STATE OF MICHIGAN

COURT OF APPEALS

ARTHUR HILL, JR., Plaintiff-Appellant,	UNPUBLISHED October 2, 2012
v	No. 304700 Oakland Circuit Court
CITIZENS INSURANCE COMPANY OF AMERICA, Defendant-Appellee.	LC No. 2010-111539-NF

Before: JANSEN, P.J., and BORRELLO and BECKERING, JJ.

PER CURIAM.

In this automobile no-fault case, plaintiff Arthur Hill, Jr. seeks to determine whether his no-fault insurer, defendant Citizens Insurance Company of America ("Citizens"), must reimburse him for medical expenses that were paid by his employee health plan provider, ArvinMeritor, Inc. Salaried Employees' Health & Welfare Benefits Plan ("ArvinMeritor"), but that he now has to repay according to ArvinMeritor's subrogation rights. Plaintiff appeals as of right the trial court's opinion and order granting summary disposition under MCR 2.116(C)(10) in favor of Citizens. We affirm.

I. FACTS AND PROCEDURAL HISTORY

On July 4, 2009, plaintiff was involved in an automobile accident with an uninsured at-fault driver and sustained injuries. Plaintiff incurred numerous hospital and medical expenses. At the time of the accident, plaintiff was eligible for medical benefits under an employee health and welfare benefits plan issued by ArvinMeritor ("the ArvinMeritor plan"), which is governed by the Employee Retirement Income Security Act (ERISA), 29 USC 1001 *et seq*. The ArvinMeritor plan contains specific provisions regarding nonduplication of medical benefits, priority rules, a right to recovery in the event that excessive benefits are paid under the plan, and ArvinMeritor's right to subrogation. Also at the time of the accident, plaintiff was an insured under a coordinated Michigan no-fault automobile insurance policy issued by Citizens ("the Citizens policy"). The Citizens policy contained the following exclusion:

> B. We do not provide Personal Injury Protection Coverage for:
>
> 1. Medical expenses for you or any "family member":

> a. To the extent that similar benefits are paid, payable, or required to be paid, under any individual, blanket, or group accident or disability insurance, service, benefit, reimbursement or salary continuance plan (excluding Medicare benefits provided by the federal government) . . . .

ArvinMeritor paid plaintiff over $375,000 in medical benefits and notified him of its right to subrogation to the extent that plaintiff received a recovery from a third party for damages arising out of the accident. After receiving notice of ArvinMeritor's right to subrogation, plaintiff initiated the present action against Citizens to obtain sums that he alleged were "lawfully due and owing," i.e., continuing medical benefits, wage loss, replacement services, rehabilitation and vocational-training expenses, and reimbursement to plaintiff's health-plan providers. Citizens answered plaintiff's complaint and filed a counterclaim, emphasizing that the Citizens policy was "issued on a coordinated basis pursuant to MCL §500.3109a" and that "coverage under the ArvinMeritor plan is primary to coverage under the Citizens no-fault policy." Citizens requested that the trial court declare as a matter of law that plaintiff "is only entitled to excess benefits from Citizens" and that Citizens is not obligated to indemnify plaintiff against a reimbursement or subrogation claim asserted by ArvinMeritor.

In a settlement with Citizens, plaintiff recovered $500,000 in uninsured-motorist benefits. ArvinMeritor sent Citizens a letter explaining its right to subrogation and demanding reimbursement for the medical benefits that it provided to plaintiff.

Plaintiff then filed a separate action in the United States District Court against Citizens and ArvinMeritor. Plaintiff requested that the district court (1) enjoin ArvinMeritor from seeking reimbursement of the paid medical expenses from plaintiff's uninsured-motorist recovery and (2) compel Citizens to reimburse ArvinMeritor or otherwise resolve the reimbursement claim without jeopardizing his uninsured-motorist recovery.

