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No. 167772

STATE OF MICHIGAN
IN THE SUPREME COURT

JOSEPH CANTY,

Plaintiff-Appellant,
v.

MICHAEL MASON,

Defendant-Appellee.

ON APPEAL FROM THE COURT OF APPEALS
Court of Appeals Case No. 365327
3rd Circuit Court Case No. 21-004799-NI
Hon. Kathleen McCarthy

PLAINTIFF-APPELLANT'S SUPPLEMENTAL BRIEF APPENDIX

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STATEMENT OF QUESTIONS PRESENTED

I. **DID THE COURT OF APPEALS ERRONEOUSLY HOLD THAT ELDERLY MOTORISTS WHO RECEIVE MEDICARE AND OPT OUT OF PIP MEDICAL BENEFITS HAVE A DUTY TO PROVE THAT THEY TRIED TO MITIGATE THE MEDICAL EXPENSES BY SEEKING PAYMENT FROM MEDICARE IN THE FIRST INSTANCE WHERE MEDICARE IS SECONDARY PAYOR IN THIS SITUATION, WHERE THE BURDEN OF PROVING THE ABSENCE OF MITIGATION OF DAMAGES IS ON THE DEFENDANT, AND WHERE THE STATUTE EXPRESSLY HOLDS THAT THE DAMAGES ARE WITHOUT LIMITATION?**

Plaintiff-Appellant answers, "Yes."
Defendant-Appellee answers, "No."
Court of Appeals answers, "No"
The Trial Court interpreted the statute consistent with Plaintiff's view,

II. **DID THE COURT OF APPEALS ERR IN EXPANDING THE FEE CAP LIMITS OF** MCL 500.3157 **TO INCLUDE THIRD-PARTY CLAIMS FOR MEDICAL TREATMENT EXPENSES WHERE THE LEGISLATURE DID NOT INCLUDE THESE CLAIMS IN THEIR LIST OF ADOPTED STATUTES IN** MCL 500.3107**?**

Plaintiff-Appellee answers, "Yes."
The Trial Court answers, "No."
The Court of Appeals, "Yes."
Defendant-Appellant answers, "No."

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JURISDICTION

This involves an accident that took place on February 15, 2021. Plaintiff filed a lawsuit in Wayne County Circuit Court. Defendant subsequently filed motions for summary judgment which were denied. Defendant then filed an Application for Leave to Appeal in the Court of Appeals. This was granted and the case went through full briefing and arguments.

On October 4, 2024, the Court of Appeals reversed the trial court on both issues, Judge Mariani dissenting on the need to follow the statutory amount in tort claims. This Application for Leave to Appeal was filed on October 4, 2024. On September 17, 2025, this Court ordered oral arguments on the Application

> On order of the Court, the application for leave to appeal the October 4, 2024 judgment of the Court of Appeals is considered. We direct the Clerk to schedule oral argument on the application. MCR 7.305(I)(1). The parties shall file supplemental briefs in accordance with MCR 7.312(E), addressing: (1) whether a plaintiff seeking allowable expenses for medical treatment in a tort action under MCL 500.3135(3)(c) has a duty to mitigate their damages by seeking payment from Medicare; and (2) whether the fee schedules in MCL 500.3157 apply to a tort action under MCL 500.3135(3)(c).

Michigan Access to Justice (who filed an amicus brief at the application stage), The Insurance Alliance of Michigan, Michigan Defense Trial Counsel, Inc., and CPAN were specifically invited to file a supplemental brief.

This is Mr. Canty's brief.

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STATEMENT OF FACTS

Plaintiff believes that there are no real disputes as to the facts of the case and thus the facts prior to the Court of Appeals activity are taken from the brief of the Defendant (with minor changes but no additions).

Plaintiff Joseph Canty opted out of PIP benefits because he had Medicare.[1] When he needed medical care, he treated with a Veterans Affairs' provider.[2]

On February 15, 2021, Canty and Defendant Michael Mason got in a car accident.[3] After the accident, Canty treated with no-fault providers.[4] Those providers accepted Medicare, but they didn't bill Medicare or charge Medicare rates.[5] These rates were unrelated to the fee schedule in MCL 500.3157.[6]

Mr. Canty sued Mr. Mason under MCL 500.3135(3)(c) for unlimited allowable expenses.[7] Mason sought summary disposition on the portion of the bills that he argued Medicare

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[1] Canty's PIP opt-out form. Defendant's MSD, Appx 7-D.

[2] Defendant's MPSD, (7); Appx 7 .

[3] Complaint, Plaintiff's MOA Appx 5.

[4] Medical Bills, Defendant's MPSD MOA Appx 7C.

[5] Participating Insurers, Defendant's COA Appx 8E, p. 164.

[6] Medical Bills, MOA Appx 7C, p. 128-137.

[7] Complaint, MOA Appx 5.

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would have covered. He argued that Canty had a common law duty to mitigate his damages and use his Medicare. He also argued that Canty's recovery was limited to allowable expenses as defined in MCL 500.3107, which required applying the fee schedule in MCL 500.3157.[8]

At the hearing on Mason's motion for summary disposition, the trial court agreed that Canty had a duty to mitigate his damages.[9] The trial court found that Canty's providers weren't bound by the fee schedule in MCL 500.3157 because it was a third-party case.[10] Mason submitted an order under the 7-day rule. Canty objected.[11]

The trial court held a hearing on Canty's objections. During that hearing, the trial court reversed its ruling regarding Canty's common-law duty to mitigate damages. The trial court held that Canty had no duty to use his Medicare.[12] The trial court reaffirmed its holding that MCL 500.3107 defines allowable

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[8] Defendant's MPSD, MOA Appx 7.

[9] January 4, 2023 Hearing Transcript, MOA. Appx 9 (p. 13 Transcript.

[10] *Id.* at 23..

[11] Plaintiff's objections to Defendant's proposed 7-day order .

[12] Feb. 7, 2023 Hearing Transcript, Plaintiff S. Ct. Appx 8; Transcript, p. 37.

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expenses as stated in MCL 500.3135(3)(c) but that the fee schedule in MCL 500.3157 didn't apply in third-party cases.[13]

Mr. Mason filed an Application for Leave to Appeal in the Court of Appeals and leave was subsequently granted. After full briefing and argument, the Court reversed the matter in a published opinion. Two judges, Judge Gadola and Judge Swartzle, reversed the trial court on both issues. Judge Mariani concurred in part and dissented in part.

Canty, who had opted out of PIP insurance by relying on Medicare, argued that MCL 500.3135(3)(c) allowed him to recover medical costs without limitation. Mason, however, argued that Canty's recoverable expenses were constrained by the statutory fee schedules and by a duty to mitigate damages by using Medicare [*3].[14]

The majority concluded that MCL 500.3135(3)(c) requires Canty's damages to align with "allowable expenses" as defined in MCL 500.3107. Therefore, Canty's recoverable medical expenses must be "reasonable charges incurred for reasonably necessary products, services, and accommodations," [*8]. The

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[13] *Id.* at 37.

[14] Star pagination markers are tied to the Lexis version of the opinion available at *Canty v Mason*, No. 365327; 2024 Mich App LEXIS 7934 (Mich App 2024). This version of the decision appears in the Appendix to this brief at Appx. 2

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court further ruled that the fee schedules in MCL 500.3157 apply to limit Canty's recovery, as MCL 500.3135(3)(c) incorporates all relevant limitations within Chapter 31 of the Insurance Code, including the fee schedule provision, [*11] .

