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STATE OF MICHIGAN
IN THE SUPREME COURT

JOSEPH CANTY,	Supreme Court No. 167772
Plaintiff-Appellant,	Court of Appeals No. 365327
-v-	Wayne Circuit No. 21-004799-NI
MICHAEL MASON,	
Defendant-Appellee,	

Defendant-Appellee Michael Mason's Supplemental Brief

Oral Argument Requested

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Jurisdictional Statement

Defendant-Appellee Michael Mason agrees that this Court has jurisdiction to consider Plaintiff-Appellant Joseph Canty's application for leave to appeal.

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Questions Presented

I.

Plaintiff Joseph Canty opted out of personal protection insurance (PIP)[1] benefits under the no-fault act because he had Medicare. After Canty was in a car accident with Mason, he saw providers who participate in Medicare, but Canty didn't use his Medicare coverage. In this tort action, Canty seeks to recover damages he could have mitigated had he used his Medicare. The no-fault act does not abrogate the common-law duty to mitigate damages.

Does a plaintiff seeking allowable expenses for medical treatment in a tort action under MCL 500.3135(3)(c) have a duty to mitigate their damages by seeking payment from Medicare?

The trial court answered:	Yes, then no.
Canty answers:	No.
Mason answers:	Yes.
The Court of Appeals answered:	Yes.
This Court should answer:	Yes.

[1] "Personal protection insurance benefits are abbreviated PIP by convention, with the abbreviation PPI being used for property protection insurance benefits." *McKelvie v Auto Club Ins Ass'n*, 459 Mich 42, 44 n. 1; 586 NW2d 395 (1998).

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II.

The Legislature abolished tort liability for car accidents with certain exceptions. One exception allows recovery of "allowable expenses" as defined in sections 3107 to 3110. Section 3107(1), in turn, makes allowable expenses "[s]ubject to the exceptions and limitations in this chapter." MCL 500.3107(1). "[T]his chapter"—Chapter 31 of the Insurance Code of 1956—includes a fee schedule. MCL 500.3157.

Does the fee schedule in MCL 500.3157 apply to a tort action under MCL 500.3135(3)(c)?

The trial court answered:	No.
Canty answers:	No.
Mason answers:	Yes.
The Court of Appeals answered:	Yes.
This Court should answer:	Yes.

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Introduction

Plaintiff Joseph Canty had Medicare parts A and B. Because Canty had Medicare when he purchased a Michigan no-fault insurance policy, he elected not to carry personal protection insurance (PIP). But after Canty got in a car accident with defendant Michael Mason, he didn't use his Medicare coverage. He treated with well-known no-fault providers who, although they participate in Medicare, didn't bill Medicare or tether their rates to what Medicare would pay.

Canty sued Mason, alleging negligence and seeking the amount billed by his medical providers. But Canty has a duty to mitigate his damages. The no-fault act doesn't abrogate that duty. So Canty can't recover damages that he could have avoided.

If Canty used his Medicare coverage, Medicare would have paid his covered medical expenses, which would extinguish the balance of the medical bills. Medicare would also have a lien on any judgment in this case. Canty's failure to use his Medicare coverage delayed payment and created excess economic waste, which he aims to pass on to Mason. The Court of Appeals correctly held that the duty to mitigate precludes him from doing so.

The Court of Appeals also held that the no-fault act's fee schedule for allowable expenses, MCL 500.3157, applies to Canty's claim. This is an issue of statutory interpretation, and the Court of Appeals got it right.

The Legislature abolished tort liability for car accidents with certain exceptions. One exception allows recovery of "allowable expenses" as defined in MCL 500.3107 to MCL 500.3110. Section 3107(1) makes allowable expenses "[s]ubject to the exceptions and limitations in this

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chapter." Those limitations include the fee schedule in MCL 500.3157, which is in "this chapter"—Chapter 31 of the Insurance Code of 1956.

Because the Court of Appeals reached the right result for the right reasons, this Court should deny leave to appeal. Alternatively, this Court should affirm.

Statement of Facts[2]

A. Canty opted out of PIP under MCL 500.3107d.

Plaintiff Joseph Canty opted out of PIP benefits because he had Medicare.[3]

On February 15, 2021, Canty and Mason got in a car accident.[4] After the accident, Canty treated with well-known no-fault providers.[5] Those providers accepted Medicare, but they didn't bill Medicare or charge Medicare rates.[6] And they didn't align their rates with the fee schedule in MCL 500.3157.[7]

B. Canty sued Mason for unlimited allowable expenses.

Canty sued Mason under MCL 500.3135(3)(c).[8] Mason sought summary disposition on the portion of Canty's medical bills that Medicare

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[2] "AT Apx." refers to the appendix Canty filed with his supplemental brief. "AE Apx." refers to the appendix filed with this brief.

[3] AT Apx. 063a-112a, Canty's Insurance Policy; AT Apx. 128a, Canty's PIP opt-out form.

[4] AT Apx. 017a-027a, Complaint.

[5] AT Apx. 114a-122a, Medical Bills (MPSD Exhibit C).

[6] *Id.*; AT Apx. pp. 10-20, Participating Insurers (MSD Reply Exhibit E)

[7] AT Apx. 114a-122a, Medical Bills.

[8] AT Apx. 017a-027a, Complaint.

