addresses the insured's obligation to cooperate with BCBSM in recovering payments from another source. It does purport to define when BCBSM is liable or not liable for making the payments in the first instance. But, BCBSM's interpretation is far too broad. BCBSM ignores its own obligation to pay and by wrongfully denying payment at the inception hopes to create an escape from its obligations. The instant clause, "that should have been paid by another person, insurance company or organization", is directed at those kinds of tort actions wherein the plaintiff may recover both economic and non-economic damages. This is so because you cannot separate this clause from the instructions that follow. The contract provides,

> In these cases:
>
> • You grant us a lien or right of reimbursement on any money or other valuable consideration you or your covered dependents or representatives receive through a judgment, settlement, or otherwise. . . .
>
> * * *
>
> • You must do whatever is necessary to help us recover the money we paid to treat the injury that caused you to claim damages for personal injury.

The recovery to which BCBSM refers is a recovery from a judgment or settlement for a claim for personal injury damages. The plaintiff's benefits from ACIA do not arise by virtue of a claim for personal injuries resulting in a judgment or settlement for damages for personal injury.

For the foregoing reasons, we conclude that the trial court erred in determining that the BCBSM certificate coordinated with the no-fault policy. Accordingly, the trial court's grant of summary disposition to BCBSM, which was premised on its flawed interpretation of the BCBSM policy, is reversed. However, we affirm the trial court's denial of plaintiff's motion for summary disposition because a determination that the BCBSM contract does not coordinate with no-fault insurance does not resolve the claims and reimbursements between the parties.

Affirmed in part, reversed in part, and remanded for further proceedings not inconsistent with this opinion. We do not retain jurisdiction.

/s/ Peter D. O'Connell
/s/ Pat M. Donofrio

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Before: O'CONNELL, P.J., and MURRAY and DONOFRIO, JJ.

MURRAY, J. (*concurring in part/dissenting in part*).

I concur in the majority's decision to affirm the trial court's order denying plaintiff's motion for summary disposition, as well as the dismissal of Auto Club Insurance Association, but dissent from its conclusion that the order granting defendants Blue Cross Blue Shield of Michigan's motion for summary disposition should be reversed. In my view, the contract between BCBSM and plaintiff precluded plaintiff from receiving a double recovery.

In particular, the contract between plaintiff and BCBSM indicates that BCBSM will not pay for care and services "for which you legally do not have to pay or for which you would not have been charged if you did not have coverage under this certificate." In considering this language, we must be ever mindful that "[t]he fundamental goal of contract interpretation is to determine and enforce the parties' intent by reading the agreement as a whole and applying the plain language used by the parties to reach their agreement." *Dobbelaere v Auto-Owners Ins Co*, 275 Mich App 527, 529; 740 NW2d 503 (2007).

The clause "for which you legally do not have to pay" is written in the present tense. Thus, whether we look to the factual situation at the time the complaint was filed or when plaintiff submitted his demand upon BCBSM, we know that plaintiff did not legally have to pay anything. It is undisputed that AAA has paid the outstanding medical bills incurred for plaintiff's treatment, and

continues to do so. Most importantly, AAA was required to pay these bills because under the law it was first in priority. See *Farmer's Ins Exch v Farm Bureau Ins*, 272 Mich App 106, 112; 724 NW2d 485 (2006), citing MCL 500.3114(5)(a); *Leja v Health Alliance Plan*, 202 Mich App 582, 586; 509 NW2d 871 (1993). Consequently, the exclusionary clause applied because plaintiff and BCBSM contractually agreed that BCBSM would not pay for services which "you [plaintiff] legally do not have to pay." This clause is clear and unambiguous, and enforcement of the terms required the trial court to grant BCBSM's motion for summary disposition.

Shanafelt v Allstate Ins Co, 217 Mich App 625; 552 NW2d 671 (1996) does not alter this conclusion. As the majority opinion recognizes, *Shanafelt* addressed what "incurred" means under MCL 500.3107(1)(a), while this case requires interpretation of a contract phrase contained in a health insurance plan that does not contain the word "incurred" or "incur." See *Twichel v MIC Gen Ins Co*, 469 Mich 524, 534; 676 NW2d 616 (2004) (Court of Appeals erred in importing statutory definition of term used in a contract that is unrelated to the statute.). Hence, *Shanafelt* offered no insight into the meaning of the phrase "for which you legally do not have to pay" contained within a contract providing health care benefits. Indeed, the *Shanafelt* Court made clear that it was only addressing the meaning of a term "within the context of the [no-fault] statute." *Shanafelt*, 217 Mich App at 638.

