STATE OF MICHIGAN

COURT OF APPEALS

MARTHA HOLMES,

Plaintiff-Appellant,

v

FARM BUREAU GENERAL INSURANCE COMPANY,

Defendant-Appellee,

and

JEREMY FLECHSIG,

Defendant.

UNPUBLISHED
May 19, 2015

No. 320723
Oakland Circuit Court
LC No. 2012-127080-NI

Before: HOEKSTRA, P.J., and SAWYER and BORRELLO, JJ.

PER CURIAM.

Plaintiff appeals as of right an order granting defendant[1] Farm Bureau's motion for partial summary disposition and denying plaintiff's motion for partial summary disposition in this action for underinsured motorist coverage and no-fault benefits. Because the no-fault insurance policy in question provided plaintiff with primary medical coverage and plaintiff may bring a private cause of action under 42 USC 1395y(b)(3)(A) to recover amounts paid by Medicare, we reverse and remand for further proceedings.

The material facts of the case are not in dispute. Plaintiff was injured in an automobile accident when her vehicle was hit from behind by a vehicle driven by Flechsig. At the time of the accident, Flechsig had an auto insurance policy with State Farm with an upper coverage limit of $50,000. Plaintiff was insured by defendant Farm Bureau, and her policy included $500,000 in underinsured motorist coverage. Plaintiff's medical and care expenses related to the accident totaled more than $70,000. Medicare covered most of plaintiff's submitted expenses and

[1] Because defendant Jeremy Flechsig is not a party to this appeal, as used in this opinion "defendant" refers to defendant Farm Bureau General Insurance Company.

plaintiff's Medicare AARP Supplemental Insurance covered the remaining portion. Farm Bureau paid none of the medical expenses.

Plaintiff filed this action against Flechsig and Farm Bureau. Plaintiff alleged that she was "entitled to the entire amount of underinsured motorist coverage available to her" under her automobile insurance policy. She also claimed a breach of contract and asserted that her medical expenses were allowable personal protection insurance (PIP) benefits that defendant was obligated to pay under the No-Fault Insurance Act, MCL 500.3101 *et seq*.

Defendant moved for partial summary disposition under MCR 2.116(C)(10) with regard to plaintiff's claim for PIP benefits, noting that plaintiff had admitted that all of her medical bills stemming from the accident had been paid by Medicare and her Medicare Supplemental Insurance. In response, plaintiff argued that her admission that all of her medical bills had been paid did not eliminate defendant's no-fault liability and, under federal law, defendant should pay for plaintiff's medical bills related to the accident, not Medicare. Plaintiff further maintained that federal law had created a private cause of action for when Medicare had paid for expenses that should have been paid by a no-fault insurer. Plaintiff argued partial summary disposition should be granted in her favor under MCR 2.116(I)(2).

The trial court granted defendant's motion for partial summary disposition and denied plaintiff's motion for partial summary disposition. In doing so, the court made two determinations which are at issue on appeal. First, the court found that plaintiff's medical coverage under her insurance policy was coordinated and therefore not primary, meaning that plaintiff could not look to defendant for payment of medical expenses which had already been covered by Medicare. Second, the trial court reasoned that, even if defendant had been primary over Medicare, it was up to Medicare, not plaintiff, to seek reimbursement for medical expenses paid on plaintiff's behalf. Plaintiff now appeals as of right.

On appeal, consistent with her arguments in the trial court, plaintiff again argues that defendant issued a no-fault auto insurance policy that provided her with "uncoordinated" or primary medical benefits. Because her medical benefits under the auto policy are primary benefits, plaintiff argues that she may recover medical expenses from defendant notwithstanding that those amounts have been paid by Medicare. Further, plaintiff argues that 42 USC 1395y(b)(3)(A) specifically creates a private cause of action which enables her to sue defendant for recovery of medical expenses expended by Medicare on her behalf.

This Court reviews de novo a trial court's decision to grant or deny a motion for summary disposition. *Taylor v Mich Petroleum Technologies, Inc*, 307 Mich App 189, 194; 859 NW2d 715 (2014). We also review de novo the proper interpretation of contracts and the legal effect of contractual provisions. *Quality Prods & Concepts Co v Nagel Precision, Inc*, 469 Mich 362, 369; 666 NW2d 251 (2003); *Wright v Wright*, 279 Mich App 291, 297; 761 NW2d 443 (2008). Likewise, this Court reviews de novo issues of statutory interpretation. *Ardt v Titan Ins Co*, 233 Mich App 685, 690; 593 NW2d 215 (1999).