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would have covered.[9] He argued that Canty had a common-law duty to mitigate his damages and use his Medicare coverage.[10] He also argued that Canty's recovery was limited to allowable expenses as defined in MCL 500.3107,[11] which required applying the fee schedule in MCL 500.3157.[12]

C. The trial court denied partial summary disposition.

At the hearing on Mason's motion for summary disposition, the trial court agreed that Canty had a duty to mitigate his damages.[13] But 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.[14]

Mason submitted an order under the 7-day rule and Canty objected to it.[15] During a hearing on Canty's objection, the trial court reversed its ruling regarding Canty's common-law duty to mitigate damages.[16] The trial court held that Canty had no duty to use his Medicare.[17] The trial court reaffirmed its holding that MCL 500.3107 defines allowable 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.[18]

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[9] AT Apx. 040a-049a, Defendant's MPSD.

[10] *Id.*

[11] *Id.*

[12] *Id.*

[13] AT Apx. 146a, January 4, 2023 Hrg. Tr., p. 4.

[14] *Id.*, p. 14.

[15] **AE Apx. 224-228**, Plaintiff's objection to Defendant's proposed 7-day order.

[16] AT Apx. 133a, February 7, 2023 Hrg. Tr., p. 5.

[17] *Id.*

[18] *Id.*, p. 10.

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D. The Court of Appeals affirmed in part and reversed in part.

Mason sought interlocutory appellate review, which the Court of Appeals granted.[19] After full briefing and argument, the Court of Appeals issued a published opinion.[20] The Court of Appeals unanimously agreed with Mason that the no-fault act did not abrogate the common-law duty to mitigate damages. It reversed that part of the trial court's decision.[21]

Next, the court unanimously agreed with Mason that the Legislature's reference to "limits" in MCL 500.3135(3)(c) referred to the coverage limits enumerated in MCL 500.3107(c).[22] The Legislature's use of the phrase "without limit" meant that there was no underlying PIP policy to exhaust before the injured person could seek economic damages from the tortfeasor.[23]

Finally, the court held that "allowable expenses" in MCL 500.3135(3)(c) should receive the same treatment and be subject to the same parameters as "allowable expenses" under MCL 500.3107. It unanimously affirmed the trial court's ruling that medical-expense damages were subject to the requirements for reasonableness and necessity. And the majority reversed the trial court's ruling that the fee

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[19] *Mason v Canty*, unpublished order of the Court of Appeals, issued Aug. 28, 2023 (Docket No. 365327).

[20] **AE Apx. 230-237**, *Canty v Mason*, __ Mich App __; __ NW2d __; 2024 WL 4428146 (Oct. 4, 2024); **AE Apx. 239-241,** *Canty v Mason*, __ Mich App __; __ NW2d __; 2024 WL 4428146 (Oct. 4, 2024) (Mariani, J., concurring in part and dissenting in part).

[21] *Canty*, slip op., p. 7; *Canty*, slip op., p. 1 (Mariani, J., concurring in part and dissenting in part).

[22] *Canty*, slip op., p. 5; *Canty*, slip op., p. 1 (Mariani, J., concurring in part and dissenting in part).

[23] *Canty*, slip op., p. 5; *Canty*, slip op., p. 1 (Mariani, J., concurring in part and dissenting in part).

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schedule in MCL 500.3157 didn't apply.[24] It arrived at this conclusion because the Legislature expressly defined allowable expense under MCL 500.3135(3)(c) as those in MCL 500.3107 to MCL 500.3110.[25] In doing so, the Legislature necessarily incorporated all of MCL 500.3107 into MCL 500.3135(3)(c), including its language in MCL 500.3107(1) that stated that personal protection insurance benefits are "subject to the exceptions and limitations in this chapter[.]"[26]

The dissent mostly agreed with the majority, except that it didn't think that the Legislature incorporated all of MCL 500.3107.[27] It believed that the Legislature omitted MCL 500.3107(1)'s language that allowable expenses were subject to all exceptions and limitations in the no-fault act and only meant to refer to MCL 500.3107(1)(a).[28] As a result, the dissent didn't think that the fee schedule in MCL 500.3157 applied to economic damages in third-party cases.[29]

E. This Court ordered supplemental briefing and argument on two issues.

Canty sought leave to appeal the Court of Appeals' decision and this Court ordered supplemental briefing addressing:

> (1) Whether a plaintiff seeking allowable expenses for medical treatment in a tort action under MCL 500.3135(3)(c) has a duty

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[24] *Canty*, slip op., pp. 5-6.

[25] *Id.*

[26] *Id.*

[27] *Canty*, slip op., pp. 1-2 (Mariani, J., concurring in part and dissenting in part).

[28] *Id.*

[29] *Id.*

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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). [*Canty v Mason*, 25 NW3d 131, 131-132 (Mich, 2025).]

Standard of Review

This Court reviews a trial court's decision to grant or deny summary disposition de novo. *Meemic Ins Co v Fortson*, 506 Mich 287, 296; 954 NW2d 115 (2020). This Court also reviews issues of statutory construction de novo. *Roberts v Mecosta Co Gen Hosp*, 466 Mich 57, 62; 642 NW2d 663 (2002).