The majority also held that Canty had a duty to mitigate damages by utilizing available Medicare coverage. Under common-law mitigation principles, which apply by incorporation into MCL 500.3135(3)(c), Canty must take reasonable steps to limit his recoverable expenses. This includes billing Medicare for his treatment. If Canty's chosen providers do not accept Medicare, the trial court must assess the reasonableness of that choice, [*15].

Based on these conclusions, the court affirmed in part and reversed in part, remanding the case for further proceedings to assess the reasonableness of Canty's medical expenses and his provider choices given the duty to mitigate damages, [*17].

In his dissent, Judge Mariani agreed that "allowable expenses" under MCL 500.3107(1)(a) constrains tort damages and concurred with the duty to mitigate. However, he strongly disagreed with the majority's application of the fee schedules in MCL 500.3157 to Canty's tort claim. Mariani argued that the Legislature specifically referenced MCL 500.3107 through MCL 500.3110 in defining "allowable expenses" for tort recovery

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under MCL 500.3135(3)(c) and deliberately excluded the fee schedule in MCL 500.3157 [*19].

Judge Mariani maintained that applying MCL 500.3157 to limit tort damages extended beyond the statute's plain language and legislative intent. He contended that the Legislature intended to impose fee schedules solely on PIP claims, not tort actions. In his view, the statutory structure indicates distinct frameworks for no-fault benefits and tort claims, and the majority's interpretation improperly blurred this boundary, imposing unintended constraints on Canty's tort recovery, [*21].

This Application for Leave to Appeal was filed on October 4, 2024.[15] On September 17, 2025, this Court ordered oral arguments and supplemental briefs on the Application addressing the following: (1) whether a plaintiff seeking allowable expenses for medical treatment in a tort action under MCL 500.3135(3)(c) has a duty to mitigate their damages by seeking payment from Medicare; and (2) whether the fee schedules in MCL 500.3157 apply to a tort action under MCL 500.3135(3)(c). Michigan Access to Justice (who filed an amicus brief at the application stage), The Insurance Alliance of Michigan, Michigan Defense Trial Counsel, Inc., and CPAN were specifically invited to file a supplemental brief.

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[15] MOA App'x 1.

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This is Mr. Canty's brief.

STANDARD OF REVIEW

On appeal, a trial court's grant or denial of summary disposition is reviewed de novo.[16] This Court must review the record in the same manner as the trial court to determine whether the movant was entitled to judgment as a matter of law.[17] "A motion for summary disposition under MCR 2.116 tests whether there is factual support for a claim."[18] "When deciding a motion for summary disposition under MCR 2.116, a court must consider the pleadings, affidavits, depositions, admissions, and other documentary evidence submitted in the light most favorable to the nonmoving party." Id. "[A] court may not weigh the evidence before it or make findings of fact; if the evidence before it is conflicting,

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[16] *First Pub Corp v Parfet*, 468 Mich 101, 104; 658 NW2d 477 (2003).

[17] *Morales v Auto-Owners Ins Co*, 458 Mich 288, 294; 582 NW2d 776 (1998).

[18] *Shepherd Montessori Ctr Milan v Ann Arbor Charter Tp*, 259 Mich App 315, 324; 675 NW2d 271 (2003).

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summary disposition is improper."[19] Michigan courts are liberal in finding factual disputes for summary disposition purposes.[20]

Legal questions are likewise reviewed de novo.[21] This includes the interpretation of Michigan statutes and court rules.[22]

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[19] *Lysogorski v Bridgeport Charter Tp*, 256 Mich App 297, 299; 662 NW2d 108 (2003), citing *DeFlaviis v Lord & Taylor, Inc*, 223 Mich App 432, 436; 566 NW2d 661 (1997) (emphasis in original).

[20] *Piccione as Next Friend of Piccione v Gillette*, 327 Mich App 16; 932 NW2d 197 (2019).

[21] *In re Estate of Moukalled*, 269 Mich App 708, 713; 714 NW2d 400 (2006).

[22] *State Farm Fire & Cas Co v Corby Energy Servs., Inc*, 271 Mich App 480, 483; 722 NW2d 906 (2006); *Webb v Holzheuer*, 259 Mich App 389, 391; 674 NW2d 395 (2003).

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INTRODUCTION

This case involves multiple issues dealing with the appropriate metrics and burdens to be applied in cases involving personal injuries needing medical treatment in automobile negligence cases where the plaintiff has previously opted out of PIP – particularly those who are receiving Medicare. The published ruling below can easily be read to say that the Court of Appeals has placed the burden on the plaintiff to prove that they have mitigated damages. In all other areas of law and consistent with the common law, that burden falls on the Defendant to show a failure to mitigate damages. The last issue holds that the fee schedule contained in MCL 500.3157 for first party claims applies to third party claims even though the medical provider assumes a much higher risk treating these individuals.

A review of the majority opinion by Judge Swartzle and Gadola versus Judge Mariani's dissent in a published opinion shows that this case is an important case for this Court to consider. The panel sharply divided on a number of questions (many of first impression), including:

- *Definition of Allowable Expenses.* The majority interprets "allowable expenses" under MCL 500.3107(1)(a) as reasonable charges for services necessary for the injured party's care, recovery, or rehabilitation. This definition limits Canty's recovery to reasonable, necessary medical costs as specified in the statute, and governs the determination of allowable

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expenses in tort claims under MCL 500.3135(3)(c) [*8], [*10]. Judge Mariani superficially concurs with this interpretation, agreeing that allowable expenses must align with the statutory requirement of reasonable charges for necessary medical services. This agreement forms a foundation for assessing Canty's medical costs within the statute's language [*10], but note Judge Mariani's difference about the use of the fee schedule to limit expenses and the differing opinion on the without limitations language.

- *Applicability of Fee Schedule (MCL 500.3157***).** The majority asserts that the fee schedule established in MCL 500.3157 applies to Canty's tort recovery, reasoning that MCL 500.3135(3)(c) implicitly incorporates this provision through the broader framework of Chapter 31. According to the majority, this interpretation prevents Canty from bypassing the fee limitations by pursuing a third-party claim instead of no-fault benefits [*11]. The dissent however believes that MCL 500.3157's fee schedule is intended solely for first-party no-fault claims and was not legislatively intended to constrain tort damages under MCL 500.3135(3)(c). Judge Mariani maintains that applying the fee schedule here improperly broadens the statute beyond its explicit language, thereby contradicting the statutory separation of no-fault benefits and tort claims [*12].

- *Interpretation of "Without Limit" Language in MCL 500.3135(3)(c).* The majority interprets the "without limit" language as indicating that a plaintiff can recover allowable expenses starting from "dollar one" without the need to exhaust PIP benefits. However, it emphasizes that the term does not eliminate the statutory restrictions on recoverable expenses, such as the requirement for reasonableness and necessity, nor does it exclude fee schedules and other Chapter 31 limitations [*10]. Judge Mariani interprets the "without

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limit" phrase more expansively, contending that it reflects the legislature's intent to exclude fee schedules from tort claims under MCL 500.3135(3)(c). The dissent views the majority's limitation on the "without limit" language as narrowing the statutory scope without clear legislative authority to do so [*12];

- *Duty to Mitigate Damages by Utilizing Medicare Coverage.* The majority holds that Canty has a duty to mitigate damages by using available Medicare benefits where applicable. It emphasizes that under common-law principles incorporated by MCL 500.3135(3)(c), Canty cannot recover costs that could have been avoided by utilizing Medicare. If Canty seeks recovery for expenses charged by providers who do not accept Medicare, the reasonableness of his provider choice may be a factual issue for the trier of fact [*9]. The dissent concurs that Canty must mitigate damages by minimizing avoidable costs; however, Judge Mariani does not believe this principle should force Canty to limit his provider choices solely based on Medicare's availability. The dissent argues that tort victims should retain flexibility in their choice of care providers without being subject to rigid Medicare-based constraints [*9].