Plaintiff moved the trial court in the present case to hold the proceedings in abeyance until the resolution of the federal action, but the trial court denied the motion. Citizens moved the trial court for summary disposition under MCR 2.116(C)(8) and (C)(10). It insisted that the Citizens policy is coordinated under MCL 500.3109a and, thus, only provides for payment of excess insurance coverage while ArvinMeritor provided plaintiff primary medical coverage. Furthermore, it argued that "Michigan law does not require Citizens to indemnify [plaintiff] against [ArvinMeritor's] subrogation/reimbursement claim." Plaintiff responded that there is a priority dispute between Citizens and ArvinMeritor, which the trial court lacked subject-matter jurisdiction to resolve. Plaintiff argued that, under the language of the Citizens policy, Citizens is required to pay him the medical expenses paid by ArvinMeritor. Plaintiff therefore asserted that he was entitled to summary disposition under MCR 2.116(I)(2) (party opposing motion for summary disposition entitled to judgment).

The trial court granted summary disposition under MCR 2.116(C)(10) in favor of Citizens, concluding that Citizens was not required to reimburse plaintiff under Michigan law. The court opined as follows in pertinent part:

> Plaintiff selected an insurance policy with [Citizens] that provided medical excess coverage. Therefore, the coordinated benefit rules and the subrogation and reimbursement rules under the Arvin Meritor plan apply.
>
> * * *
>
> Plaintiff is not entitled to indemnification by defendant related to Arvin Meritor's subrogation/reimbursement claim against the uninsured motorist settlement for plaintiff's non-economic damages. [*Dunn v Detroit Auto Inter-Ins Exch*, 254 Mich App 256; 657 NW2d 153 (2002).] Summary disposition is, therefore, appropriate as to the indemnification claim.
>
> * * *
>
> As to any remaining issues related to liable [sic] for accrued and accruing medical and wage benefits, those issues are better decided in federal court where Arvin Meritor is included as a party.

After the trial court's decision in this case, the United States District Court in the federal action determined that (1) ArvinMeritor has a right to reimbursement from plaintiff's uninsured-motorist benefits and (2) that ArvinMeritor, not Citizens, is the primary insurer for plaintiff's medical expenses.

II. DISCUSSION

At the outset, we note what issues are not before this Court: (1) the priority dispute between ArvinMeritor and Citizens to determine the primary insurer for plaintiff's economic damages and (2) whether plaintiff must reimburse ArvinMeritor. These issues have been litigated in and determined by the United States District Court as discussed above. The only issue before this Court is whether, under Michigan law, Citizens is required to reimburse plaintiff for any amount of the uninsured-motorist benefits that plaintiff uses to reimburse ArvinMeritor for ArvinMeritor's payment of medical benefits.

A. STANDARD OF REVIEW

We review de novo a trial court's summary-disposition ruling. *Maiden v Rozwood*, 461 Mich 109, 118; 597 NW2d 817 (1999). When reviewing a motion brought under MCR 2.116(C)(10), this Court considers the pleadings, affidavits, depositions, admissions, and any other documentary evidence submitted by the parties in a light most favorable to the nonmoving party. *The Cadle Co v City of Kentwood*, 285 Mich App 240, 247; 776 NW2d 145 (2009). A motion for summary disposition under MCR 2.116(C)(10) may be granted where there is no genuine issue as to any material fact and the moving party is entitled to judgment as a matter of law. *Campbell v Dep't of Human Servs*, 286 Mich App 230, 235; 780 NW2d 586 (2009). Moreover, the interpretation and construction of insurance contracts are questions of law, which this Court reviews de novo. *Citizens Ins Co v Secura Ins*, 279 Mich App 69, 72; 755 NW2d 563 (2008).