Legal Background

The no-fault act is complex. Its interaction with common-law rules is complex. And the vast array of statutes and regulations related to Medicare is very complex. So a primer of the relevant laws and principles is helpful before answering the specific questions this Court asked the parties to address.

A. Michigan's no-fault act

Under Michigan's common-law tort system, automobile-negligence claims encountered a host of inequitable and inefficient problems, including long payment delays. See *Shavers v Attorney General*, 402 Mich 554, 578-579; 267 NW2d 72 (1978). The no-fault act was an innovative and comprehensive response to those problems. *Id.*

The act is "'designed to provide sure and speedy recovery of certain economic losses resulting from motor vehicle accidents.'" *Esurance Prop & Cas Ins Co v Mich Assigned Claims Plan*, 507 Mich 498, 517; 968

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NW2d 482 (2021), quoting *Belcher v Aetna Cas & Surety Co*, 409 Mich 231, 240; 293 NW2d 594 (1980). It does this through "a system of compulsory insurance, whereby every Michigan motorist [is] required to purchase no-fault insurance or be unable to operate a motor vehicle legally in this state." *Shavers*, 402 Mich at 579.

Under the act, an insured's losses are primarily compensated by their own insurer—first-party benefits. *Belcher*, 409 Mich at 240. No-fault insurance coverage includes "benefits under personal protection insurance, property protection insurance and residual liability insurance." *Belcher*, 409 Mich at 240 (footnotes omitted). Personal protection insurance (PIP) includes coverage for "allowable expenses." *Johnson v Recca*, 492 Mich 169, 173; 821 NW2d 520 (2012) ("PIP benefits are payable for four general categories of expenses and losses: survivor's loss, allowable expenses, work loss, and replacement services."). And allowable expenses generally "consist[] of reasonable charges incurred for reasonably necessary products, services and accommodations for an injured person's care, recovery, or rehabilitation." MCL 500.3107(1)(a). Before 2019, coverage for allowable expenses under the act "provided uncapped lifetime medical care." *Andary v USAA Cas Ins Co*, 512 Mich 207, 214; 1 NW3d 186 (2023).

In exchange for the right to compensation from an insurer without regard to fault, the Legislature abolished tort liability with certain exceptions. See MCL 500.3135; *Shavers*, 402 Mich at 622-623; *Johnson*, 492 Mich at 175 ("Although the no-fault act generally abolishes tort liability arising from the ownership, maintenance, or use of a motor vehicle, MCL 500.3135 provides several exceptions to the general rule."). Those exceptions allow tort claims—third-party actions—for (among other things) allowable expenses. See MCL 500.3135(2)(c), as enacted by 1972 PA

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294 ("Damages for allowable expenses, work loss, and survivor's loss as defined in [MCL 500.3107 to MCL 500.3110] in excess of the daily, monthly, and 3–year limitations contained in those sections."); *Workman v DAIIE*, 404 Mich 477, 508-509; 274 NW2d 373 (1979) ("The legislative intent, inferable from the face of this provision, is clear: the Legislature intended to allow the catastrophically injured victim and the victim of extraordinary economic losses compensation in addition to that provided by §§ 3107 to 3110 of the act.").

Cost considerations have always been at the forefront of the no-fault act. See *Shavers*, 402 Mich at 580 (addressing measures to ensure "fair and equitable rates" for no-fault insurance); *Andary*, 512 Mich at 217, 269 (observing that recent reforms were designed to facilitate "fair and reasonable rates" for no-fault insurance).

The cost concerns related to the no-fault act extend beyond premiums for no-fault insurance. "'The no-fault act was as concerned with the rising cost of health care as it was with providing an efficient system of automobile insurance.'" *Spectrum Health Hospitals v Farm Bureau Mut Ins Co of Mich*, 333 Mich App 457, 479; 960 NW2d 186 (2020), quoting *Dean v Auto Club Ins Ass'n*, 139 Mich App 266, 273; 362 NW2d 247 (1984). Of course, "it is well established that Medicare generally pays less to reimburse medical providers for treatment than most other payors." *Andary*, 512 Mich at 270.

B. The Medicare Secondary Payer Act

The Sixth Circuit succinctly explained the history of the Medicare Secondary Payer Act—it was an effort to shift some medical expenses away from the federally funded program:

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> Medicare, a federal health-insurance program, provides health-insurance benefits to people sixty-five years of age or older, disabled people, and people with end-stage renal disease. For many years, Medicare served as the primary payer of health costs for eligible individuals, but in 1980 Congress enacted the Medicare Secondary Payer Act to counteract escalating healthcare costs. [*Bio-Med Applications of Tennessee, Inc v Cent States Se & Sw Areas Health & Welfare Fund*, 656 F3d 277, 281 (CA 6, 2011) (citations omitted).]

The court also succinctly explained how the Medicare Secondary Payer Act works:

> To this end, when both Medicare and a private plan would cover a Medicare beneficiary's expenses, the Act makes Medicare the "secondary" payer and the private plan the "primary" payer. The primary payer is responsible for paying for the patient's medical treatment; however, if Medicare expects that the primary payer will not pay promptly, then Medicare can make a "conditional payment" on its behalf and later seek reimbursement. [*Id.*]

The Medicare Secondary Payer Act is codified in 42 USC 1395y(b). It defines a "primary plan." 42 USC 1395y(b)(2)(A)(ii). That term includes a group health plan, worker's compensation policy, liability policy, no-fault insurance policy, and tortfeasors without insurance coverage. *Id.*; see also *Aetna Life Ins Co v Big Y Foods, Inc*, 52 F4th 66, 75 (CA 2, 2022) (explaining that "a tortfeasor, insured or self-insured, can be a 'primary plan'" (citation omitted)).