- *Majority Opinion*: The majority posits that the legislature, by referencing MCL 500.3107 within MCL 500.3135(3)(c), implicitly intended to incorporate all related limitations in Chapter 31, including the fee schedule. The majority argues that interpreting the statute otherwise would render parts of Chapter 31 surplusage and disregard the legislature's presumed awareness of these statutory interconnection. Conversely, Judge Mariani's dissent criticizes this approach, arguing that the majority's reading overreaches by incorporating additional limitations not specified by MCL 500.3135(3)(c). The dissent asserts that the majority's

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> interpretation disregards the distinct statutory purposes of tort recovery and no-fault benefits and effectively rewrites the statute to impose unintended constraints on tort recoveries [*12].

The Court of Appeal ruling, as it stands, has the effect of allowing the Defendant's in these cases to simultaneously maintain that the plaintiff should lose because they failed to take enough efforts to rehabilitate from their injuries or because the plaintiff overworked their rehabilitation thereby failing to minimize the medical expenses. This creates an untenable heads they win; tails we lose situation.

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ARGUMENT

I. OUR LEGISLATURE HAS ALLOWED ELDERLY MOTORISTS WHO RECEIVE MEDICARE TO OPT OUT OF PIP MEDICAL BENEFITS. MEDICARE IS STATUTORILY BARRED FROM BEING THE PRIMARY INSURER IN THESE CASES. THIS HAS CREATED A DIFFICULT SITUATION FOR PATIENTS AND MEDICAL CARE PROVIDERS WHO ARE NECESSARILY TAKING ON AN ADMINISTRATIVE NIGHTMARE AND DELAYED PAYMENTS AT A MINIMUM AND LITIGATION AT WORST. THE COURT OF APPEALS RULING HAS MADE THE SITUATION MUCH WORSE BY NOW POTENTIALLY SAYING THAT THE ELDERLY MOTORIST MUST PROVE THAT THEY MITIGATED DAMAGES AND BY STRONGLY SUGGESTING THAT MEDICARE WILL PAY BENEFITS THAT THEY WILL NOT.

The Court of Appeals' opinion creates a poorly defined duty to mitigate before pursuing third party medical claims. A careful reading of the case shows that a court could easily believe that the Court shifted the burden of proof concerning mitigation of damages to the Plaintiff.

Defendant has not questioned the treatment; he has questioned the prices the Plaintiff's doctors and medical providers

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have chosen for their services. Medical services are, by their definition, highly personal, and a poor choice of doctors can result in catastrophic results. A doctor/patient relationship is highly personal and the selection process of the appropriate doctor should not be curtailed through the Defendant's novel argument.

This brief will argue that a plaintiff seeking allowable expenses for medical treatment in a tort action under MCL 500.3135(3)(c) does not have a duty to mitigate their damages by seeking payment from Medicare; and (2) whether the fee schedules in MCL 500.3157 do not apply to a tort action under MCL 500.3135(3)(c).

A. A Plaintiff Seeking Allowable Expenses in a Tort Action Under MCL 500.3135(3)(c) Does Not Have a Duty to Mitigate Damages by Seeking Payment from Medicare.

Mitigation of damages is an affirmative defense, and proof of Plaintiff's failure to mitigate rests upon the defendant.[23] Reviewing

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[23] *Fothergill v McKay Press*, 374 Mich 138; 132 NW2d 144 (1965); *Froling v Bischoff*, 73 Mich App 496, 499; 252 NW2d 832 (1977); *Walters v Nadell*, 481 Mich 377; 751 NW2d 431 (2008) (defendant must establish factual basis for affirmative defenses). *See gen* 3 Diana T. Axelrod, Richard P. Goldstein, Clark D. Kimball, Marilyn Minzer, & Jerome H. Nates, Damages in Tort Actions § 16.01 (Matthew Bender & Company, Inc., 2025) ("Mitigation of damages is an affirmative defense on which the defendant bears the burden of proof. The affirmative defense of mitigation of damages requires the defendant to prove that the plaintiff failed to exercise reasonable care to mitigate his or her post-injury damages").

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the Court of Appeals opinion, one would easily believe the law was to the contrary.[24]

The defendant bears the burden of proving that the Plaintiff failed to make reasonable efforts to mitigate damages. *Id.* The question of whether the Plaintiff's efforts to mitigate damages were reasonable under the circumstances is one for the trier of fact.[25] Defendant may very well be entitled to a jury instruction such as M Civ JI 53.05 (Mitigation of Damages--Failure to Exercise Ordinary

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[24] Some examples include the following statements: "It is incumbent on a person who has been harmed by the commission of a tort to use such means that are reasonable under the circumstances to minimize or mitigate the amount of damages" and a plaintiff "is not entitled to recover for any item of damage that could have been avoided." *Canty v Mason*, 2024 Mich App LEXIS 7934, *13–14. The Court further reaffirmed that, because "the no-fault act does not specifically abrogate the common-law principle that a plaintiff is obligated in a tort action to mitigate his or her damages, the defense remains viable," id. at *14, the plaintiff must demonstrate that his conduct was reasonable, including that "the failure to seek payment from Medicare would not have been reasonable as a matter of law if the medical provider accepted Medicare." Id. at *16. Correspondingly, any recoverable damages require proof that the expenses were "reasonably necessary" and that "the charge was reasonable." Id. at *10 n 5 (citing Douglas). The Court also emphasized that "the trier of fact must resolve whether any incurred expenses… were reasonably incurred for purposes of mitigating damages." Id. at *16–17.

[25] *Morris v Clawson Tank Co*, 459 Mich 256, 271; 587 NW2d 253 (1998). See also *Landin v Healthsource Saginaw, Inc*, 305 Mich App 519, 539; 854 NW2d 152 (2014).

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Care) but they have not demonstrated that they are entitled to summary disposition on this affirmative defense.

Mitigation of damages is normally a question of fact for a jury, not for summary disposition.[26] There is a real danger that his process will expand the law on first-party claims to much more complex third-party claims where there is no guarantee of ever being paid.

In *Klanseck v Anderson Sales & Serv, Inc*, 426 Mich 78, 91; 393 NW2d 356 (1986), this Court stated that it "is well-settled that an injured party has a duty to exercise reasonable care to minimize damages, including obtaining proper medical or surgical treatment. While the Court found that the evidence was slight supporting that plaintiff's failure to mitigate damages by declining some treatment recommended by his doctor, this Court stated that the issue belonged to a jury. Applying *Klanseck*, the Court of Appeals explained in *Brehmer v. State Farm Mut. Ins. Co.*, No. 318839, 2015 Mich. App. LEXIS 530, at *9 (Ct. App. Mar. 17, 2015) (App. 10:

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[26] *Blatt v Coll of Staten Island*, No. 04-CV-2263 (ERK), 2005 WL 8160053, at *4 (EDNY, November 30, 2005) (App'x 14) ("While this alleged failure to mitigate may be pressed by the defendants at trial, at this juncture there cannot be a determination as a matter of law, to preclude the plaintiff from seeking back pay"). S*ee also Chainey v St*, No. CIV.A. 03-6248, 2005 WL 696883, at *2 (ED Pa, March 22, 2005) (App'x 15) ("There is no doubt that some mitigation of damages may be called for, but at [the summary judgment] stage such a ruling is premature,").