B. ANALYSIS OF THE ISSUE

With respect to coordinated no-fault policies, the Legislature enacted MCL 500.3109a "to address the problem of overlapping no-fault and private health or accident insurance benefits." *O'Donnell v State Farm Mut Auto Ins Co*, 404 Mich 524, 550; 273 NW2d 829 (1979). The Legislature intended to "provide individuals with an opportunity to reduce premiums if they already had health insurance that covered automobile accidents." *Smith v Physicians Health Plan, Inc*, 444 Mich 743, 749; 514 NW2d 150 (1994). MCL 500.3109a states the following:

> An insurer providing personal protection insurance benefits shall offer, at appropriately reduced premium rates, deductibles and exclusions reasonably related to other health and accident coverage on the insured. The deductibles and exclusions required to be offered by this section shall be subject to prior approval by the commissioner and shall apply only to benefits payable to the person named in the policy, the spouse of the insured and any relative of either domiciled in the same household.

Thus, MCL 500.3109a requires no-fault insurers to offer consumers the option of coordinated medical benefits at a reduced premium. See MCL 500.3109a. The consumer then has the choice of whether to coordinate medical benefits in exchange for a reduced premium "or to reject that opportunity for such savings and, in the event of subsequent injury, to recoup a double recovery that is not a 'windfall.'" *Dunn*, 254 Mich App at 269, quoting *Yerkovich v AAA*, 231 Mich App 54, 70; 585 NW2d 318 (1998) (MARKMAN, J., dissenting), rev'd on other grounds 461 Mich 732 (2000); see also *Smith*, 444 Mich at 754. When a consumer chooses to coordinate benefits, "the health insurer becomes primarily responsible to pay for medical expenses resulting from injuries sustained in automobile accidents, even when the health insurance policy also contains a COB clause." *Yerkovich*, 231 Mich App at 60 (citation omitted). "However, when the health insurance plan at issue is established pursuant to the ERISA, an unambiguous COB clause in the ERISA plan controls . . . ." *Id.*; see also *Auto Club Ins Ass'n v Frederick & Herrud, Inc (After Remand)*, 443 Mich 358, 389; 505 NW2d 820 (1993).

There are three Michigan cases pertinent to our analysis that address whether a no-fault carrier must reimburse an insured when the insured is required either by law or contract to reimburse another source for medical or wage-loss benefits that he or she received.

In the first case, *Sibley v Detroit Auto Ins-Exch*, 431 Mich 164, 166; 427 NW2d 528 (1988), the plaintiff was injured in an automobile accident during the course of his employment with the United States Postal Service. The plaintiff received $17,221.87 in medical benefits and lost wages from the federal government under the Federal Employees' Compensation Act (FECA), 5 USC 8101 *et seq*. *Id.* The plaintiff also filed a claim with the defendant for no-fault benefits. *Id.* at 167. Section 3109(1) of the no-fault act provided the following: "Benefits provided or required to be provided under the laws of any state or the federal government shall be subtracted from the personal protection insurance benefits otherwise payable for the injury." *Id.* at 168. After deducting no-fault benefits otherwise payable but received by the plaintiff under FECA, the no-fault insurer honored the plaintiff's claim, paying $14,498.68 in lost wages not reimbursed under FECA. *Id.* at 167. The plaintiff then settled for $32,500 a tort claim for noneconomic damages against the driver of the automobile that hit him. *Id.* Pursuant to federal

law (5 USC 8132), the federal government sought reimbursement of the FECA benefits it paid to the plaintiff from the amount received by the plaintiff in the tort-claim settlement; the plaintiff paid the federal government $14,382.29. *Id.* The plaintiff then sought reimbursement from the no-fault insurer for the amount he paid back to the federal government, but the no-fault insurer refused under section 3109(1). *Id.*

Our Supreme Court held that the no-fault insurer was required to reimburse the plaintiff. *Id.* at 171. The Court opined that section 3109(1) did not apply because the section's use of the words "benefits provided" means benefits "permanently provided." *Id.* at 170. Because the plaintiff was required to reimburse the federal government pursuant to federal law, the FECA benefits paid to the plaintiff were no longer "benefits provided" under section 3109(1). *Id.* The Court emphasized that, "[b]ecause [the] plaintiff was ultimately required to refund the FECA benefits he had received, he was left without that compensation for his medical services and lost wages. Therefore, his only recourse for economic damages was to seek payment from his no-fault carrier." *Id.* at 170-171. Furthermore, the Court explained that, "in order to prevent a worker injured in an automobile accident from, in effect, paying his own work loss/medical benefits, we can require the automobile no-fault insurer to repay benefits to that extent, in order to effectuate the underlying policies of the automobile no-fault act." *Id.* at 170.