Medicare beneficiaries have one year from the date of service to file a claim with Medicare. 42 CFR 424.44 ("[T]he claim must be filed no later than the close of the period ending 1 calendar year after the date of

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service."). Medicare-participating providers are required to file Medicare claims, but, if they don't, Medicare beneficiaries can submit their own claims. See 42 CFR 424.32(b) (claim form CMS-1490S is for "a patient to request payment for medical expenses"); 42 CFR 424.34.[30]

Medicare will not pay for medical services when "payment has been made, or can reasonably be expected to be made" by a primary plan. 42 USC 1395y(b)(2)(A). But Medicare will pay when a primary plan isn't reasonably expected to pay "promptly:"

> **(B) Conditional payment**
>
> **(i) Authority to make conditional payment**
>
> The Secretary may make payment under this subchapter with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made **or cannot reasonably be expected to make payment with respect to such item or service promptly** (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection. [42 USC 1395y(b)(2)(B)(i) (emphasis added).]

As the statute indicates, regulations define the term "promptly." Generally, "promptly" means within 120 days:

> Prompt or promptly, when used in connection with primary payments, except as provided in § 411.50, for payments by liability insurers, means payment within 120 days after receipt of the claim. [42 CFR 411.21.]

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[30] See also Medicare.gov, Filing a Claim, available at https://www.medicare.gov/providers-services/claims-appeals-complaints/claims (last accessed January 13, 2026).

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The rule is slightly different—but still based on a 120-day window—for claims under liability policies, including claims against self-insured or uninsured tortfeasors:

> Prompt or promptly, when used in connection with payment by a liability insurer means payment within 120 days after the earlier of the following:
>
> (1) The date a claim is filed with an insurer or a lien is filed against a potential liability settlement.
>
> (2) The date the service was furnished or, in the case of inpatient hospital services, the date of discharge. [42 CFR 411.50(b).]

When a primary plan doesn't or isn't reasonably expected to pay promptly (within 120 days), Medicare will make a "conditional" payment. 42 USC 1395y(b)(2)(B)(i). The payment is "conditional" because Medicare retains a right to reimbursement from any proceeds recovered later through a judgment or settlement:[31]

> **(ii) Repayment required**
>
> Subject to paragraph (9), a primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this subchapter with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or

[31] The Centers for Medicare & Medicaid Services (CMS) also provides a helpful summary of how this works. See Centers for Medicare & Medicaid Services, Medicare Secondary Payer, available at https://www.cms.gov/medicare/coordination-benefits-recovery/overview/secondary-payer (last accessed January 13, 2026).

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> service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means. [42 USC 1395y(b)(2)(B)(ii).]

Providers who receive a Medicare payment, including a conditional payment, cannot pursue the patient for the difference between the amount Medicare paid and the amount the provider billed for the service. 42 USC 1395cc(a)(1)(A); 42 USC 1396a(n). This is true even when the plaintiff recovers in a tort action. See *Rybicki v Hartley*, 792 F2d 260, 261 (CA 1, 1986), citing 42 USC 1395cc(a)(1)(A) and 42 CFR 489.21(a).

So, in context, the terms primary and secondary aren't references to when the payment is made. Nor do they reflect who is ultimately responsible—there are many scenarios in which Medicare makes a conditional payment but there's ultimately no primary plan to reimburse Medicare, e.g., an unsuccessful tort claim.

In tort cases (like Canty's), the alleged tortfeasor or his insurer are rarely reasonably expected to make a prompt payment, so Medicare often makes a conditional payment. If the plaintiff recovers, Medicare has a lien on the recovery. If the defendant prevails, Medicare has covered the plaintiff's health care expenses—if the plaintiff uses their Medicare coverage, that is.

C. Michigan's no-fault opt-out provision

In a game of legislative pickle ball, Michigan's Legislature amended the no-fault act to shift some healthcare costs back to Medicare.

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In 2019, the Legislature enacted "sweeping changes" to the no-fault act. *Andary*, 512 Mich at 218. "A key goal of the 2019 no-fault reforms was to drive down premiums for all operators of automobiles in Michigan and to curb what had been portrayed as exploitative billing by medical providers." *Id.* at 269.