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> An injured party's duty to exercise reasonable care to minimize damages includes the obligation to obtain proper medical or surgical treatment. *Klanseck v Anderson Sales & Serv, Inc*, 426 Mich 78, 91; 393 NW2d 356 (1986). The defendant has the burden to prove that a plaintiff failed to make a reasonable effort to mitigate his or her damages. *Landin v Healthsource Saginaw, Inc*, 305 Mich App 519, 539; 854 NW2d 152 (2014). "The question whether the plaintiff's efforts to mitigate damages were reasonable under the circumstances is one for the trier of fact." *Id*.

While *Brehmer* is unpublished it nicely explains Michigan law on the subject. *See also Webster v Edward D Jones & Co, LP*, 197 F3d 815, 821 (CA 6, 1999) (applying Michigan law and reversing for new trial on damages and directing that the jury be instructed on the plaintiff's duty to mitigate and on the defendant's burden to show that the plaintiff failed to do so).

Any duty to mitigate, however, does not override a plaintiff's right to choose the doctor of their choosing or to credit their advice. In *Geer v First Nat'l Supermarkets, Inc*,[27] for example, the defendant argued that the plaintiff had failed to mitigate her damages because she did not "pursue a treatment plan

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[27] *Geer v First Nat Supermarkets, Inc*, 5 Conn App 175, 178; 497 A2d 999 (1985).

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advised by the defendant's medical expert." The court rejected that argument unequivocally, holding that it was "not unreasonable for the plaintiff wife to follow the treatment recommendations of her own doctor and that her actions were those of a reasonably prudent person." Id. at 178. *Geer* thus illustrates the well-settled rule that a plaintiff satisfies the duty to mitigate when she follows the advice of her own providers, even when the defendant's expert asserts that a different course of treatment might have been preferable. The law does not penalize a patient for selecting one medically accepted option over another, nor does it require her to choose the least expensive, least invasive, or defendant-endorsed option.

Similarly, the Wisconsin Supreme Court has noted that a plaintiff's duty to mitigate did not require them to go to the nearest hospital or doctor when the plaintiff had a preference to be treated by a more distant doctor and this caused a delay in getting treated. *Burke v Natl Farmers Union Prop & Cas Co*, 36 Wis 2d 427, 439; 153 NW2d 545 (1967) ("an injured person is not required to undergo treatment at the nearest hospital or with the nearest doctor"). *Burke* reinforces that the duty mitigate is a standard of reasonableness, not a mandate to select defense retroactively approved medical providers. A defendant should not be able to dictate the plaintiff's provider selection under the guise of a mitigation defense.

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Mitigation of damages doesn't require the Plaintiff to take the cheapest doctor. In the area of wrongful discharge, the Court of Appeals had the opportunity to remark:[28]

> It is well established that a plaintiff must make every reasonable effort to mitigate damages. *Edgecomb v Traverse City Sch Dist*, 341 Mich 106, 115; 67 NW2d 87 (1954); *Rich v Daily Creamery Co*, 296 Mich 270, 282; 296 NW 253 (1941). Such a defense, however, is an affirmative one, and proof of Plaintiff's failure to mitigate rests upon the defendant. *Fothergill v McKay Press*, 374 Mich 138; 132 NW2d 144 (1965); *Froling v Bischoff*, 73 Mich App 496, 499; 252 NW2d 832 (1977). A wrongfully discharged employee is obligated to mitigate damages by accepting employment of a "like nature". *Flickema v Henry Kraker Co*, 252 Mich 406; 233 NW 362 (1930); *Michigan Employment Relations Comm v Kleen-O-Rama*, 60 Mich App 61; 230 NW2d 308 (1975). The criteria for determining "like nature" include the type of work, the hours of labor, the wages, tenure, working conditions, etc. Whether or not an employee is reasonable in not seeking or accepting particular employment is a question for the trier of fact. 2 Restatement (Second) of Agency § 455 (1958), comment

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[28] *Higgins v Lawrence*, 107 Mich App 178, 181–82; 309 NW2d 194 (1981).

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> d, p. 373, Restatement (First) of Contracts § 336 (1932) Williston, Contracts (3rd ed.), s 1359, p. 306.
>
> In the instant case, the trial court made the following pertinent findings of fact: that the evidence gave no indication that if Plaintiff sought employment he would have obtained it within the 60-day period; that the contract limited plaintiff to seeking employment in an area outside of a ten mile radius; that podiatry is a profession rather than a job; and that Plaintiff required at least 60 days to find proper employment. Hence, the trial court concluded that the burden of proof on mitigation of damages had not been met by defendant.

While the appellate court played lip service to this principle, their opinion also suggests that the Plaintiff has a duty of showing an objective reason for choosing a course of treatment which results in additional costs to the Defendant.[29]

As noted earlier in this issue, the Court of Appeals opinion may easily be read as saying that someone who opts out of PIP coverage because they have Medicare assumes the burden for their own medical treatment even though federal law passed long before

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[29]*Canty*, 2024 Mich App LEXIS 7934, at *16 ("if necessary, the trier of fact must resolve whether any incurred expenses for services rendered by providers who did not accept Medicare were reasonably incurred for purposes of mitigating damages").

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this amendment reduced Medicare to a secondary payor in this situation.[30]

The duty to mitigate damages also does not mean that the Plaintiff had to follow the Defendant's previously undisclosed roadmap.[31] Claims are time sensitive, and the Plaintiff has to make the choice early to determine the most appropriate course to deal with an ailment which could be cured with one session or require continuous course of treatments.[32]

Mitigation of damages should not be used as an exercise in armchair quarterbacking the Plaintiff's decisions. Defendant's viewpoint would attribute to the Plaintiff a duty to know the insurance and coverage ramifications of his decisions very early in

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[30] *Canty*, 2024 Mich App LEXIS 7934, at 15–16 (rejecting the trial court's suggestion that Medicare could not be considered on mitigation because Medicare is "exempt from the no-fault statute," and explaining that federal law "did not prohibit Canty from receiving Medicare benefits for medical expenses incurred as a result of the accident," and that failure to seek Medicare payment would be unreasonable if a provider accepted Medicare).

[31] *See Aristocrat Leisure Ltd v Deutsche Bank Tr. Co Americas*, 727 F Supp 2d 256, 279 (SDNY, 2010) ("Proof of mitigation of damages requires only a showing that plaintiff took reasonable steps to cut its losses, not that plaintiff did what the defaulting defendants would have had it do, or what in hindsight seems most effective to reduce the defaulting defendants' damages.").

[32] *Aristocrat Leisure Ltd*, 727 F Supp 2d at 279 ("'[D]efendant [must] establish not only that the plaintiff unreasonably failed to mitigate, but that reasonable efforts would have *reduced* the damages.' ").

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the proverbial game and it is has not even been demonstrated Medicare coverage would have been available to him for accident related coverage. Placing the burden on the Plaintiff would allow the Defendant to fault the Plaintiff for receiving too much (not reasonable actions) or too little treatment (failing to mitigate).

