

intentionally inflicted emotional distress upon plaintiff. However, under the clear language of the amended statute, a guardian ad litem is immune from civil liability for injuries to persons or damages to property whenever the guardian is acting within the scope of authority as guardian ad litem. M.C.L. § 691.1407(6); M.S.A. § 3.996(107)(6). Further, because the Legislature provided that the amendment is to have retroactive effect, it applies to this case. *Id.* Accordingly, we hold that under the amendment of the statute effectuated by 1996 P.A. 143, defendant is immune from liability for any injuries to plaintiff caused when defendant was acting within the scope of her authority as a guardian ad litem for plaintiff in the underlying child custody suit between Ronald Bullock and Sharon Pope. Therefore, with regard to plaintiff's claims that defendant acted in a negligent or grossly negligent manner while performing her duties as guardian ad litem, defendant is immune from liability for those acts and summary disposition must be entered with regard to those claims under MCR 2.116(C)(7). However, because plaintiff also raises claims of breach of express and implied contract and intentional misconduct, we remand this matter to the trial court for a determination whether the complained-of acts were committed when defendant was acting within the scope of her authority as guardian ad litem and whether defendant may be held liable for those acts.

[2] With respect to defendant's claim that plaintiff is collaterally estopped from relitigating the propriety of the circuit court orders in the underlying custody case, we reiterate that because the ultimate issue in this case, defendant's negligence or misconduct as guardian ad litem, was not essential to the custody decision, the trial court's denial of defendant's motion for summary disposition on collateral estoppel grounds was proper. *Detroit v. Qualls*, 434 Mich. 340, 357, 454 N.W.2d 374 (1990).

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



218 Mich.App. 375

**MUNSON MEDICAL CENTER,  
Plaintiff–Appellee,**

v.

**AUTO CLUB INSURANCE ASSOCIATION,  
also known as AAA Insurance  
Company, Defendant–Appellant.**

**Docket No. 177469.**

Court of Appeals of Michigan.

Submitted March 5, 1996, at Grand Rapids.

Decided Aug. 23, 1996, at 9:10 a.m.

Released for Publication Oct. 15, 1996.

Health care provider brought action against no-fault insurer, seeking unpaid billed charges submitted to insurer for medical services provided to insureds. The Circuit Court, Grand Traverse County, Philip E. Rodgers, Jr., J., granted summary disposition for provider, and insurer appealed. The Court of Appeals, Saad, P.J., held that: (1) “customary charges” that may be reimbursed means standard amount that provider bills, regardless of whether provider routinely accepted less than that amount in some cases; (2) provider bore burden of proving reasonableness and customariness of its charges; (3) insurer bore blame for any harm suffered by insurer as result of not allowing insurer to discover certain information; and (4) insurer could not use workers’ compensation payment schedule to determine amount of reimbursable charges.

Affirmed.

#### 1. Insurance ⇨531.4(5)

“Customary charges,” as used in Michigan No-Fault Act provision stating that health care provider’s reimbursable charge for services may not exceed the amount the provider customarily charges for such services, meant standard amount billed for services, not amount that provider routinely accepted in other cases such as Medicare,

Medicaid, and Blue Cross and Blue Shield of Michigan. M.C.L.A. §§ 500.3105, 500.3107, 500.3157.

See publication Words and Phrases for other judicial constructions and definitions.

## 2. Insurance ⇨532.20

Health care provider seeking reimbursement of services it provided under Michigan No-Fault Act had burden of proving both reasonableness and customariness of its charges. M.C.L.A. §§ 500.3105, 500.3107, 500.3157.

## 3. Judgment ⇨185.3(12)

Health care provider's affidavit stating that all parties were billed the same charge and that no other no-fault insurers had claimed that provider's charges were unreasonable or not customary charges was sufficient to meet burden of provider, as summary judgment movant, of supporting its position that there were no disputed facts regarding whether charges for medical services were customary charges. MCR 2.116(G)(4).