The second and third cases, *Yerkovich* and *Dunn*, are more similar to the present case because they involve ERISA welfare benefit plans and coordinated no-fault policies.

In *Yerkovich*, the plaintiff's daughter suffered injuries in an automobile accident. *Yerkovich*, 231 Mich App at 58. The plaintiff participated in a self-funded employee welfare benefit plan governed by ERISA, and the plan paid the plaintiff $6,832 in medical-expense benefits. *Id.* The plaintiff also had a no-fault policy with AAA, but AAA denied coverage on the basis that the plaintiff's policy contained a coordination-of-benefits clause that made the ERISA plan primarily responsible for the plaintiff's medical expenses. *Id.* The plaintiff filed a negligence claim against the driver of the vehicle that her daughter occupied, and the claim settled for $20,000. *Id.* In the trial court, the parties (the plaintiff, the ERISA fund, and AAA) disputed whether the plaintiff was required to reimburse the ERISA fund from the third-party tort recovery under a subrogation agreement and, if so, whether AAA would be responsible for the plaintiff's medical expenses. *Id.* at 58-59. On appeal, this Court first concluded that the subrogation agreement required the plaintiff to reimburse the ERISA fund. *Id.* at 62. The Court then concluded that AAA was required to reimburse the plaintiff for any amount that the plaintiff reimbursed the ERISA fund. *Id.* at 68. This Court explained that "it is appropriate to use the approach set forth in *Sibley* and allow the plaintiff to look to her no-fault carrier to make her whole." *Id.*

Dissenting, Judge MARKMAN distinguished *Yerkovich* from *Sibley* and concluded that AAA was not required to reimburse the plaintiff:

> Perhaps the most fundamental rule of Michigan insurance jurisprudence is that an insurer can never be held liable for a risk it did not assume and for which it did not charge or receive any premium.
>
> * * *

In this case, plaintiff pocketed the savings generated by electing to coordinate her employer-sponsored health and accident benefits with her no-fault insurance, thereby reducing her no-fault insurance premiums. Yet although she reduced her premiums in this way, she appears to have given up nothing in reality because the liability of the no-fault insurer is apparently unaffected by the reduced premiums under the analysis of the majority. The insurer here is held to have provided coverage exactly equivalent to what would have been appropriate had it not received a reduced premium.

* * *

What distinguishes *Sibley* from the present case, however, is that, in *Sibley*, the insured did not arrange a lower premium on the basis of such federal benefits; rather, insureds generally receive the benefit of lower premiums because the no-fault statute requires that state and federal benefits of that type be deducted from no-fault benefits. Insurers thus calculate actuarially the extent to which the general population of insureds will be able to avail itself of such benefits, and premiums are determined accordingly, without regard to individual cases. Thus, in *Sibley*, the Court merely announced to the actuaries that they should consider only benefits to be paid and retained under such federal and state programs as being within the offset allowed.