While the Defendants have previously spoken contemptuously of doctors who service automobile victims, they also neglect to indicate that these doctors may have developed an infrastructure to assist people with these injuries. These doctors may well be the best equipped and most willing to assume the risks and complexities of handling a case involving state laws and federal laws which are at sometimes at odds with each other. They also assume a much greater risk of non-payment of fees.

B. Medicare as a Unique Secondary Payer With Very Limited Responsibilities in a Third Party Claim Under Michigan's No Fault Law.

Medicare is strictly a secondary payer whenever a "primary plan," including automobile liability insurance, is available.[33] Medicare may make conditional payments, but only if

[33] 42 USC 1395y(b)(2).

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reimbursement is guaranteed; it may not be treated as an ordinary primary insurer.[34]

Because Mason carried automobile liability insurance, Medicare cannot be the primary payor as a matter of federal law, and any payment would be conditional and must be reimbursed from the tort judgment. This extinguishes any conceivable mitigation argument.

Mitigation requires reasonable steps a plaintiff can lawfully take. A duty to seek illegal primary payment from Medicare is neither lawful nor reasonable. In fact, the trial court initially recognized exactly this: submitting to Medicare only creates a lien and therefore *does not reduce the harm*. That is the opposite of mitigation.

C. *Even assuming Medicare paid, Michigan law prohibits the introduction or use of Medicare payments to reduce damages. Medicare is expressly excluded from the collateral-source statute. A plaintiff cannot mitigate with something the Legislature has declared inadmissible and legally irrelevant.*

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[34] *Marietta Mem Hosp Employee Health Benefit Plan v DaVita Inc*, 596 US 880; 142 S Ct 1968; 213 L Ed 2d 376 (2022); *Aetna Life Ins Co v Big Y Foods, Inc*, 52 F4th 66 (CA 2, 2022) (discussed extensively in the MAJ original amicus brief at p.23).

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Even assuming Medicare paid, Michigan law prohibits the introduction or use of Medicare payments to reduce damages.[35] Medicare is expressly excluded from the collateral-source statute. A plaintiff cannot mitigate with something the Legislature has declared inadmissible and legally irrelevant.

MCL 600.6303 clearly provides that in a personal-injury action seeking recovery for medical expenses and other enumerated losses, the court may consider evidence *after a verdict and before entry of judgment* that some or all of the claimed losses were paid or are payable by a collateral source. If the court determines that a collateral source has paid or owes payment for part of the plaintiff's economic loss, the court must reduce the economic-loss portion of the judgment by that amount, subject to the limitations in subsection. The Court then deducts from that figure any premiums the plaintiff, the plaintiff's family, or the plaintiff's employer paid to obtain the particular benefit, except premiums for insurance mandated by law. For purposes of this section, a "collateral source" includes insurance benefits; benefits under contracts with health-care, dental-care, or HMO corporations; employee benefits; Social

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[35] MCL 600.6303(4); *Tebo v Havlik*, 418 Mich 350; 343 NW2d 181 (1984); *Nasser v Auto Club Ins Ass'n*, 435 Mich 33; 457 NW2d 637 (1990); *Greer v Advantage Health*, 305 Mich App 192; 852 NW2d 198 (2014)

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Security; workers' compensation; and *Medicare*.[36] In fact, the exclusion applies by its plain terms to all benefits "paid or payable" by a legal entity that timely asserts a contractual lien pursuant to MCL 600.6303(3).[37]

D. Defendant Has the Burden of Proof on a Failure to Mitigate Defense.

At various points in the Court of Appeals opinion, the majority stated that the Plaintiff rather than the Defendant carried the burden of proving reasonable efforts to mitigate damages.

Specifically, the court determined that Canty had to show that the charges by his medical providers were reasonable and necessary under MCL 500.3107 and its interpretation of allowable expenses. This could be easily read to mean that Canty must demonstrate that the medical expenses incurred were not only necessary but also reasonable, which could extend to proving the reasonableness of his choice in medical providers.[38]

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[36] It does not include life-insurance proceeds or payments by entities entitled to a statutory lien against the plaintiff's recovery.

[37] *Greer*, 305 Mich App at 207

[38] The opinion additionally makes clear that a plaintiff pursuing allowable-expenses damages must select medical providers in a manner consistent with cost efficiency and economic reasonableness. The Court emphasized that recoverable allowable expenses must be "reasonable charges" for "reasonably necessary" services, *Canty*, 2024 Mich App LEXIS 7934, *10 n 5, thereby placing the burden on the plaintiff to demonstrate that the chosen treatment and associated costs were prudent.

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As noted above, the Defendant *not* the Plaintiff has to prove failure to mitigate. Nothing in this statute purports to abrogate this common law defense. As this Court has recently noted:[39]

> We presume that the Legislature "know[s] of the existence of the common law when it acts. heretofore, we have stated that "[w]e will not lightly presume that the Legislature has abrogated the common law" and that "the Legislature should speak in no uncertain terms when it exercises its authority to modify the common law.

The fact that the Defendant's doctor may have accepted Medicare for some procedures does not prove they would have accepted it for these procedures and/or more importantly that Medicare would have agreed to pay the claim. As is discussed later

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The Court further held that, under both MCL 500.3109(1) and common-law mitigation principles, "the failure to seek payment from Medicare would not have been reasonable as a matter of law if the medical provider accepted Medicare," id. at *16, directly signaling that a plaintiff may not unreasonably bypass lower-cost, Medicare-participating providers or payment avenues. Reinforcing this, the Court concluded that the trier of fact must determine "whether any incurred expenses for services rendered by providers who did not accept Medicare were reasonably incurred for purposes of mitigating damages," id. at *17, confirming that the plaintiff bears the burden to justify the cost-efficiency of selecting higher-priced, non-Medicare providers.

[39] *Murphy v Inman*, 509 Mich 132, 153; 983 NW2d 354 (2022)

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in this issue, Medicare has actually promulgated policies stating that the automobile insurer is the primary provider of coverage in accident-related treatment and they are secondary. The Defendant has presented no evidence showing that Medicare would have covered this accident.

Because the Defendant was permitted, over Plaintiff's objection, to prematurely appeal on the duty to mitigate issue before the issue was ripe, there is not a proper record below. From the limited record available, the Court of Appeals assumed that: "Canty was covered by an automobile insurance policy; however, he had "elect[ed] to not maintain coverage for [PIP] benefits payable under section 3107(1)(a)."[40] He was able to do so because he otherwise had "qualified health coverage," MCL 500.3107d(1), in the form of "parts A and B of the federal Medicare program," MCL 500.3107d(7)(b)(ii). The Court of Appeals noted that "[b]enefits provided or required to be provided under the laws of any state or the federal government shall be subtracted from the [PIP] benefits otherwise payable for the injury under this chapter." MCL 500.3109(1).[41]

The Court of Appeals remanded the matter to allow Mr. Canty to show why he opted for treatment outside the Medicare

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[40] MCL 500.3107d(1).

[41] *Canty* at *3.