## 4. Judgment ⇨181(23)

No-fault insurer, as party not moving for summary judgment, failed to show there was dispute of material fact over whether charges for medical services were health care provider's customary charges merely by arguing for its statutory interpretation of "customary charges." MCR 2.116(G)(4).

## 5. Appeal and Error ⇨882(18)

Any harm that occurred from granting summary disposition without permitting no-fault insurer to discover certain information from health care provider would be attributed to insurer where insurer did not file motion to compel following provider's allegedly inadequate deposition, and first time that insurer argued the issue was during its motion for rehearing.

## 6. Insurance ⇨531.4(5)

Phrase "in cases not involving insurance" in no-fault reimbursement statute, which states that reimbursable charge for products, services, and accommodations in

treating injured persons shall not exceed amount the provider customarily charges for like products, services, and accommodations in cases not involving insurance, means those situations in which there is literally no insurance in the lay sense of the term (e.g., no Medicare, no Medicaid, or no Blue Cross and Blue Shield of Michigan). M.C.L.A. § 500.3157.

See publication Words and Phrases for other judicial constructions and definitions.

## 7. Insurance ⇨531.4(5)

No-fault insurer could not unilaterally decide to use workers' compensation schedule of payments as basis for determining amount of reimbursement to health care provider, in light of controlling statutory language of no-fault act, which required that charges to be reimbursed were charges customarily billed by provider, and in light of failure of referendum that would have allowed insurer to pay claims according to fee schedules.

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Honigman Miller Schwartz & Cohn by Michael A. Gruskin, Detroit, and Munson Healthcare by Stephen P. Clifton, Corporate Vice President and General Counsel, Traverse City, for plaintiff.

Becker, Lanctot, McCutcheon, Schoolmaster, Taylor & Hom by Clair W. Hoehn Gross, Nemeth & Silverman, P.L.C., by Steven G. Silverman, of Counsel, Detroit, for defendant.

Mantese & Carozza, P.L.L.C. by Gerard Mantese and Regis A. Carozza, Huntington Woods, for Amicus Curiae, Michigan Health and Hospital Association.

Before SAAD, P.J., and McDONALD and M.A. CHRZANOWSKI,\* JJ.

SAAD, Presiding Judge.

This case arises out of a payment dispute for medical services rendered and billed by plaintiff Munson Medical Center under the no-fault act to defendant Auto Club Insurance Association (ACIA). The dispute centers on the appropriate statutory amount assignment.

\* Circuit judge, sitting on the Court of Appeals by

ACIA is required to pay Munson under the no-fault act. ACIA appeals from the circuit court's order (1) granting Munson's motion to amend its complaint, (2) granting summary disposition pursuant to MCR 2.116(C)(10) against ACIA, and (3) entering judgment in favor of Munson in the amount of \$100,141.66 plus interest. ACIA also challenges the trial court's denial of its motion for rehearing. We affirm on all grounds.

## I

## BACKGROUND AND FACTS

Under Michigan's no-fault act, M.C.L. § 500.3101 *et seq.*; M.S.A. § 24.13101 *et seq.*, when a person is injured in an automobile-related accident, a hospital that provides medical care is to be reimbursed by the injured person's no-fault insurance company. Since 1973, a number of ACIA insureds were treated at Munson Medical Center for injuries arising out of automobile accidents. Historically, Munson would bill ACIA for the services, and, until 1992, ACIA paid the full no-fault amounts billed by Munson. However, beginning in 1992, ACIA stopped paying the entire amount of Munson's no-fault bills and began paying only a *portion* of the charges. It is undisputed that, instead of paying the full amount billed by Munson, ACIA began to pay Munson according to the fee schedule promulgated under the Worker's Disability Compensation Act, M.C.L. § 418.101 *et seq.*; M.S.A. § 17.237(101) *et seq.* As a practical matter, payments made pursuant to this fee schedule were routinely less than the amount actually billed<sup>1</sup> by Munson to ACIA.