Here, in contrast, the ERISA-plan benefits are not provided "under the laws of any state or the federal government," that is, from the public treasury, but rather by virtue of funding furnished by plaintiff's employer. To reduce its costs, the employer has established subrogation rights, but this has nothing to do with defendant no-fault insurer, which was not informed by plaintiff of her election to sign the subrogation agreement before reducing plaintiff's no-fault premium pursuant to her § 3109a election. Rather, this is between plaintiff and the ERISA plan. Presumably, by the manner in which the ERISA plan subrogates itself to plaintiff's tort recovery, it reduces the cost of the plan to the employer, and thereby either allows the employer to afford the plan at all, or encourages the employer to provide a better benefit package for its employees. Either way, that is a direct benefit to plaintiff, but the quid pro quo is that she must reimburse the ERISA plan where, as here, she obtains a tort recovery for the same injury. There is no reason why this must absolve plaintiff of the consequences of her election of coordinated benefits for a reduced premium or why the insurer must pay no-fault benefits as though plaintiff had not elected coordination.

* * *

This is a suit by an insured who has invoked her statutory right to a reduced premium in exchange for coordinated benefits, and who opted to use as her primary medical insurance an ERISA plan that reserved and invoked subrogation rights against an eventual tort recovery. No one forced her to make that election, but now that it has come time to accept the consequences of that election, there is no reason in law or logic to relieve her of the concomitant burdens that attend the

> reduced premium benefits already enjoyed. [*Id.* at 70-71, 73-75 (MARKMAN, J., dissenting).]

Two years later, our Supreme Court reversed this Court's decision in *Yerkovich*, holding that "the [ERISA] fund was not entitled to a reimbursement from [the] plaintiff" because the plaintiff's duty to reimburse the ERISA fund was unenforceable under the preexisting-duty rule. *Yerkovich v AAA*, 461 Mich 732, 741-742; 610 NW2d 542 (2000).

In *Dunn*, this Court addressed the same issue addressed by this Court in *Yerkovich* but reached the opposite result. See *Dunn*, 254 Mich App at 268, 272. The plaintiff was injured in an automobile accident. *Id.* at 257. He had a coordinated no-fault insurance policy with the defendant.[1] *Id.* at 258. Rockwell International Corporation Employee Health Plan (Rockwell), a self-funded group health plan governed by ERISA, paid the plaintiff $96,125.65 for medical expenses. *Id.* at 257-258 & n 1. Later, the plaintiff settled a third-party lawsuit for an undisclosed amount. *Id.* at 258. Rockwell sought reimbursement from the plaintiff under a provision in the ERISA plan that provided that the plaintiff would reimburse Rockwell from any third-party recovery for any sums expended on the plaintiff's behalf for the accident. *Id.* The plaintiff reimbursed Rockwell and then sued the defendant no-fault insurer for the $96,152.65. *Id.* at 258-259. On appeal, this Court first concluded that it was not bound to follow *Yerkovich* because a Court of Appeals decision that has been reversed on other grounds has no precedential value. *Id.* at 262-266. We then held that the plaintiff was not entitled to reimbursement from the defendant. *Id.* at 267, 272. We explained that the "[p]laintiff pocketed savings by electing to coordinate benefits, but now seeks to hold his no-fault insurer to providing coverage exactly equivalent to what would have been appropriate had it not received a reduced premium. We find it illogical to hold the insurer liable for a risk it did not assume . . . ."[2] *Id.* at 268. Furthermore, this Court expressly adopted specific portions of Judge MARKMAN's dissent in *Yerkovich*. *Id.* at 268-271.

---

[1] The coordination-of-benefits clause provided the following:

> If the Declaration Certificate shows "COORDINATED MEDICAL BENEFITS", it is agreed that all other medical insurance or health care benefit plans available to *you* or *a resident relative* are your primary source of protection. *We* will pay benefits for all reasonable charges incurred for reasonably necessary products, services (including chiropractic services) and accommodations for the care, recovery or rehabilitation of you or a resident relative, except to the extent that (1) benefits are paid or payable under *your* primary protection;.... [*Dunn*, 254 Mich App at 258.]

[2] The *Dunn* Court did not squarely address whether the benefits that the plaintiff received from Rockwell were "paid or payable" under the coordination-of-benefits clause. However, given the *Dunn* Court's conclusion that requiring the defendant no-fault insurer to reimburse the plaintiff would make the insurer liable for a risk it did not assume, it is reasonable to conclude that the *Dunn* Court necessarily, albeit implicitly, determined that the benefits that the plaintiff reimbursed were "paid or payable" under the coordination-of-benefits clause.