The ability to "opt out" of coverage for allowable expenses was among the new cost-saving features of the 2019 reforms. See MCL 500.3107d, added by 2019 PA 21 and 2019 PA 22. The act now allows drivers to opt out of PIP medical coverage if they are a "qualified person," which means they have coverage under Medicare parts A and B:

> (1) For an insurance policy that provides the security required under section 3101(1)[1] and is issued or renewed after July 1, 2020, the applicant or named insured may, in a way required under section 3107e[2] and on a form approved by the director, elect to not maintain coverage for personal protection insurance benefits payable under section 3107(1)(a) if the applicant or named insured is a qualified person, and if the applicant's or named insured's spouse and any relative of either that resides in the same household have qualified health coverage or have coverage for benefits payable under section 3107(1)(a) from an insurer that provides the security required by section 3101(1).
>
> * * *
>
> (7) As used in this section:
>
> * * *
>
> (b) "Qualified health coverage" means either of the following:
>
> (*i*) Other health or accident coverage to which both of the following apply:

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> (A) The coverage does not exclude or limit coverage for injuries related to motor vehicle accidents.
>
> (B) Any annual deductible for the coverage is $6,000.00 or less per individual. The director shall adjust the amount in this sub-subparagraph on July 1 of each year by the percentage change in the medical component of the Consumer Price Index for the preceding calendar year. However, the director shall not make the adjustment unless the adjustment, or the total of the adjustment and previous unadded adjustments, is $500.00 or more.
>
> (*ii*) Coverage under parts A and B of the federal Medicare program established under subchapter XVIII of the social security act, 42 USC 1395 to 1395*lll*.
>
> (c) "Qualified person" means a person who has qualified health coverage under subdivision (b)(*ii*). [MCL 500.3107d(7)(b)(ii).]

The addition of the opt-out provision required amendment of the exception for third-party claims to recover allowable expenses. See MCL 500.3135(3)(c), as amended by 2019 PA 21 and 2019 PA 22. The additions to the statutory exception are in bold:

> (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**[32] **or** the daily, monthly, and 3-year limitations contained in those sections**, or without limit for allowable expenses if an election to not**

[32] The 2019 amendments allowed insureds, for the first time, to select less than unlimited PIP coverage, i.e., an "applicable limit under section 3107c." See MCL 500.3107c, as added by 2019 PA 21 and 2019 PA 22.

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> **maintain that coverage was made under section 3107d or if an exclusion under section 3109a(2) applies**. [*Id.*]

The amended exception still permits third-party claims for certain PIP benefits in excess of no-fault coverage. It added permission for third-party claims benefits in excess of policy limits, which were new. See MCL 500.3107c, as added by 2019 PA 21 and 2019 PA 22. And it added permission for those who opt out to recover "without limit for allowable expenses," *id.*, which means they "can recover dollar one in allowable expenses from the tortfeasor." *Canty*, slip op., p. 5.[33]

Medicare is a foundation for the opt-out provision. Because the insured must have Medicare, the opt-out provision doesn't resurrect the pre-no-fault tort system in which medical bills piled up while automobile-negligence claims were litigated over years. See *Shavers*, 402 Mich at 578-579. Insureds can only decline the "'sure and speedy recovery of certain economic losses'" that PIP coverage provides if they have a similar source of sure, speedy payment, i.e., Medicare. *Esurance Prop*, 507 Mich at 517, quoting *Belcher*, 409 Mich at 240.

An insured who opts out doesn't have no-fault coverage for purposes of the Medicare Secondary Payer Act. See 42 CFR 411.50 ("No-fault insurance means insurance that pays for medical expenses for injuries sustained … in the use, occupancy, or operation of an automobile, regardless of who may have been responsible for causing the accident."). So, when the insured who opts out doesn't have a claim against another driver, Medicare will cover the medical expenses—there's no "primary plan" under the Medicare Secondary Payer Act. When the insured who

[33] Canty doesn't dispute this aspect of the Court of Appeals' holding, which was unanimous. The MAJ's amicus brief also agrees with it. (MAJ Amicus Brief, pp. 14, 15).

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opts out is hit by an uncollectible driver who doesn't have liability coverage, Medicare will cover the medical expenses—the uninsured tortfeasor is a "primary plan" but Medicare's conditional payment would be the only payment. And when the insured sues another driver who has liability coverage, Medicare will make a conditional payment while the action is litigated.

In short, the new opt-out provision exists and works within the no-fault model to provide assured payment of medical expenses. *Esurance Prop*, 507 Mich at 517; *Belcher*, 409 Mich at 240. It works within the no-fault model **because** Medicare makes conditional payments—if the plaintiff uses their Medicare coverage, that is.

D. The duty to mitigate

1. The common-law rule

The common-law duty to mitigate prevents an injured party from recovering economic damages that the injured party could have avoided. *Morris v Clawson Tank Co*, 459 Mich 256, 263; 587 NW2d 253 (1998). It "seeks to minimize the economic harm." *Id.* This Court has explained that a plaintiff is required to make reasonable effort to minimize their damages:

> "Where one person has committed a tort, breach of contract, or other legal wrong against another, it is incumbent upon the latter to use such means as are reasonable under the circumstances to avoid or minimize the damages. The person wronged cannot recover for any item of damage which could thus have been avoided." [*Id.*, quoting *Shiffer v Gibraltar Sch Dist Bd of Ed*, 393 Mich 190, 197; 224 NW2d 255 (1974), quoting McCormick, Damages, § 33, p. 127.]

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The doctrine "protect[s] and conserve[s] the economic welfare and prosperity of the whole community" because it discourages economic waste and "promotes cost savings for consumers as well as insurers." *Shiffer*, 393 Mich at 198, quoting McCormick, Damages, § 33, p. 127; *Marquis v Hartford Acc & Indem*, 444 Mich 638, 655; 513 NW2d 799 (1994).