In December 1992, Munson filed suit against ACIA under the no-fault act for the unpaid portion of its bills. Munson thereafter amended its complaint to increase the amount of damages sought. In October 1993, Munson filed a motion for summary disposition pursuant to MCR 2.116(C)(9) (failure to state a valid defense) and MCR

2.116(C)(10) (no genuine issue of material fact). Munson argued (1) that ACIA made only partial payments to Munson, according to the payment schedule of the Workers Disability Compensation Act, even though the injuries did not arise from employment, (2) that the worker's compensation payment schedule had not been promulgated pursuant to the no-fault act, and (3) that the no-fault act itself required payment of all of the insureds' allowable medical expenses. With its motion for summary disposition, Munson provided affidavits attesting that its charges were "customary" (because they were uniform to all who used its services, regardless of whether an insurer ultimately paid the entire amount billed), and that its charges were reasonable because none of the twenty-five to thirty other no-fault insurers with whom Munson dealt objected to the reasonableness of the charges. The unpaid portion of the bills at issue is \$100,274.41.

ACIA opposed Munson's motion for summary disposition and sought summary disposition. Basically, ACIA argued that Munson was not entitled to summary disposition because Munson's motion was unsupported by competent evidence that its charges were reasonable or customary. In support of ACIA's own motion for summary disposition, ACIA argued that its payments accurately reflected what Munson's reasonable charges *should have been*, so that the resulting payments (computed according to the worker's compensation payment schedule) were reasonable as a matter of law. ACIA reasoned that hospitals such as Munson were unable to obtain adequate (full) payment from Medicare, Medicaid, and Blue Cross and Blue Shield of Michigan (hereafter BCBSM) to cover the hospital's actual costs, and this meant that hospitals such as Munson would unfairly shift these unmet costs onto no-fault insurers like ACIA. ACIA further reasoned that this cost shifting resulted in unreasonable charges, so that ACIA could no longer accept Munson's charges as reasonable. In-

1. The actual payments were calculated using a basic worker's compensation payment ratio, plus a "cost to charge" ratio for each specific hospital. ACIA explained that Munson's "cost to charge ratio" was 0.7, to which was added a thirteen percent "profit factor" for the hospital.

Thus, if the amount billed was \$100, application of the "cost to charge ratio" (0.7) rendered \$70, plus the thirteen percent profit, which resulted in a payment of \$79.10. ( $100 \times 0.7 = 70$   $70 \times 1.13 = 79.10$ ).

stead, ACIA determined that the worker's compensation payment scheme was a suitable objective measure of "reasonable" costs.

In a nutshell, ACIA complained that if it paid the *entire* bill submitted by Munson for a particular injury, it would be paying more than Medicare, Medicaid, or BCBSM would pay for the same injury. ACIA pointed out that a broken leg is a broken leg, whether broken on the job or in an automobile accident. Accordingly, it argued that it was unreasonable and unfair for ACIA to be billed by hospitals more to treat a broken leg because the leg was broken in an automobile accident rather than in a manner that is covered by Medicare, Medicaid, or BCBSM. Although Munson claimed that it billed everyone the same "customary charges" for the same services, ACIA argued that the customary charges were not "customary" at all, because Munson did not expect to receive and did not actually *receive* the same amount from all payors as payment in full.

The circuit court issued a bench opinion that granted summary disposition in favor of Munson. The court agreed with ACIA that the cost for treating identical broken legs should be identical for each patient, but noted that government regulation of the insurance and health-care industries prevented that result. The court therefore found that Munson had a legal right to payment in full of its "customary charges," but expressly noted that in its view ACIA had the "high moral ground" with regard to its concerns about cost shifting. ACIA's subsequent motion for rehearing was denied as untimely and lacking substantive merit. This appeal followed.

On appeal, the Michigan Health and Hospital Association filed an amicus curiae brief in support of Munson. The brief discusses that fact that ACIA has not singled out Munson alone for its partial payments—in fact it has used the worker's compensation payment schedule to reduce payments at numerous hospitals across the state. The amicus curiae brief also discussed several lower court cases in which hospitals have been forced to litigate their claims against ACIA to obtain full payment for the medical services rendered to ACIA's insureds. Appar-

ently, this is the first such case to reach this Court.