We conclude that, under current Michigan law, Citizens is not required to reimburse plaintiff for any amount of the uninsured-motorist benefits that plaintiff uses to reimburse ArvinMeritor for ArvinMeritor's payment of medical benefits. This Court's decision in *Dunn* applies in this case, and we must follow it. See MCR 7.215(J)(1) ("A panel of the Court of Appeals must follow the rule of law established by a prior published decision of the Court of Appeals issued on or after November 1, 1990, that has not been reversed or modified by the Supreme Court, or by a special panel of the Court of Appeals as provided in this rule."). Under *Dunn*, Citizens is not required to reimburse plaintiff. See *Dunn*, 254 Mich App at 272, 276. Plaintiff in this case elected to receive only excess benefits from Citizens by coordinating his benefits; plaintiff cannot now hold Citizens liable for a risk it did not assume.[3] See *id.* at 268. Furthermore, *Yerkovich* has no precedential value. *Id.* at 266. Our Supreme Court reversed *Yerkovich* on grounds other than those at issue in *Dunn* and this case; a Court of Appeals decision that has been reversed on other grounds has no precedential value. *Id.* at 262; see also *Horace v City of Pontiac*, 456 Mich 744, 754; 575 NW2d 762 (1998); *Taylor v Kurapati*, 236 Mich App 315, 345-346 & n 42; 600 NW2d 670 (1999). Indeed, the *Dunn* Court explicitly held that *Yerkovich* has no precedential value, *Dunn*, 254 Mich App at 266, and we must follow *Dunn* as previously discussed, see MCR 7.215(J)(1).

Accordingly, we hold that Citizens is not required to reimburse plaintiff for any amount of the uninsured-motorist benefits that plaintiff uses to reimburse ArvinMeritor for ArvinMeritor's payment of medical benefits.

---

[3] Plaintiff argues that Citizens has failed to prove that it complied with the statutory condition imposed by MCL 500.3109a of offering him a reduced premium rate associated with excess or coordinated coverage. The United States District Court directly addressed this argument and rejected it:

> Hill claims that Citizens has to prove that it actually gave him a lower premium in conjunction with the coordination of benefits clause. This claim is unsound. While Citizens may have a burden of proof as to *how* the provision is to be applied in a particular case, *see Morrill v. Gallagher*, 370 Mich. 578, 587 (1963), it need only show that Hill signed the policy to show he is, in fact, bound to it. *See Smith v. Physicians Health Plan, Inc.*, 444 Mich. 743, 756 (1994) ("Section [500.3109a] does not require a health insurer to demonstrate a premium rate reduction to validate a coordination of benefits clause in the certificate of coverage."). It is true, as Hill points out, that *Smith* only mentions a "health insurer." But it interprets the same statute in dispute here, and therefore, the distinction between "health insurance" and other kinds of insurance makes no difference in resolving the argument over the statute's meaning.

C. PLAINTIFF'S RELIANCE ON *SHIELDS*[4]

Plaintiff argues that this Court should adopt the analysis of the United States Court of Appeals for the Sixth Circuit in *Shields v Gov't Employees Hosp Ass'n Inc*, which criticized and rejected this Court's decision in *Dunn*. While we must follow *Dunn*, we find that the sixth circuit court of appeals's decision in *Shields* is convincing.