Mitigation includes obtaining alternative suitable employment to mitigate lost-income damages. See, e.g., *Morris*, 459 Mich at 264. It also involves avoiding aggravation of injuries by seeking proper medical attention and following a physician's reasonable instructions. E.g., *Poikanen v Thomas Furnace Co*, 226 Mich 614, 620-621; 198 NW 252 (1924) (holding that, as a matter of law, it was unreasonable for the plaintiff to refuse minor operations that would cure his condition). So when, for example, a plaintiff refuses medical treatment that would reasonably correct an ailment, their failure to mitigate precludes them from recovering damages that the treatment would have prevented. *Id.*

The duty to mitigate is an affirmative defense. *Rasheed v Chrysler Corp*, 445 Mich 109, 124; 517 NW2d 19 (1994). And the reasonableness of the plaintiff's actions is usually a question of fact. *Id.* But, like many issues, a failure to mitigate can be decided as an issue of law when there's no material issue of fact. See, e.g., *Poikanen*, 226 Mich at 620-621; *Carter v State Farm Mut Auto Ins Co*, 350 Mich 535, 544-545; 87 NW2d 105 (1957) (affirming directed verdict based on failure to mitigate); see also *Case v Consumers Power Co*, 463 Mich 1, 7; 615 NW2d 17 (2000) (observing that, while the specific standard of care is "usually" a jury issue, courts can decide it when reasonable persons would agree or "there is an overriding legislatively or judicially declared public policy …'" (emphasis and citations omitted)); *Genna v Jackson*, 286 Mich App 413, 418; 781 NW2d 124 (2009) ("Normally, the existence of cause in fact is a question for the jury

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to decide, but if there is no issue of material fact, the question may be decided by the court.").

2. The no-fault act doesn't abrogate the common-law duty to mitigate.

"It is well established that common-law defenses 'shall remain in force and effect until they expire by their own limitations, or are changed, amended or repealed.'" *Bazzi v Sentinel Ins Co*, 502 Mich 390, 400; 919 NW2d 20 (2018), quoting Const 1963, art 3, § 7. Courts do not lightly presume that the Legislature changed the common law. *Id.* "When [the Legislature] does so, it should speak in no uncertain terms." *Hoerstman Gen Contr, Inc v Hahn*, 474 Mich 66, 74; 711 NW2d 340 (2006).

So, absent express statutory abrogation, common-law defenses—like, the duty to mitigate—apply to the third-party claims allowed under the no-fault act. Not surprisingly, this Court and the Court of Appeals have concluded that no-fault act does not abrogate the common-law duty to mitigate. See *Marquis*, 444 Mich at 651; *Bak v Citizens Ins Co of America*, 199 Mich App 730, 739; 503 NW2d 94 (1993).

In *Bak*, the plaintiff couldn't return to her job and made no effort to obtain other suitable work after her accident. *Id.* at 732. She sued her insurer for three years of work-loss damages. *Id.* She claimed she didn't have to mitigate her damages under the no-fault act. *Id.* at 732-733. The Court of Appeals held that the no-fault act did not abrogate the common-law duty to mitigate damages and thus held that the defense remained available. *Id.* at 738.

This Court adopted *Bak*'s holding in *Marquis*, which considered the plaintiff's efforts to find suitable post-accident work. *Marquis*, 444 Mich at 650. *Marquis* explained that, far from abrogating the common-law duty to

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mitigate, the doctrine served the overall goal of the no-fault act to provide timely redress through affordable insurance coverage:

> A primary goal of the no-fault act is to "provid[e] an equitable and prompt method of redressing injuries in a way which made the mandatory insurance coverage **affordable** to all motorists." (Emphasis added). This policy promotes cost savings for consumers as well as insurers by encouraging those injured in an auto accident to rehabilitate themselves and to regain their lost earning capacity. [*Id.* at 654-655, quoting *Tebo v Havlik*, 418 Mich 350, 366; 343 NW2d 181 (1984) (emphasis in original).]

Marquis and *Bak* teach that the common-law duty to mitigate damages applies in no-fault cases and supports the goals of the no-fault act. While those cases involved first-party actions and work-loss claims, nothing in the statute allowing a third-party claim for allowable expenses even plausibly suggests an intent to abrogate the duty to mitigate damages. So the duty to mitigate applies to third-party claims under the no-fault act, too.

3. The no-fault act's set-off provision

In a third-party claim, a plaintiff who opts out of PIP coverage can recover allowable expenses "as defined in sections 3107 to 3110." MCL 500.3135(3)(c). Section 3109 of the no-fault act is (obviously) "in sections 3107 to 3110." So section 3109 applies to a third-party claim for allowable expenses.

Section 3109 requires the subtraction of certain collateral-source benefits from PIP benefits, which include allowable expenses:

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> Benefits provided or required to be provided under the laws of any state or federal government shall be subtracted from the personal protection insurance benefits otherwise payable for the injury under this chapter. [MCL 500.3109(1).]

This Court has explained that, in the context of a third-party claim, section 3109 controls insurance premium rates by reducing exposure for the liability insurer of the tortfeasor. *Tebo*, 418 Mich at 367-368. (stating that section 3109 limits exposure for "the liability insurer of the tortfeasor," which is, "normally, a no-fault insurer").