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regime, but it is not entirely clear that this remand also allowed him to explain why Medicare is not the primary insurer in this situation and that the Michigan scheme in fact allows seniors to opt out of PIP coverage even though Medicare will never be the primary insurer under these circumstances. That Court's exact language was: "that, if necessary, the trier of fact must resolve whether any incurred expenses for services rendered by providers who did not accept Medicare were reasonably incurred for purposes of mitigating damages."[42]

42 U.S.C. § 1395y(b)(2)(A)(ii) ("MSP") states that Medicare is a secondary provider and that their duty is subordinate to any automobile negligence policy which might be responsible for costs related to the accident. 42 CFR 489.20(g) states that providers commit "[t]o bill other primary payers before Medicare").[43]

> "Medicare does not make payment for covered items or services to the extent that payment has been made, or can reasonably be expected to be made under a liability insurance policy or plan."[44] Medicare has a

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[42] *Canty* at *16

[43] *See also Gregg v Providence St Joseph Health*, 519 F Supp 3d 693, 701 (ND Cal, 2021).

[44] Medicare Secondary Payer (MSP) Manual, Ch. 2, s. 40 -Liability Insurance (2023). As one federal judge explained the purpose of this manual:

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> "statutory, direct right of recovery from liability insurance was well as any entity that has received payment directly or indirectly from the proceeds of liability insurance payments. Medicare's recovery rights take precedent over the claims of any other party, including Medicaid." *Id,* 40.1.

This statute was enacted in 1980 to reduce federal health care costs by transforming Medicare from the primary payer to the secondary payer, with a right of reimbursement.[45] The MSP "makes Medicare the secondary payer for medical services provided to Medicare beneficiaries whenever payment is available from another

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> The Medicare Secondary Payer manual is a lengthy and comprehensive agency manual governing the complex workings of the Medicare Secondary Payer program and reflects the longstanding policy of the agency. While the majority opinion is correct when it says that such policy statements and guidance interpretations are not entitled to the force of law, it ignores what is required of us in the way of deference to agency interpretations of the complex statutory and regulatory schemes they administer. Statements and guidance interpretations such as the Medicare Secondary Payer manual "reflect 'a body of experience and informed judgment to which courts and litigants may properly resort for guidance."

Bradley v Sebelius, 621 F3d 1330, 1341 (CA 11, 2010) (Martin, J. dissenting).

[45] *See United States v Baxter Intern, Inc*, 345 F3d 866, 874 (CA 11, 2003); *Bradley*, 621 F3d at 1335–37.

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primary payer."[46] "This means that if payment for covered services has been or is reasonably expected to be made by someone else, Medicare does not have to pay . . . ."[47]

Medicare is expressly precluded from making payment where payment "'has been made or can reasonably be expected to be made' under liability insurance including*** no-fault insurance."[48] Providers who accept Medicare, must generally bill the providers, physicians, and other suppliers "prior to the expiration of the promptly period rather than bill Medicare."[49]

Medicare was not a viable alternative and forcing the U.S. Government to assume Defendant's legal obligation of damages shifts financial responsibility to the taxpayers rather creating a method to mitigate damages. At the very least, this Court should modify the Court of Appeals opinion to allow the Plaintiff to present evidence concerning what Medicare will cover in this matter.

E. A Doctor Who Chooses to Treat a Patient Based on the Hopes that a Third Party Will Ultimately

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[46] *Cochran v US Health Care Fin Admin*, 291 F3d 775, 777 (CA 11, 2002).

[47] *Id.; see* 42 USC 1395y(b)(2)(A)(i) (2006).See also 1 Guide to Medicare Secondary Payer Compliance § 1.01 (Matthew Bender, 2024).

[48] MSP Manual, Ch. 2, s. 40.2(A) – Difference Between Liability Insurance and Other Primary Plans.

[49] Id. s. 40.2(B) – Billing Options and Requirements Alternate Billing.

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be Deemed Responsible for the Payment is Not Analogous to a First Party Claimant Where Prompt Payments are Guaranteed and Where Fault Does Not Need to be Determined.

A doctor who agrees to treat under these circumstances is not akin to a PIP treater. They are not assured prompt payment of a claim, the patient may not be able to directly afford to pay the doctor and even if they are, it might take years to become whole assuming the patient does not declare bankruptcy.

A physician who opts to treat a person based on the hope that they prevail against a third party is taking a much greater risk than collecting against a third party and thus is similar to the increase in hourly attorney fees in civil rights cases..[50] In litigation under 42 USC 1983, courts can increase attorney fees somewhat to compensate for the risk an attorney takes taking a case on a contingency basis.[51]

As the *Mitchell* Court recognized:[52]

> [In] Certain conditions, courts have recognized an upward or downward adjustment of attorney fees. *Id.* at 434; *Howard v Canteen Corp*, 192 Mich App 427, 439; 481 NW2d 718 (1991), Rafferty v Markovitz, 461 Mich 265; 602 NW2d 367

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[50] Cf Mitchell v Cole, 196 Mich App 675, 680; 493 NW2d 427 (1992).

[51] Id.

[52] *Mitchell*, 493 NW2d at 430.

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> (1999). The burden of establishing the circumstances under which an enhancement is appropriate is on the fee applicant. Blum, supra at 898. Conclusory statements regarding the complexity of the case and significant results are not enough to justify enhancement. Id. The determination whether an enhancement is appropriate in each case is within the discretion of the trial court. *Pennsylvania v Delaware Valley Citizens' Council for Clean Air*, 483 US 711, 728; 107 S Ct 3078; 97 L Ed 2d 585 (1987). We have recently recognized that this discretion is limited and that an enhancement should be saved for those rare circumstances where an attorney's work is so superior and outstanding that it exceeds the client's expectations. Howard, supra at 439. In addition, where the enhancement is necessary to attract competent counsel, the court may apply a multiplier within reason. Id. at 439-440.

The Legislature may very well have considered this purpose when not applying the feel schedule contained in MCL 500.3107.

Moreover, choosing a doctor is an incredibly personal decision. The Plaintiff has the right to choose his medical provider based on his comfort with the provider, his belief in their medical abilities, and his experience in the relevant areas of medicine. A person's decisions regarding their physical treatment are deeply

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personal.[53] At the summary disposition hearing, Plaintiff presented evidence that he attempted to be reimbursed by Medicare for these treatments and was denied.

F. Like the Court of Appeals, this Court Should Decline to Address Defendant's Passing Comments About Potential Veteran's Benefits.

It should be noted that while Defendant briefly mentioned that Plaintiff had access to Veteran's benefits, their question presented and their brief speaks about Medicare.[54] Issues are necessarily limited by their Statement of Questions Presented, and

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[53] *See, e.g. Cruzan by Cruzan v Dir, Missouri Dept of Health*, 497 US 261, 287; 110 S Ct 2841; 111 L Ed 2d 224 (1990) (O'Connor, J. concurring).

[54]Mason referenced the Veterans Administration only in passing to describe his pre-accident medical history, noting merely that he had previously received his medical care through a VA provider, (Appellee's Ans. to App, p. 4), and asserting that after the accident he chose neither Medicare nor the VA but instead sought treatment from well-known no-fault providers who accepted Medicare but did not bill it, (Appellee's Ans. to App, p. 4), while later reiterating that Canty "apparently treated with a Veterans Affairs provider" such as a local VA clinic before the crash, (Appellee's Ans. to App, p. 6), yet nowhere in its brief did the Appellee articulate, develop, or rely upon a Veterans Administration payor theory, nor did it analyze VA eligibility, VA billing rules, coordination with Medicare, or any statutory mechanism by which VA care could reduce tort damages, confirming that the VA was invoked only as factual background and not as a serious payor-defense argument, (Appellee's Ans. to App, p. 6).