We turn first to consideration of whether plaintiff's policy provided coordinated or uncoordinated medical coverage. Under the no-fault act, specifically MCL 500.3109a, individuals with existing health care coverage have the option of choosing between coordinated

and uncoordinated insurance. *Smith v Physicians Health Plan, Inc*, 444 Mich 743, 751; 514 NW2d 150 (1994). Coordination of no-fault benefits results in a reduction of premiums, and it is only available to insureds who have existing health care coverage in place. *Id.* at 752. When there is a contract in place for uncoordinated coverage, the no-fault carrier has agreed to be "primary" in the event of a claim. *Id.* at 754. An insured who elects to receive an uncoordinated no-fault policy may obtain double recovery in certain circumstances if the health insurance coverage in place is also uncoordinated. *Harris v Auto Club Ins Ass'n*, 494 Mich 462, 470; 835 NW2d 356 (2013). In comparison, when a no-fault policy is primary, and the medical coverage is coordinated, an insured is not entitled to duplicative recovery but must look only to the no-fault insurer for coverage. See *Smith*, 444 Mich at 758-761. Notably, with the enactment of the Medicare Secondary Payer (MSP) provision of the Omnibus Budget Reconciliation Act of 1980, as a matter of law, Medicare will not provide primary coverage when coverage is also provided by a "primary payer" such as no fault insurance. 42 USC 1395y(b)(2)(A)(ii). See also *Varacalli v State Farm Mut Auto Ins Co*, 763 F Supp 205, 208 (ED Mich 1990).[2]

In this case, after considering the policy language, we conclude that defendant agreed to provide plaintiff with uncoordinated coverage, meaning that defendant is obligated to provide plaintiff with primary coverage for her medical expenses. In particular, to begin with, plaintiff's policy contains a "COORDINATION OF BENEFITS" section, which states: "Your auto medical payments and work loss may be coordinated with other insurance policies. If so, it is designated excess. . . . If you coordinate your coverage, we will reduce the price you pay for your automobile insurance." The policy goes on to state: "For example, the law mandates that Medicare is excess to all automobile insurance policies, and that auto injury coverage cannot be offset by Medicare or Medicaid benefits. If you are under Medicare or Medicaid, your personal automobile insurance benefits must be primary and cannot be coordinated." Given that plaintiff received medical coverage through Medicare, it follows from the plain policy language that the coverage available to plaintiff through defendant "must be primary" and it "cannot be coordinated." Indeed, as the policy language recognizes, as a matter of law, plaintiff and defendant could only contract for a policy which made Medicare secondary to the insurance coverage provided by defendant. See *Varacalli*, 763 F Supp at 209.

Consistent with this conclusion, the Policy Change Declarations page of plaintiff's policy specifically indicates that her medical coverage is "primary." In particular, in a column labeled "Coverages and Limits of Liability," among several other types of coverages, the phrase "Primary Medical Payments" appears. In corresponding columns for "Premiums By Vehicles," an "x" is marked next to "Primary Medical Payments" for each of plaintiff's four insured vehicles. Relevant to the significance of this "x," a section of the policy entitled "IMPORTANT INFORMATION ABOUT YOUR AUTO DECLARATIONS" explains that "[w]hen an 'x' appears in the 'Premiums by Vehicle' area, the coverage listed in the 'Coverages and Limits of Liability' area applies to that vehicle." Thus, given that an "x" has been marked next to

[2] Although not binding, "federal precedent is generally considered highly persuasive when it addresses analogous issues." *Wilcoxon v Minn Mining & Mfg Co*, 235 Mich App 347, 360 n 5; 597 NW2d 250 (1999).

"Primary Medical Payments" for each of plaintiff's insured vehicles, it follows that defendant has contracted to provide plaintiff with primary or uncoordinated medical coverage.[3] Given that defendant has agreed to provide primary medical coverage for plaintiff's injuries arising from an auto accident, it follows as well that Medicare was not responsible for plaintiff's medical expenses because 42 USC 1395y(b)(2)(A)(ii) specifies that Medicare will not pay for services to the extent that payment has been made, or can reasonably be expected to be made, under a no-fault insurance policy.