## II

### ANALYSIS

#### A. Reasonable and Customary Charges.

[1] ACIA's obligation to pay and Munson's right to be paid for the injured's no-fault medical expenses arise pursuant to M.C.L. §§ 500.3105, 500.3107, and 500.3157; M.S.A. §§ 24.13105, 24.13107, and 24.13157, which provide in part as follows:

Sec. 3105. (1) Under personal protection insurance an insurer is liable to pay benefits for accidental bodily injury arising out of the ownership, operation, maintenance or use of a motor vehicle as a motor vehicle, subject to the provisions of this chapter.

Sec. 3107. (1) Except as provided in subsection (2), personal protection insurance benefits are payable for the following:

(a) Allowable expenses consisting of all reasonable charges incurred for reasonably necessary products, services and accommodations for an injured person's care, recovery, or rehabilitation.

Sec. 3157. A physician, hospital, clinic or other person or institution lawfully rendering treatment to an injured person for an accidental bodily injury covered by personal protection insurance, and a person or institution providing rehabilitative occupational training following the injury, may charge a reasonable amount for the products, services and accommodations rendered. *The charge shall not exceed the amount the person or institution customarily charges for like products, services and accommodations in cases not involving insurance.* [Emphasis added.]

Under this statutory scheme, ACIA is required to pay the "customary charges" for services rendered by Munson. The critical issue in this case is what the statutory term "customary charges" means. Munson, of course, argues that "customary charges" means the standard amount it *bills* on behalf of every patient treated, regardless of the fact that Munson routinely *accepts* less than

this amount in many cases (Medicare, Medicaid, and BCBSM insured cases). ACIA argues that "customary charges" means the lesser amount that Munson actually *accepts* in full satisfaction of the bill for the services rendered. ACIA argues on appeal that the lower court erred in construing M.C.L. § 500.3157; M.S.A. § 24.13157 according to the meaning urged by Munson. We disagree and therefore affirm the decision of the trial court.

A trial court's grant of summary disposition is reviewed de novo by this Court to determine whether the prevailing party was entitled to judgment as a matter of law. *Borman v. State Farm Fire & Casualty Co.*, 198 Mich.App. 675, 678, 499 N.W.2d 419 (1993). Statutory construction is a question of law for the court. See *Aikens v. Dep't of Conservation*, 387 Mich. 495, 499, 198 N.W.2d 304 (1972).

This Court recently considered ACIA's proffered construction of the term "customary charge" and found ACIA's position "untenable . . . in light of the clear statutory language of § 3157." *Hofmann v. Auto Club Ins. Ass'n*, 211 Mich.App. 55, 113, 535 N.W.2d 529 (1995).<sup>2</sup> In *Hofmann*, ACIA argued that the amount BCBSM paid to the plaintiff health-care providers<sup>3</sup> should serve as the benchmark for determining the amount of plaintiffs' "customary charges" for x-rays. This Court disagreed:

We find that ACIA's reasoning is flawed.

ACIA's reasoning is premised on the principle that BCBSM's "payments" to plaintiffs for x-rays, as opposed to plaintiffs' "charges" to BCBSM for those x-rays, are the proper criteria to be used in determining the plaintiffs' "customary charge" for x-rays. This position is untenable, however, in light of the clear statutory language of § 3157, which states that a "charge" in a no-fault case "shall not exceed the amount [a] person or institution customarily *charges* for like products, services and accommodations in cases not involving insurance" (emphasis added).

2. *Hofmann* was released after ACIA's briefs were filed on appeal.

Thus, ACIA's reliance on the amount that was "paid" by BCBSM, as opposed to the amount that plaintiffs "charged," is unwarranted.

Furthermore, ACIA's position ignores the fact that the amounts that plaintiffs receive in payment from BCBSM are subject to contractual limitations, whereas the amounts that ACIA must pay for covered medical expenses are not limited contractually. [*Hofmann, supra* at 113, 535 N.W.2d 529 (emphasis in original).]