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Plaintiff will confine himself to that point.[55] Should the Defendant make the needed correction to the point issue and advance this issue which would give the Defendant further and difference relief before this Court, then this Court should ignore the same because it was never addressed by the Court of Appeals, there are no reasons for this Court to entertain such an issue for the first time on appeal to this Court, and it would require factual development.

The Veteran's Administration and the level of medical treatment it provides to veterans have been a sore spot in our nation's history.[56] As noted above, failure to mitigate damages is an affirmative defense which the Defendant must shoulder the burden. They have not offered any evidence suggest the unreasonableness of the Defendant's choices of doctors.

This Court should affirm the trial court's ruling and reverse the Court of Appeals ruling.

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[55] The scope of this appeal is limited to those issues that are set forth in defendant's statement of questions presented. *City of Lansing v Hartsuff*, 213 Mich App 338, 351; 539 NW2d 781 (1995); *Meagher v McNeely & Lincoln, Inc*, 212 Mich App 154, 156; 536 NW2d 851 (1995).

[56] See, eg. A Continued Assessment of Delays In Va Medical Care And Preventable Veterans Deaths, COMMITTEE ON VETERANS' AFFAIRS, U.S. HOUSE OF REPRESENTATIVES ONE HUNDRED THIRTEENTH CONGRESS, SECOND SESSION, Serial No. 113-64, U.S. GOVERNMENT PUBLISHING OFFICE (Washington DC, 2015).

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II. THIRD-PARTY CLAIMS FOR MEDICAL TREATMENT EXPENSES ARE NOT SUBJECT TO THE LIMITATIONS OF MCL 500.3107, WHICH APPLIES ONLY TO FIRST PARTY PERSONAL PROTECTION INSURANCE BENEFITS; THE COURT OF APPEALS ERRED IN IMPOSING SUCH LIMITATIONS ON THIRD-PARTY CLAIMS.

Plaintiff's third-party claim for the allowable expenses of his medical treatment is not restricted by MCL 500.3107. That statute on its face is restricted to first party claims for "personal protection insurance benefits. The Court of Appeals erred in engrafting this limitation into third party claims. The doctors who choose to treat cases such as this one are not guaranteed prompt payment; they may not be paid at all. Even if they are ultimately paid, the payments are significantly more complicated to obtain. They must first bill the third-party driver's insurance. If that fails, they may be able to bill Medicare as a secondary provider. These files are far from routine and providers may ultimately decide that it "just isn't worth treating these individuals.

A. The Court of Appeals Erred in Engrafting the 1st Party Fee Schedule to 3rd Party Claims. The Legislature Did Not Specifically Adopt the Schedule and the Court of Appeals Erred Pulling it in from the Penumbra of the Statute.

While the Defendant and the Court of Appeals majority spent a great deal of time speaking about some undisputed canons of

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statutory construction they avoid the text of the statutes at issue and effectively make a policy based argument that this Court should treat the cardinal principle of the no-fault statute as not increasing the cost of health care, and then propose an activist construction of the statute to reach their policy based aim. They infer that this Court should second guess the Plaintiff's choice of doctor, treatment, and then engraft provisions on third party claims that were made expressly applicable to first party claims.

The first piece in the Defendant's convoluted road map is MCL 500.3135 which provides:

> (3) Notwithstanding any other provision of law, tort liability arising from the ownership, maintenance, or use within this state of a motor vehicle with respect to which the security required by section 3101(1) was in effect is abolished except as to:
>
> (c) Damages for allowable expenses, work loss, and survivor's loss as defined in sections 3107 to 3110, including all future allowable expenses and work loss, in excess of any applicable limit under section 3107c or the daily, monthly, and 3-year limitations contained in those sections, or without limit for allowable expenses if an election to not maintain that coverage was made under section 3107d or if an exclusion under section 3109a(2) applies. The party liable for damages is entitled to

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> an exemption reducing his or her liability by the amount of taxes that would have been payable on account of income the injured person would have received if he or she had not been injured.

MCL 500.3135. Defendant theorizes that this Court should read this phrase to mean the same thing as the phrase allowable expenses under MCL 500.3107 which provides in relevant part:[57]

> Sec. 3107. (1) Subject to the exceptions and limitations in this chapter, and subject to chapter 31A, *personal protection insurance benefits* are payable for the following:
>
> (a) Allowable expenses consisting of reasonable charges incurred for reasonably necessary products, services and accommodations for an injured person's care, recovery, or rehabilitation. Allowable expenses do not include either of the following:
>
> (*i*) Charges for a hospital room in excess of a reasonable and customary charge for semiprivate accommodations, unless the injured person requires special or intensive care.
>
> (*ii*) Funeral and burial expenses in excess of the amount set forth in the policy, which

[57] MCL 500.3107.

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> must not be less than $1,750.00 or more than $5,000.00.

Defendant glazes over the express inclusion of the phrase "personal protection insurance benefits" contained in MCL 500.3107 and argues that notwithstanding this definitional limitation, the Court should apply this definition to third party claims. Strangely, the Defendant seems to invoke the plain meaning rule to reach this goal. Defendant's Answer to Application, p. 35.[58]

B. The "Without Limits" Language in the Statute Needs to be Given Full Effect.

In both issues, this Court is presented with the "without limits" issue mentioned in the statute and inadequately addressed by the Court of Appeals. Mr. Canty was allowed to seek "[d]amages for allowable expenses… …without limit for allowable expenses if an election to not maintain that coverage was made under section 3107d…" through tort.[59]

As the Massachusetts Supreme Judicial Court has noted: "we understand the phrase 'without limitation' to mean the broadest

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[58] In the original application for leave to appeal, the Plaintiff stated that the Defendant has misapplied the "absurd results" doctrine of statutory construction. Answer to Application, p. 35. Based on this, the Plaintiff has removed this argument from this brief.

[59] MCL 500.3135(3)(c)

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reasonable definition of acts, without exception.[60] It also should be noted that 2021 MI H.B. 5931 would have eliminated the without limitation language and failed to pass.

The Court of Appeals erred in divining into the statute an overarching purpose (viz. that the Legislature must have intended parity between tort claim medicals and PIP medicals) and then ignoring the Legislature words to carry out their supposed intent.

As Justice Zahara recently noted,[61] this Court has reaffirmed on multiple occasion that: "no intent may be imputed to the legislature in the enactment of a law other than such is supported by the face of the law itself. The courts may not speculate as to the probable intent of the legislature beyond the words employed in the act."[62]

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[60] *Fed Nat Mortg Ass'n v Nunez*, 460 Mass 511, 519; 952 NE2d 923 (2011) (quoting *Pyle v Sch Comm of S Hadley*, 423 Mass 283, 285–286; 667 NE2d 869 (1996) (without limitation "leaves no room to construe exceptions other than as listed in the statute")).

[61] *In re H.R. Request for Advisory Op. Regarding Constitutionality of 2018 PA 368 & 369,* 505 Mich. 884, 936 N.W.2d 241 (2019) (Zahra, J.)

[62] *Id. (Quoting City of Lansing v Lansing Tp*, 356 Mich 641, 649–650; 97 NW2d 804 (1959) (Not surprisingly, we have recognized that it is error to "focus[]on the history behind [a constitutional provision] and the intent of the constitutional convention delegates in proposing it, rather than on the interpretation that the people would have given the provision when they adopted it").