In *LeBlanc v State Farm Mut Auto Ins Co*, 410 Mich 173; 301 NW2d 775 (1981), this Court held that Medicare benefits were subject to coordination under section 3109a,[34] not offset under section 3109. *Id.* at 186-187, 206. But, as a federal court explained, *LeBlanc* involved a dispute before Congress enacted the Medicare Secondary Payer Act, when "the Medicare program accepted responsibility as the primary payor," which is "no longer the case." *Varacalli v State Farm Mut Auto Ins Co*, 763 F Supp 205, 209 (ED Mich, 1990).[35] Under the Medicare Secondary Payer Act, Medicare cannot be coordinated with no-fault coverage. *Id.* at 209 (holding that the Medicare Secondary Payer Act preempts coordination under section 3109a). This is why the Legislature enacted the opt-out provision—medical expenses can be shifted to Medicare only when there's no coverage for allowable expenses.

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[34] MCL 500.3109a allows insurers to offer reduced premiums in exchange for deductibles and exclusions that shift losses to other health or accident coverage. MCL 500.3109a(1).

[35] If *LeBlanc*'s holding applies despite the enactment of the Medicare Secondary Payer Act, then section 3109 does not apply, but the common-law duty to mitigate still does.

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Section 3109(1) doesn't apply when the benefits provided under federal law are refunded under a lien. *Sibley v DAIIE*, 431 Mich 164, 166; 427 NW2d 528 (1988). In *Sibley*, the plaintiff was a postal worker who was injured at work in a car accident. *Id.* at 166. He received federal workers' compensation benefits. *Id.* When he settled with the tortfeasor, he had to repay the federal workers' compensation benefits. *Id.* at 167. He then sought no-fault benefits, which his no-fault insurer denied. *Id.* The no-fault insurer argued that, under section 3109(1), the federal workers' compensation benefits offset the benefits it would have owed. *Id.*

This Court held that section 3109(1) didn't apply. It explained that benefits the plaintiff had to repay were not "benefits provided" within the meaning of the statute. *Id.* at 169-170.

So, if Medicare made a conditional payment and it is repaid pursuant to its lien, section 3109(1) does not reduce the recoverable allowable expenses. See *id.* But if the plaintiff doesn't use their Medicare coverage, there's no payment to reimburse and no lien. In that case, as the Court of Appeals recognized, the Medicare benefits that were "required to be provided" setoff the plaintiff's allowable expenses. *Canty*, slip op., p. 8. It's a built-in mitigation rule. *Id.*; see *Tebo*, 418 Mich at 367-368.

E. The common-law collateral-source rule and the statutory collateral-source rule.

There are two collateral-source rules in Michigan—one common law and one statutory.

1. The common-law collateral source rule

The common-law collateral-source rule prohibits the argument that the plaintiff has no damages because a third party compensated the plaintiff. *Tebo v Havlik*, 418 Mich 350, 366; 343 NW2d 181 (1984) ("The

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common-law collateral-source rule provides that the recovery of damages from a tortfeasor is not reduced by the plaintiff's receipt of money in compensation for his injuries from other sources.").

For example, when an insurer reimburses the plaintiff for the value of items destroyed in a fire, the plaintiff can still recover the amount the insurer paid from the person who negligently caused the fire. See, e.g., *Perrott v Shearer*, 17 Mich 48 (1868). Likewise, a defendant can't use an insurer's payment of healthcare expenses to argue that the plaintiff has no medical-expense damages. See, e.g., *Tebo*, 418 Mich at 366-368 (explaining that a plaintiff could recover economic damages in a dramshop action despite receiving no-fault benefits covering the same damages).

Under the common-law collateral source rule, the plaintiff's recovery is not reduced by the amount of money an insurer pays. *Tebo*, 418 Mich 366. But the amount paid is still evidence of the plaintiff's losses. In other words, when the plaintiff's injury requires medical services, the amount paid for those services is directly relevant to **establishing** the damages.

In *Alt v Konkle*, 237 Mich 264; 211 NW 661 (1927), for example, the plaintiff was injured in a car accident and relied on the amounts paid for his medical treatment to establish his past medical expenses. The defendant objected, arguing that the payment didn't show that the amount was reasonable. The trial court overruled the objection. This Court affirmed. It explained that, though the defendant was free to argue the amount paid was unreasonable, the amount paid established the amount of the plaintiff's recoverable damages: "The plaintiff is entitled to recover a reasonable sum, necessarily expended, or as was held in the Sherwood Case, supra—'his reasonable and necessary outlays in an attempt to be cured of the injuries resulting from the negligence of the defendant.'" *Id.*

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at 269-270, quoting *Sherwood v Chicago & WM Ry Co*, 82 Mich 374, 385; 46 NW 773 (1890); see also *Herter v City of Detroit*, 245 Mich 425, 428; 222 NW 774 (1929) (holding that an unpaid physician's bill was not evidence of the reasonable value of the physician's services).

This Court has also explained that compensatory damages are "limited by the amount of the loss:"

> Because the purpose of compensatory damages is to make the injured party whole for the losses actually suffered, the amount of recovery for such damages **is inherently limited by the amount of the loss; the party may not make a profit** or obtain more than one recovery. [*McAuley v Gen Motors Corp*, 457 Mich 513, 520; 578 NW2d 282 (1998) (emphasis added); accord *Rafferty v Markovitz*, 461 Mich 265, 271; 602 NW2d 367 (1999).]