And, even though *Bombalski v Auto Club Ins Ass'n*, 247 Mich App 536; 637 NW2d 251 (2001), also addressed a no-fault issue, it's understanding of the term "liable" (a term not used in the relevant portion of the no-fault act) supports this reading of the BCBSM provision. In that case plaintiff was injured when riding a motorcycle, and his health insurer, also BCBSM, paid the medical providers. However, defendant ACIA was also required to pay benefits because of state law and the policy held by the driver who hit plaintiff. *Bombalski*, 247 Mich App at 539. Plaintiff filed suit arguing that ACIA owed plaintiff the full amount of the cost of the medical services provided, since he had "incurred" those services when they were provided, citing *Shanafelt*. The trial court granted ACIA's motion for summary disposition, holding that plaintiff was limited to recovering the amount of costs that the medical providers subsequently accepted from BCBSM. *Id*. at 538. This Court affirmed, holding that because at the time plaintiff sought benefits from ACIA he was not legally obligated to pay for the costs of services beyond what BCBSM had already paid, he had not incurred those expenses:

> *Plaintiff submits that he likewise became liable for the amounts charged by his health care providers when he accepted their services and that consequently he incurred the full amounts charged*. Plaintiff's claim does not persuade us, however, because plaintiff overlooks the significance of 'liable,' which means '[r]esponsible or answerable in law; legally obligated.' Black's Law Dictionary, *supra* at 927. *The satisfaction of plaintiff's medical bills by BCBSM through payment of less than the amounts charged by the providers relieved plaintiff of any responsibility or legal obligation to pay the providers further amounts exceeding those proffered by BCBSM and accepted by plaintiff's health care providers.* Because plaintiff bears no liability for the full medical service amounts initially charged by his health care providers, he has not *incurred* these full charges. [*Bombalski*, 247 Mich App at 543 (Emphasis supplied.).]

Consequently, according to the *Bombalski* Court, what payments are made after the services are actually "incurred" is relevant in determining whether an individual is "legally obligated" to pay

some or all of the benefits paid on his behalf. Similarly, here plaintiff was not liable to pay for any services, as ACIA had already paid their full cost. Since plaintiff was not "legally obligated" to pay for these services, BCBSM was not required by contract to pay plaintiff the value of those services.

And, although ACIA argues that this interpretation results in unfair or absurd results, in my view it is an interpretation consistent with the plain language. In fact, this conclusion is consistent with both our rules of contract interpretation as well as the scheme established by the no-fault act. Coordination of benefits within no-fault policies is permitted by MCL 500.3109a. However, as the Supreme Court noted in *Smith v Physicians Health Plan*, 444 Mich 743, 749; 514 NW2d 150 (1994), the purpose of that coordination of benefits provision "was not to provide a guarantee of double recovery regardless of whatever provisions might be contained in other insurance contracts." This holds true because "[s]ection 3109a controls the treatment of the no-fault insurance, not the status of health insurance." *Id*. at 756. The legislative purpose of allowing coordination of benefits under the no-fault act was to allow consumers who have health insurance the choice to pay a reduced premium for coordinated no-fault coverage. *Id*. at 753. And, when both the no-fault policy and the health policy are uncoordinated, the injured person may recoup from both insurers. *Id*. at 752. But what is contained in the health insurance plan is purely a matter of contract, and it is those contract terms that control what obligations BCBSM has toward its insured. *Leja*, 202 Mich App at 584.

ACIA's argument that BCBSM unfairly benefits from the fact that ACIA paid the benefits first is without merit. First, as ACIA readily admits, the only reason it was primarily responsible was because *Michigan law required* that result when plaintiff was an injured motorcyclist hit by a motor vehicle operator who owned an uncoordinated policy. MCL 500.3114(5)(a). Second, even assuming this result provides a "windfall" to BCBSM, it is not unwarranted because it is merely the result of no-fault requirements and a plain reading of the contract agreed to by the parties. And, of course, not requiring a health insurer to pay benefits to an individual who has had them already paid reduces health insurance and medical costs. *Smith*, 444 Mich at 754-755. In essence, all parties received the benefits of their particular bargains. Plaintiff received the benefit of Michigan law regarding coverage for motorcycle injuries caused by motor vehicles when all of his medical bills were paid by ACIA. ACIA performed as it was contractually required when it paid as first in priority as a result of receiving from the motor vehicle driver higher premiums for the uncoordinated provision. Finally, between BCBSM and plaintiff, both received the benefit of the bargain since plaintiff presumably paid a reduced premium for a coordinated benefit policy (though not coordinated with no-fault), and BCBSM did not have to pay for benefits that were required to be paid by ACIA. See *Smith*, 444 Mich at 760. I would affirm.

/s/ Christopher M. Murray