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C. *The Court of Appeals Should Have Applied Textualist Principles in Interpreting the Statute.*

Part of this rule includes the doctrine that "this Court must presume that every word, phrase, and clause in the statute has meaning and must avoid any construction that would render any part of the statute surplusage or nugatory." *People v Aguwa*, 245 Mich App 1, 3–4; 626 NW2d 176 (2001). If the Legislature intended this statute to apply to third party as well as first party expenses it would have said so. There is considerable difference between a tortfeasor and a first party insurer and this Court should presume that the Legislature's express limitation was intentional.

With legislation, "[i]f a statute specifically defines a term, the statutory definition is controlling." *People v Lewis*, 302 Mich App 338, 342; 839 NW2d 37 (2013). However, when "'terms are not expressly defined anywhere in the statute, they must be interpreted on the basis of their ordinary meaning and the context in which they are used.' "[63] It is well settled that a Michigan court cannot fill possible gaps in legislation.[64]

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[63] *Id*., quoting *People v Zajaczkowski*, 493 Mich 6, 13; 825 NW2d 554 (2012).

[64] *Cnty. of Ingham v Michigan Cnty. Rd Comm Self-Ins Pool*, 508 Mich 461, 489; 975 NW2d 826 (2021) (Viviano, J.).

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Congress or the Michigan Legislature is free to affix any definition it wishes to a particular statute, but that act does not transform it into a universal truth. For example, at one time Congress defined Lake Champlain to be a "Great Lake."[65] Senator Patrick J. Leahy, Democrat of Vermont, inserted this provision into a Bill to give Vermont and New York federal research money destined for the Great Lakes.[66] For purposes of that one Act, only Lake Champlain was briefly a Great Lake, but this did not make it a universal truth and amend other statutes by implication.

This Court should reject Defendant's skillful but misplaced wordsmithing.

D. The Limited Value of House Fiscal Analysis.

Defendant also relies on the House Fiscal Analysis at various points in its brief. Significantly, the Michigan Court of Appeals chose not to similarly rely on this analysis. Nonetheless, it is to remind this Court of the limitations of these histories.

While they can be considered, they are "generally unpersuasive tool[s] of statutory construction."[67] This is

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[65] https://www.nytimes.com/1998/03/07/us/champlain-becomes-the-sixth-great-lake.html

[66] *Id.*

[67] *Frank W Lynch & Co v Flex Techs., Inc*, 463 Mich 578, 587; 624 NW2d 180 (2001).

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because legislative analyses are prepared by House and Senate staff members and do not necessarily represent the views of any individual legislator.[68] The problem with the Defendant's approach is that it imputes a generalized intent to lower insurance rates to the Legislature and then treats this as a shopping list to import any doctrines it wishes.

E. Michigan's No-Fault Law Has Been Extensively Modified Over the Years. The Drafter's Decision Not to Include MCL 500.3157's Fee Schedule Must be Regarded as Purposive.

Michigan's no-fault statute has been subject to numerous amendments, yet the Legislature has never deleted the language limiting the definition at issue to first party suits. This Court should not do it for them. As Judge McKee of the Third Circuit noted in his concurrence: "it is not our job to rewrite what Congress has decreed unless a literal application of the statute would "lead to a patently absurd result that no rational legislature could have intended."[69] "The words chosen by Congress are a restraint upon the courts, and if we are not tethered by them in all but the most compelling of cases, then there is left no restraint effectively to corral the power of

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[68] *Id*. at 588 n. 7.

[69] *People v McIntire*, 461 Mich 147, 153; 599 NW2d 102 (1999)

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the courts from substituting their judgment of proper public policy for that of the legislature's."[70]

The Court of Appeals majority's correctly found that MCL 500.3135(3)(c) incorporates the definition of the "allowable expenses" in MCL 500.3107(1)(a). Here, Mr. Canty's tort-damages claim for medical expenses comprises "reasonable charges incurred for reasonably necessary products, services and accommodations." Defying principles of textualism, the majority found that the fee schedule set forth in MCL 500.3157 applies to a tort-damages claim under MCL 500.3135(3)(c).

Plaintiff's tort-damages claim was proceeding under MCL 500.3135(3)(c), which preserves from abolition by the no-fault act third-party tort liability for certain damages—namely, as relevant here, "[d]amages for allowable expenses . . . as defined in sections 3107 to 3110[.]" The Legislature clearly identified the precise range of statutory provisions to define the scope of these available tort damages.

MCL 500.3157 is not in this list, nor does that provision itself say otherwise. While the Legislature could have expressly identified MCL 500.3157 to help define the scope of these damages, as it did with the other handful of statutory sections it designated for the

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[70] *State of NY by Coughlin v Poe*, 835 F Supp 585, 589 (1993).

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task. The Legislature chose not to which must be deemed intentional. This principle is further supported by the doctrine of *expressio unius est exclusio alterius*. *Expressio unius* is a principle of statutory interpretation meaning "the expression of one thing is the exclusion of another."[71] Nothing could be clearer than a roadmap which adopted some provisions, but not others by analogy. The majority erred in rewriting MCL 500.3135(3)(c) to include it.

The majority grounds its conclusion otherwise on MCL 500.3107, which is one of the provisions expressly identified in MCL 500.3135(3)(c). Section 3107 contains a subsection specifically defining the term "allowable expenses." While it is true that when the Legislature said "[d]amages for allowable expenses . . . as defined in section[] 3107," it meant to adopt that specific definition to help delineate the scope of tort damages preserved via MCL 500.3135(3)(c).

This, however, does not mean that this statutory language is proof of an intent to apply MCL 500.3157 to those tort damages as well. The majority finds such intent in Section 3107's general prefatory language, which states, "Subject to the exceptions and limitations in this chapter, and subject to chapter 31A, personal protection insurance benefits are payable for the following"—with

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[71] *Michigan Ambulatory Surgical Ctr v Farm Bureau Gen Ins Co of Michigan*, 334 Mich App 622, 632; 965 NW2d 650 (2020).

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the section then proceeding to provide specific definitions of various things, including allowable expenses. "[T]his chapter" is Chapter 31 of the Insurance Code, which spans all of MCL 500.3101 (West) through MCL 500.3179.

The majority reasons that, because MCL 500.3157 is among "the exceptions and limitations in" Chapter 31, it is a part of what MCL 500.3135(3)(c) incorporated when referring to Section 3107—a conclusion that presumably would hold for any other potentially relevant "exceptions and limitations" in Chapter 31 as well.

In a third-party action, the question of what an allowable expense is a question of fact for the jury. This Court should reverse the Court of Appeals. Alternatively, this Court should grant full leave to appeal.

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RELIEF

WHEREFORE, Plaintiff-Appellee asks this Court to REVERSE the Court of Appeals and/or to grant full leave to appeal to hear this issue.

Respectfully submitted,

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CERTIFICATION

The attached Brief contains 8,173 words. The cover page, table of contents, statement of questions, table of authorities, this certification, request for oral arguments, and proof of service are excluded. This brief was produced using Microsoft Office 365 (2022 version).

Respectfully submitted,

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PROOF OF SERVICE

STATE OF MICHIGAN)
) SS.
COUNTY OF OAKLAND)

The undersigned declarant being first duly sworn, deposes and says that on December 10, 2025, (s)he did mail a copy of the attached PLAINTIFF-APPLICATION FOR LEAVE TO APPEAL, on all counsel of record via the Court's True Filing System.

Declaration in Lieu of Notarization. I declare that the foregoing is true and correct to the best of my information, knowledge, and belief.

Respectfully submitted,

/s/ Erik J. Stone

Declarant

DATED: December 10, 2025