Although defendant contracted to provide plaintiff with primary medical coverage and Medicare is not responsible for plaintiff's expenses, it is uncontested that Medicare has paid plaintiff's medical expenses at this time. In particular, while Medicare was not responsible for payment of plaintiff's medical expenses, 42 USC 1395y(b)(2)(B) authorizes conditional payments by Medicare with the caveat that such payments must be reimbursed if it is demonstrated that a primary plan has or had responsibility to make payment with respect to the services. Because Medicare has paid plaintiff's expenses, defendant claimed in the court below, and the trial court concluded, that plaintiff cannot seek recovery from defendant and that any right to recoup funds expended by Medicare belongs solely to Medicare. Defendant's argument in this respect is without merit, however, in light of the private cause of action created by 42 USC 1395y(b)(3)(A), which expressly allows private citizens such as plaintiff to bring suit against a primary payer to effectuate recovery of funds expended by Medicare on her behalf.

Specifically, 42 USC 1395y(b)(3)(A) provides:

> (3) Enforcement.
>
> (A) Private cause of action. There is established a private cause of action for damages (which shall be in an amount double the amount otherwise provided) in the case of a primary plan which fails to provide for primary payment (or appropriate reimbursement) in accordance with paragraphs (1) and (2)(A).

By its plain terms, this provision "creates a private right of action for individuals whose medical bills are improperly denied by insurers and instead paid by Medicare . . . ." *Manning v Utilities Mut Ins Co, Inc*, 254 F3d 387, 394 (CA 2, 2001). "[T]he apparent purpose of the statute is to help the government recover conditional payments from insurers or other primary payers."

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[3] Defendant does not dispute that "primary medical payments" denotes primary, i.e., uncoordinated benefits. Instead, defendant debates the meaning of the "x" on the policy declarations page and contends that, instead of an "x," there should have appeared a dollar amount evincing plaintiff's payment of a higher premium for primary coverage if in fact she had contracted for primary coverage. This argument is belied, however, by the plain policy language specifying that an "x" appearing in the "premiums by vehicle" area indicates that the coverage listed in the "Coverages and Limits of Liability" area, in this case, primary medical coverage, applies. Moreover, defendant provides no information regarding the differential in prices for policies providing uncoordinated versus coordinated coverage to support its assertion that plaintiff did not pay a higher premium for uncoordinated coverage.

Stalley v Catholic Health Initiatives, 509 F3d 517, 524 (CA 8, 2007).[4] As an incentive to encourage private citizens to bring such suits, a private citizen may collect double damages under this provision. See *Manning*, 254 F3d at 394; *O'Connor v Mayor & City Council of Baltimore*, 494 F Supp 2d 372, 373 (D Md, 2007). In short, given the plain statutory language, it is clear that a private cause of action exists to recover funds paid by Medicare, and plaintiff is not precluded from seeking recovery from defendant merely because her bills have been paid by Medicare. See 42 USC 1395y(b)(3)(A).

In contrast to this conclusion, defendant contends on appeal that, even if a private cause of action exists, plaintiff cannot proceed because there has not been a prior judicial determination or settlement indicating that defendant is "responsible" for paying the benefits at issue. Defendant's argument rests on *Glover v Liggett Group, Inc*, 459 F3d 1304, 1308 (CA 11, 2006) and related cases. In *Glover*, which involved a private action against an alleged tortfeasor[5] to recoup funds paid by Medicare, the Court emphasized that, pursuant to 42 USC 1395y(b)(3)(A), a private cause of action could be maintained only if the primary payer failed to provide payment or reimbursement "in accordance with paragraphs (1) and (2)(A)." Paragraph (2)(A) in turn indicates that "Payment under this subchapter [by Medicare] may not be made except as provided in subparagraph (B) . . . ." The *Glover* Court thus turned to subparagraph (B), specifically 42 USC 1395y(2)(B)(ii), which states, in part, that "A primary plan . . . shall reimburse [Medicare] . . . if it is *demonstrated* that such primary plan has or had a *responsibility* to make payment . . ." (emphasis added). Based on this language, the *Glover* Court concluded that to maintain a private cause of action, as a condition precedent to filing suit, it must have previously been demonstrated that the primary payer had a responsibility to pay for the services or items in question. *Glover*, 459 F3d at 1309-1310. In this case, because there has not been a previous determination of defendant's liability, defendant claims that plaintiff cannot pursue a private cause of action under 42 USC 1395y(b)(3)(A).

