STATE OF MICHIGAN

COURT OF APPEALS

JILL ARNOTT

Plaintiff-Appellee,

v

BINSON'S HOSPITAL SUPPLIES, INC., and BINSON'S HOSPITAL SUPPLIES, INC., EMPLOYEE BENEFIT PLAN, a/k/a BINSON'S HOSPITAL SUPPLIES, INC., VOLUNTARY EMPLOYEE BENEFIT PLAN, ,

Defendants/Third Party-Plaintiffs-Appellants,

and

CONNECTICUT NATIONAL LIFE INSURANCE COMPANY,

Third Party-Defendant-Appellee.

UNPUBLISHED

No. 159726
LC No. 90-4889-CZ

Before: White, P.J., and T.G. Kavanagh* and S.N. Andrews,** JJ.

T.G. KAVANAGH, J., concurring in part and dissenting in part.

I concur with the majority that the jury's verdict in favor of plaintiff on her separate oral contract claim should be affirmed. I dissent, however, from the majority's analysis of plaintiff's ERISA claim.

Plaintiff presented sufficient evidence on her ERISA claim, subject to defendant's sole affirmative defense of a preexisting condition, to send the claim to the jury. Paragraph 4.13 of defendant's plan provided, in pertinent part:

---

* Former Supreme Court justice, sitting on the Court of Appeals by assignment.
** Circuit judge, sitting on the Court of Appeals by assignment.

> No payment of benefits will be made or provided for charges for health care expenses for any conditions which existed prior to the date the person became employed by the Employer, and for which the person received treatment within the 3 consecutive months immediately preceding the date employed. . . .

In this case, plaintiff testified that defendant's accountant assured her that the plan's preexisting condition clause no longer applied to her. Plaintiff's physician testified that, in his opinion, plaintiff did not receive "medical treatment" during the three months preceding her joining defendant's plan. Defendant's insurance coordinator told plaintiff that her surgery had been approved by the plan's administrator. Moreover, Midwest drafted checks to reimburse plaintiff's medical providers and forwarded them to defendant. Only after defendant's excess insurer, Connecticut National, denied coverage on the basis of a preexisting condition did Midwest also deny coverage. Conflicting evidence was presented by defendant and, therefore, plaintiff's ERISA claim was within the province of the jury to decide.

The trial court did not err in estopping defendant from raising the affirmative defense that plaintiff's medical expenses were excluded from coverage because they were not medically necessary. As a general rule, once an insurance company has denied coverage to an insured and stated its defense, the company has waived or is estopped from raising new defenses. *Smith v Grange Mutual Fire Ins Co of Michigan,* 234 Mich 119; 208 NW 145 (1926); *Lee v Evergreen Regency Cooperative,* 151 Mich App 281, 285; 390 NW2d 183 (1986). In its brief on appeal, defendant contends that it should not have been estopped from raising affirmative defenses, such as medical necessity, "when the facts upon which they are based are only learned at the time of trial." This contention is without merit, given that defendant had all the facts necessary to make its decision whether plaintiff's surgery was a covered benefit at the time it denied coverage solely on the basis of a preexisting condition. The subsequent deposition testimony of plaintiff's treating physician revealed no new *facts* regarding plaintiff's surgery, but instead only his *opinion* that it was not medically necessary. Thus, I would find that the general rule of estoppel was properly invoked.

A well recognized exception to the general rule of estoppel precludes its application where the result would be to broaden coverage of the policy beyond its express terms. *Ruddock v Detroit Life Ins Co,* 209 Mich 638, 654; 117 NW 242 (1920). The rationale for this exception to the general rule is that an insurer should not be required by waiver or estoppel to pay on a loss for which it charged no premium. *Lee, supra* at 285, quoting 1 ALR3d 1139, 1144. Defendant's reliance on this exception is mistaken because a finding of liability on the part of defendant will not result in broadening the coverage of the policy beyond its express terms, i.e., to include coverage for a surgical procedure that was not "medically necessary." Paragraph 13.1 of defendant's plan excluded coverage for any surgical, medical or other treatment "which is not medically necessary to the care and treatment of any Injury, Disease or Pregnancy of the covered individual." Plaintiff testified that she had various continuing complications from her original ileostomy, including skin irritation where her external appliance was attached to her abdomen, excessive emptying of her ostomy bag (every couple of hours, day and night), leakage of effluent where the ostomy bag attached to her body, and a propensity to become dehydrated because

of her system's inability to absorb enough liquid. The surgery at issue was intended not only to increase plaintiff's convenience and comfort, but to alleviate the irritation and ulceration of her stoma, to reduce the number of times that she would need to relieve herself from ten a day to approximately three, and to increase her ability to stay hydrated. I believe these facts preponderate in favor of a conclusion that the surgery was medically necessary. Moreover, plaintiff's surgery was "elective," which was defined under the plan as a non-emergency. Specific examples of covered "elective surgery" under the plan included such procedures as total knee or hip joint replacement, tonsillectomy, hysterectomy, and cataract removal. Certainly, if these procedures are deemed medically necessary because they improve the overall quality of life of a patient, then plaintiff's surgery was medically necessary.

Finally, even if plaintiff's physician was correct in opining that the surgery was not medically necessary, defendant was properly estopped on equitable grounds from raising the defense because "the inequity of forcing the insurer to pay on a risk for which it never collected premiums is outweighed by the inequity suffered by the insured because of the insurance company's actions." *Lee*, *supra* at 287. Defendant was aware that plaintiff intended to go forward with the surgery, which defendant also knew plaintiff could not afford without insurance, and plaintiff justifiably relied to her detriment on defendant's actions. In this case, the equities clearly weigh in plaintiff's favor, and defendant was properly estopped from raising the defense of medical necessity.

For these reasons, I would affirm the jury's verdicts in their entirety, and I would reverse the directed verdict in favor of third-party defendant Connecticut National Life Insurance Company.

/s/ Thomas G. Kavanagh