The *Hofmann* Court specifically noted that, "[w]hile health and accident carriers generally are free to [place dollar limits upon the amounts they will pay to doctors and hospitals for particular services], a no-fault insurer is not." *Id.*, quoting *Auto Club Ins. Ass'n v. New York Life Ins. Co.*, 440 Mich. 126, 139, 485 N.W.2d 695 (1992). "Only the statutory qualification of reasonableness limits the amount that must be paid by a no-fault carrier for covered medical expenses." *Hofmann, supra* at 113-114, 535 N.W.2d 529, quoting *New York Life Ins. Co., supra* at 139, 485 N.W.2d 695. The *Hofmann* Court continued its reasoning:

In essence, ACIA is asking this Court to establish a rule that, in situations where other health or accident insurance coverage does not exist, the obligation of a no-fault carrier must be limited to what a health insurer would have had to pay if health insurance existed, notwithstanding that the health insurer's obligation might be controlled by contract, whereas the no-fault carrier's is not. This position does not find support in the no-fault act.

We note that the absence of contractual limitations in no-fault situations does not give health-care providers liberty to charge no-fault insurers any amount. In addition to the "customary charge" limitation discussed above, §§ 3107 and 3157 also impose a statutory qualification of reasonableness, such that a no-fault carrier is liable only for those medical expenses that constitute a reasonable charge for the

3. The plaintiffs were two chiropractors, who had treated certain patients injured in automobile accidents and then submitted no-fault bills to ACIA for payment.

product or service. In this case, however, ACIA has not challenged the reasonableness of the x-ray charges that comprise the basis of its § 3157 counterclaim for reimbursement.

Accordingly, because ACIA acknowledges that it was charged approximately the same amount for x-rays that plaintiff charged BCBSM, and because ACIA did not present evidence of plaintiffs' customary charges for x-rays in other cases, we are constrained to conclude that ACIA failed to establish a § 3157 overcharge violation with respect to x-ray services. [*Hofmann, supra* at 114, 535 N.W.2d 529 (citations omitted).]

In the instant case, ACIA's proffered definition of "customary charges" is the same one that was rejected by *Hofmann*, although ACIA's benchmark is broader here than it was in *Hofmann*. (Here, ACIA defines the benchmark as the amount that Munson received from Medicare, Medicaid, BCBSM, and arguably, worker's compensation.) And, as in *Hofmann*, ACIA ignores the limitations placed upon Munson by the federal statutes governing Medicare and Medicaid, by the state statutes governing Medicaid and worker's compensation, and by the contractual arrangement between Munson and BCBSM. Defendant's argument therefore fails for the same reasons it did in *Hofmann*.

#### B. Burden of Proof.

[2] ACIA next addresses the burden of proof and correctly states that Munson bears the burden of proving both the reasonableness and the customariness of its charges according to *Nasser v. Auto Club Ins. Ass'n*, 435 Mich. 33, 49, 457 N.W.2d 637 (1990). ACIA contends that Munson failed to prove that the entire amount charged was the usual, ordinary, or common amount that a no-fault insurer expects to pay and that a health-care provider like Munson expects to be paid. ACIA also argues that the circuit court erred in failing to grant ACIA's motion for summary disposition after Munson failed to meet its burden of proof.

ACIA's argument is premised on the belief that its statutory construction would prevail; however, as shown above in *Hofmann*, ACIA's definition of "customary charges" is

erroneous. Moreover, ACIA's argument appears to be based upon a misperception of how Munson met its burden of proof in the context of a motion for summary disposition. A motion for summary disposition pursuant to MCR 2.116(C)(10) tests the factual support of a claim to determine whether the moving party is entitled to judgment as a matter of law, and a court decides the motion on the basis of the pleadings, affidavits, depositions, admissions, and other available evidence. *Radtke v. Everett*, 442 Mich. 368, 374, 501 N.W.2d 155 (1993). The moving party must specifically identify the issues on which there are no disputed facts, and that party also must support its position with affidavits, depositions, or other documentary evidence. *Patterson v. Kleiman*, 447 Mich. 429, 432, 526 N.W.2d 879 (1994); MCR 2.116(G)(4). The opposing party bears the burden of showing by evidentiary materials that a dispute exists regarding a genuine issue of material fact. *Skinner v. Square D Co.*, 445 Mich. 153, 160, 516 N.W.2d 475 (1994).