The plaintiff in *Shields* was injured in an automobile accident and insured by both a coordinated[5] Michigan no-fault policy issued by State Farm and a Government Employees Hospital Association (GEHA) benefits plan. *Shields*, 450 F3d at 645. GEHA paid the plaintiff over $160,000 in medical expenses. *Id.* The plaintiff then recovered pain-and-suffering damages in a tort claim. *Id.* Pursuant to the terms of her GEHA benefits plan, the plaintiff reimbursed GEHA out of her tort recovery. *Id.* The plaintiff then sought to have State Farm reimburse her for the cost of the medical expenses, but State Farm refused on the basis that, under the language of the plaintiff's coordinated no-fault policy, the payment initially made by GEHA was "paid or payable." *Id.*

The sixth circuit court of appeals held that State Farm was required to reimburse the plaintiff for the cost of her medical expenses. *Id.* at 644. When analyzing the issue, the *Shields* court first addressed the Michigan Supreme Court's opinion in *Sibley* and opined that its case was "materially indistinguishable from *Sibley*," explaining as follows:

> In this case, the insured received payment to cover medical expenses, that pursuant to federal law, she is required to repay from the proceeds of her tort recovery for pain and suffering damages. Because federal law preempts state law, Michigan cannot stop GEHA from requiring reimbursement. Consequently, here, as in *Sibley*, the insured is being forced to pay her own medical expenses out of her tort damages for pain and suffering. This contravenes the expressed intent of the Michigan legislature as embodied in [Michigan No-Fault Insurance Act,] MNFIA, which requires all car owners to maintain insurance coverage for medical expenses and prohibits no-fault insurers from seeking reimbursement from tort settlements. Mich. Comp. Laws §§ 3101, 3116. Furthermore, the

---

[4] *Shields v Gov't Employees Hosp Ass'n Inc*, 450 F3d 643 (CA 6, 2006), overruled on other grounds *Adkins v Wolever*, 554 F3d 650 (2008).

[5] The State Farm policy provided:

> Benefits shown as coordinated will be reduced by any amount paid or payable to *you* or any *relative* under any:
>
> 1. vehicle or premise insurance;
>
> 2. individual, blanket or group accident or disability insurance; and
>
> 3. medical or surgical reimbursement plan. [*Shields*, 450 F3d at 645.]

> Michigan legislature mandated coordinated benefits plans to avoid duplicative coverage, not to deny insured persons coverage altogether. *See Smith*, 514 N.W.2d at 154. Here the coverage is not duplicative because Plaintiff's tort damages are for pain and suffering and State Farm is covering Plaintiff's medical expenses. Thus, the fact that the State Farm Policy is coordinated with GEHA's policy is irrelevant. The insured maintains an insurance policy for medical expenses and should not be required to pay her medical expenses without help from her insurance carrier. [*Id.* at 647-648.]

The *Shields* court then discussed this Court's opinion in *Dunn*, acknowledged that *Dunn* was more analogous of its case than *Sibley*, but declined to apply *Dunn* because it "conflicts with *Sibley*" and is, therefore, not controlling Michigan law. *Id.* at 648-649. The *Shields* court opined as follows, in pertinent part:

> First, MCL § 3109 and MCL § 3109a, mandating coordinated benefits plans, were enacted for identical purposes. Both seek to eradicate duplicative insurance coverage-one by allowing subtraction of benefits provided pursuant to law, and the other by mandating policies that provide coverage only from damages not covered by other policies. Additionally, the language of MCL § 3109 and the coordinated benefits policy in *Dunn*-and in this case-are similar. MCL § 3109 refers to benefits "provided" or "required to be provided" and the coordinated benefits plans refer to benefits "paid" or "payable." Thus, in determining whether a benefit was provided under MCL § 3109 or paid under a coordinated benefits plan, this Court should assume that the Supreme Court of Michigan would take a consistent approach.
>
> Second, the *Dunn* court's primary rationale conflicts with *Sibley*. The Michigan Court of Appeals based its holding in *Dunn* on the theory that the insured would receive duplicative benefits if allowed to keep his or her tort recovery and to receive no-fault insurance coverage. *Sibley* expressly holds, however, that such coverage is not duplicative because the tort recovery was for pain and suffering, whereas the insurance coverage was for medical benefits and lost income.
>
> Finally, and perhaps most importantly, the *Dunn* decision essentially allowed a no-fault insurer to receive reimbursement from tort damages. As the Michigan Supreme Court noted in *Sibley*, by requiring an insured to pay for his or her own medical expenses from his or her tort recovery, the insurance company is saved from covering medical expenses and the tort victim thereby loses her tort recovery. Thus, in essence, the insurance company is receiving reimbursement from the tort recovery as surely as if its policy required such reimbursement. This is expressly prohibited by Michigan law[, MCL 500.3116].
>
> Moreover, the *Dunn* court's argument that one who pays reduced premiums under a coordinated benefits plans should not receive coverage equal to one who pays full premiums is severely misguided. Persons select coordinated benefits plans because they have *two* insurance plans and correspondingly two sets of premiums. Persons who pay full coverage and choose not to select a coordinated benefits