In making this argument, defendant ignores, however, that, in contrast to the present contract-based insurance dispute, *Glover* involved an action against a tortfeasor in which the injured party sought to simultaneously establish the alleged tortfeasor's responsibility and to claim double damages under 42 USC 1395y(b)(3)(A) for medical expenses paid by Medicare. More recent caselaw has persuasively distinguished *Glover* on this basis and specifically limited *Glover*'s "demonstrated responsibility" condition precedent to the context of MSP suits against

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[4] The government also has the option of bringing its own suit against a primary ayer to recover funds expended that should have been paid by the primary payer. See 42 USC 1395y(2)(B)(iii). However, "[t]he statute provides that the United States is subrogated to the rights of the Medicare beneficiaries against their insurer, to the extent of Medicare payments the government has made for the beneficiaries' expenses." *Stalley*, 509 F3d at 524, citing 42 USC 1395y(b)(2)(B)(iv).

[5] Under the MSP, following amendments in 2003, tortfeasors may constitute a "self-insured plan," meaning that tortfeasors may be liable to reimburse Medicare under the MSP. See *Bio-Med Applications of Tennessee, Inc v Cent States SE & SW Areas Health & Welfare Fund*, 656 F3d 277, 290 (CA 6, 2011).

alleged tortfeasors as opposed to contract-based disputes involving health plans. See, e.g., *Mich Spine & Brain Surgeons, PLLC v State Farm Mut Auto Ins Co*, 758 F3d 787, 791 (CA 6, 2014); *Bio-Med*, 656 F3d at 291; *Nawas v State Farm Mutual Auto Ins Co*, unpublished opinion of the federal district court (ED Mich, 2014). Most notably, the Court in *Bio-Med* concluded that Congress intended for the "demonstrated responsibility" requirement to apply only to suits involving tortfeasors. *Bio-Med*, 656 F3d at 291. Analyzing the statutory language and legislative history involved, the Court reasoned that "the concept of demonstrated responsibility makes sense only in the context of tort (where no evidence of responsibility exists until it is adjudicated ex post), rather than in the context of an insurance contract (where insurers assume the responsibility of paying for enumerated contingencies ex ante)." *Id.* The *Bio-Med* Court supported this conclusion with reference to the demonstrated responsibility provision used by *Glover*, which more fully specifies that "responsibility" may be "demonstrated" by judgment, settlement, or "other means." *Id.*, citing 42 USC 1395y(b)(2)(ii). As discussed in *Bio-Med*, by federal regulation, "other means" include a "contractual obligation," meaning that when a contract is involved there does not need to be a prior court judgment or prior settlement to determine responsibility because the contract itself establishes liability. See *id.*, citing 42 CFR 411.22(b)(3).

> In other words . . . an insurance contract automatically demonstrates a traditional private insurer's responsibility to pay, thereby rendering the "demonstrated responsibility" provision superfluous in such cases. This regulation interprets the ambiguous statutory phrase "other means" and is reasonable because it implicitly acknowledges that while a tortfeasor's responsibility must be determined ex post, the nature of insurance is the assumption of responsibility ex ante. [*Id.*]

In short, *Glover*'s "determined responsibility" condition precedent has been held not to apply to insurance contract disputes, meaning that, because defendant's liability may be established by reference to the parties' contract, plaintiff was not required to "first sue and win, in order to sue again" under the double damages private cause of action created by 42 USC 1395y(b)(3)(A). See *Bio-Med Applications of Tennessee, Inc*, 656 F3d at 291. See also *Mich Spine & Brain Surgeons, PLLC*, 758 F3d at (allowing a private cause of action to proceed without a prior judicial determination of the insurer's responsibility); *Nawas v State Farm Mutual Auto Ins Co*, unpub op at 3-5 (same). Consequently, plaintiff's private cause of action under 42 USC 1395y(b)(3)(A) may proceed.

In sum, based upon the foregoing, we find that plaintiff does have a private cause of action under the MSP and does not need to have previously demonstrated a responsibility to pay by defendant in order to proceed. The trial court erred in holding otherwise. Further, although plaintiff failed to include a claim under the MSP in her complaint, the parties addressed the issue in relation to their respective motions for summary disposition and the trial court specifically ruled on the viability of plaintiff's private cause of action. In these circumstances, we find it appropriate to allow plaintiff an opportunity to amend her pleadings on remand in order to add a claim under the MSP to her complaint. See MCR 7.216(A); MCR 2.116(I)(5); MCR 2.118(A)(2).

Accordingly, we reverse the trial court's findings that plaintiff's insurance policy with defendant was coordinated and that she did not have a private cause of action under the MSP, and we remand to allow plaintiff to add a claim for a private action under the MSP.

Reversed and remanded. Plaintiff, being the prevailing party, max tax costs pursuant to MCR 7.219. We do not retain jurisdiction.

/s/ Joel P. Hoekstra
/s/ David H. Sawyer
/s/ Stephen L. Borrello