[3] Munson recognized that there was a dispute regarding a question of law (how to interpret the statute), but claimed that there were no disputed facts regarding whether the charges for medical services rendered to ACIA's insureds were Munson's customary charges. Munson supported its position with an affidavit of Edward Carlson, which stated that all parties were billed the same charge and that none of the twenty-five to thirty other no-fault insurers had ever claimed that Munson's charges were either unreasonable or not customary charges. This was sufficient to meet Munson's burden under *Patterson*.

[4] On the other hand, ACIA did not provide documentary evidence that identified specific facts to show that there was a dispute of material fact over whether the charges for medical services were Munson's customary charges. Instead, ACIA argued for its statutory interpretation of the term "customary charges" and reasoned that, *under its construction of the term*, Munson had failed to carry its burden of proving that the charges were customary. However, this failed to raise a genuine issue of fact regard-

ing Munson's interpretation, and left Munson's asserted facts uncontroverted. With no contested facts, the only remaining task for the court was to determine whether Munson was entitled to judgment as a matter of law. *Radtke, supra*. Because the circuit court determined that Munson's statutory interpretation was correct as a matter of law, the court properly granted summary disposition for Munson pursuant to MCR 2.116(C)(10)<sup>4</sup>.

### C. Discovery.

[5] ACIA next contends that the circuit court improperly granted summary disposition without permitting ACIA the opportunity to discover certain information from Munson. ACIA asserts that this problem resulted from Edward Carlson's refusal to answer certain questions during deposition and that the circuit court directed Munson to provide certain information when the subject arose during a settlement conference. Assuming, without deciding, that any harm was actually suffered, we note three sets of facts that lead to the conclusion that defendant bears the blame for any harm that occurred. First, following Carlson's deposition, ACIA did not file a motion to compel pursuant to MCR 2.313.

Second, there is no record evidence to support ACIA's assertion that the circuit court directed Munson to provide the information. The parties disagree about the details of providing any information, and we were unable to find any order, stipulation, memorandum, or other memorial of such an agreement that would provide a factual basis for reviewing the details in dispute.

Third, ACIA did not argue this issue in its response to Munson's motion for summary disposition, either in its own motion for summary disposition or orally during the hearing regarding the motions. The first time that

4. ACIA also argues that the circuit court erred to the extent that it relied upon the amendatory language of 1993 P.A. 143 when interpreting the no-fault statute—1993 P.A. 143 became Proposal C, which was rejected in the November 1994 general election. ACIA's brief neglected to mention that its counsel had, himself, engaged the circuit court in discussion about the amendment. Assuming that there was any resulting error, ACIA contributed to it, and cannot complain on

ACIA argued this issue was during its motion for rehearing. The circuit court found that the motion was untimely and lacked merit. An appellant cannot contribute to error by plan or design and then argue error on appeal. *Bloemsma v. Auto Club Ins. Ass'n (After Remand)*, 190 Mich.App. 686, 691, 476 N.W.2d 487 (1991). This is precisely what ACIA appears to have done in this case; ACIA's strategic decisions directly contributed to whatever error may have occurred. *Id.*