> plan theoretically do so because they do not have other coverage. Thus, they pay *one* non-reduced premium. Theoretically, neither party is paying more in premiums, and neither is receiving more or less coverage. Instead, the difference is to whom they are paying the premium, and who bears the final cost of coverage. This is implicit in the MNFIA, which expressly defines what a no-fault insurance company must cover. [MCL 500.3107.]
>
> Nonetheless, the concurring opinion would hold that *Dunn* is distinguishable from *Sibley* because *Dunn*, in contrast to *Sibley*, involved whether a no-fault insurer had an obligation to compensate the plaintiff for funds repaid to a *privately* funded employer health care plan. Thus, according to the concurring opinion, the *Dunn* court did not consider the question in this case, namely whether *Sibley*'s statutory interpretation of what constitutes "government benefits" should be applied to the employer health care provider's payments.
>
> Whether the amount paid is a "government benefit" or a private benefit is irrelevant to the resolution of this case (as it was irrelevant to the resolution of *Dunn*). What is relevant is whether the benefit was "paid." Under the express terms of the contract at issue in this case, whether State Farm has a duty to reimburse Plaintiff does not hinge on whether GEHA's payments constitutes government benefits but on whether they constitute "amounts paid." The contract states that "[b]enefits will be reduced by any amount paid or payable to [Shields] under any ... individual, blanket or group accident or disability insurance." In fact, the coordinated benefits clause we are tasked with interpreting in this case does not even mention the term "government benefits."
>
> *Sibley* is relevant to this case not because it interpreted what constitutes a "government benefit" but because it interpreted when such benefits can actually be considered "provided." The *Sibley* court concluded that an amount was not "provided" if it had to be repaid. *Id.* The *Sibley* court's interpretation of provided informs our interpretation of "paid." Consequently, the concurring opinion's attempt to distinguish *Dunn* is not well-taken. [*Id.* 649-651 (internal citations omitted).]

As can be gleaned from the *Shields* court's decision, *Shields* provides a strong basis to reach the alternative conclusion in this case. While we must follow this Court's decision in *Dunn* pursuant to MCR 7.215(J)(1), we favor plaintiff's reliance on *Shields* as we find *Shields* particularly convincing. Therefore, we encourage the Michigan Supreme Court to evaluate the issue in this case if plaintiff files leave to appeal.

III. CONCLUSION

We hold that Citizens is not required to reimburse plaintiff for any amount of the uninsured-motorist benefits that plaintiff uses to reimburse ArvinMeritor for ArvinMeritor's payment of medical benefits. Our conclusion in this case is controlled by this Court's decision in *Dunn v Detroit Auto Inter-Ins Exch*, which we must follow pursuant to MCR 7.215(J)(1). However, we find the sixth circuit court of appeals's decision in *Shields v Gov't Employees Hosp*

Ass'n Inc—which rejected *Dunn*—to be convincing. We therefore encourage the Michigan Supreme Court to evaluate the issue in this case if plaintiff files leave to appeal.

Affirmed.

/s/ Kathleen Jansen
/s/ Stephen L. Borrello
/s/ Jane M. Beckering