### D. "In Cases Not Involving Insurance."

[6] ACIA argues that the circuit court erroneously interpreted the phrase "in cases not involving insurance" in § 3157.<sup>5</sup> ACIA asserts that the phrase means "not involving *no-fault* insurance." (Thus, according to ACIA, it *is* appropriate to consider the amounts paid to Medicaid, Medicare, and BCBSM.) According to ACIA, Munson's interpretation of the phrase means, "in cases not involving *non-insurance based payors*," (i.e. *not including* payments made to Medicaid, Medicare, and BCBSM). As we have discussed previously, § 3157 was addressed in *Hofmann, supra*. There, the plaintiffs were chiropractors who charged different patients varying amounts, depending upon whether the patient had insurance. The plaintiffs claimed that they had not violated § 3157 because their "customary charge" billed to ACIA was the same amount that they billed other health insurers. (It was undisputed that the plaintiffs routinely billed individuals without any insurance an amount *less* than this "customary charge.") The Court rejected the plaintiffs' argument that the "customary charge" was the amount billed to all *insurers*:

First, from a legal standpoint, whether there has been an impermissible § 3157 overcharge is determined by looking to the provider's customary charge "in cases not

appeal about error to which it contributed. *Bloemsma v. Auto Club Ins. Ass'n (After Remand)*, 190 Mich.App. 686, 691, 476 N.W.2d 487 (1991).

5. "The charge shall not exceed the amount the person or institution customarily charges for like products, services and accommodations in cases not involving insurance." M.C.L. § 500.3157; M.S.A. § 24.13157.

involving insurance." Thus, a provider cannot avoid committing a § 3157 overcharge violation simply by claiming, as plaintiffs attempt to do here, that the amount charged in a no-fault case is the "customary charge," when in fact the provider customarily charges a lesser amount in cases not involving insurance.

\* \* \* \* \*

... [T]he relevant inquiry under § 3157 is not the amount that is customarily charged to other health insurers, but rather the amount that is customarily charged "in cases not involving insurance." [*Hofmann, supra* at 104–105, 107, 535 N.W.2d 529.]

From this, it is obvious that the phrase "in cases not involving insurance" means those situations where there is literally no "insurance" in the lay sense of the term—no Medicare, no Medicaid, no BCBSM, and so forth. ACIA's argument to the contrary fails.

#### E. Fairness.

[7] While the circuit court makes a good point that ACIA has a strong equitable argument, ACIA's unilateral decision to reimburse Munson according to the worker's compensation scheme cannot be upheld given the controlling statutory language of the no-fault act. In 1992, ACIA sought passage of a referendum, Proposal D, which would have permitted ACIA to pay no-fault claims according to fee schedules (and which required ACIA to reduce its premiums). Proposal D was soundly rejected. Again in 1994, ACIA attempted to obtain passage and approval of similar amendments, which would have expressly incorporated the worker's compensation fee schedules<sup>6</sup> with an accompanying premium rollback. Again the effort was unsuccessful. Despite its failure to obtain an amendment of the no-fault law, ACIA nonetheless unilaterally implemented the result it wanted. ACIA's use of criteria imposed by other statutory schemes or contractual agreements is hereby rejected as a matter of law. We affirm the ruling of the circuit court.

6. Proposal C would have provided for payment of charges at the greater of the worker's compen-

We note for the record the excellent quality of all the briefs on appeal and the oral argument presented by both parties and the amicus curiae, Michigan Health and Hospital Association.

Affirmed.



218 Mich.App. 501

**Edward McDOUGALL, Personal Representative of the Estate of Sandra M. McDougall, Plaintiff-Appellant/Cross-Appellee,**

v.

**Larry K. Schanz, Family Practice Center, Roger A. Shomo, D.O., P.C. and Marvin Coy, D.O., Defendants,**

and

**Reuben D. ELIUK, D.O., Defendant-Appellee/Cross-Appellant,**

and

**Frederick Broniak, D.O., Garden City Hospital, A. Kania, D.O., and Stephen B. Goldfarb, Defendants-Appellees,**

and

**Michigan Trial Lawyers Association, Michigan Defense Trial Counsel, and Michigan State Medical Society, Amici Curiae.**

Docket No. 178042.

Court of Appeals of Michigan.

Submitted April 16, 1996, at Detroit.

Decided Aug. 27, 1996, at 9:10 a.m.

Released for Publication Oct. 15, 1996.

Administrator of estate of patient who had died from complications arising from un-  
sation rates or 110 percent of BCBSM rates.