So, the common-law collateral-source rule prohibits a defendant from arguing that a third-party's payment eliminates or is subtracted from the damages award. But it does not change the fact that the amount actually paid is the amount of the loss. *Alt*, 237 Mich at 269-270; *McAuley*, 457 Mich at 520; see also *Garder v Norman*, __ P3d __; 2025 UT 47, ¶31; 2025 WL 3030153, *6 (Utah, 2025) ("[Economic] damages must reflect the actual loss resulting from the tortfeasor's conduct. Under the collateral source rule, the fact that a third party bore that loss is inadmissible and cannot be used to reduce a plaintiff's recovery. But that rule does not alter the fundamental principle that [economic] damages are limited to the actual loss resulting from the injury.").

2. The statutory collateral-source rule

MCL 600.6303 is a post-verdict exception to the common-law collateral-source rule. It provides that evidence that an expense was paid

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or is payable by a collateral source is admissible post-verdict to reduce an economic-damages award:

> In a personal injury action in which the plaintiff seeks to recover for the expense of medical care, rehabilitation services, loss of earnings, loss of earning capacity, or other economic loss, evidence to establish that the expense or loss was paid or is payable, in whole or in part, by a collateral source shall be admissible to the court in which the action was brought after a verdict for the plaintiff and before a judgment is entered on the verdict. [MCL 600.6303(1).]

The term "collateral source benefits" is defined to include Medicare benefits. MCL 600.6303(4).

If the collateral source has a lien, the collateral-source benefit is **not** subtracted from the award:

> Collateral source does not include life insurance benefits or benefits paid by a person, partnership, association, corporation, or other legal entity entitled by law to a lien against the proceeds of a recovery by a plaintiff in a civil action for damages. Collateral source does not include benefits paid or payable by a person, partnership, association, corporation, or other legal entity entitled by contract to a lien against the proceeds of a recovery by a plaintiff in a civil action for damages, if the contractual lien has been exercised pursuant to subsection (3). [*Id.*]

But, absent a lien, courts must subtract the amount of collateral-source benefits that have been paid or are payable from a damages award before entering a judgment:

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> Subject to [MCL 600.6303(5)[36]], if the court determines that all or part of the plaintiff's expense or loss has been paid or is payable by a collateral source, the court shall reduce that portion of the judgment which represents damages paid or payable by a collateral source by an amount equal to the sum determined pursuant to subsection (2). [MCL 600.6303(1).]

Because Medicare has a lien when it makes conditional payments, 42 USC 1395y(b)(2)(B)(ii), its payments will not be subtracted from a damages award[37]—if the plaintiff uses their Medicare coverage, that is.

Issue 1

This Court asked, "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." *Canty*, 25 NW3d at 131-132. The answer is, yes.

Together, the no-fault act and the Medicare Secondary Payer Act establish a coordinated framework for paying automobile-accident-related medical expenses. The Legislature only allows insureds to opt out of PIP medical coverage when Medicare will substitute. Nothing in either statutory scheme abrogates Michigan's long-standing requirement to mitigate damages. And neither statutory scheme authorizes someone who opts out to disregard available Medicare coverage just to gamble on recovering more from a tort defendant.

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[36] MCL 600.6303(5) provides that collateral-source benefits are payable or receivable if "there is a previously existing contractual or statutory obligation" for a third-party to pay them.

[37] Notably, this is the same result required under section 3109—when the federal benefits are repaid under a lien, there's no reduction of the allowable expenses. *Sibley*, 431 Mich at 166.

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The Court of Appeals' unanimous holding that Canty has a duty to mitigate his damages by seeking payment from Medicare is correct. This Court should either deny leave or affirm.

A. The Court of Appeals correctly held that Canty didn't mitigate his damages when he saw providers participating in Medicare and left his decision to see non-Medicare providers for the jury.

The Court of Appeals held that:

> (1) Mason is entitled to a setoff of medical expenses from a Medicare-participating provider that Medicare would have covered, and
>
> (2) The trier of fact must decide whether Canty reasonably incurred medical expenses from non-Medicare-participating providers. *Canty*, slip op., p. 8 & n. 9.

In other words, the outcome of the mitigation issue splits based on whether Canty's medical provider participates in Medicare.

1. Canty didn't use his Medicare coverage with Medicare-participating providers.

When Canty saw Medicare-participating providers without using his Medicare coverage, he failed to mitigate his damages. This is an issue of law because the pertinent facts are undisputed. *Carter*, 350 Mich at 544-545; *Case*, 463 Mich at 7. And so is Michigan's public policy. *Case*, 463 Mich at 7 (courts may decide an issue as a matter of law when "there is an overriding legislatively or judicially declared public policy …'").

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There's no dispute that the common-law duty to mitigate applies to Canty's claim. There's no dispute that Canty saw medical providers who participate in Medicare. (See Appellant Supplemental Brief, p. 3). There's no dispute that Canty did not use Medicare for the covered services that he received from those providers. (*Id.*).[38] It's well known that Medicare pays less than a medical provider's full charge. *Andary*, 512 Mich at 270. And it's undisputed that Medicare's payment extinguishes the debt to the provider. *Rybicki*, 792 F2d at 261; 42 USC 1395cc(a)(1)(A); 42 CFR 489.21(a).

In short, Canty forwent Medicare's payment in the hope of increasing his damages claim against Mason. It's a failure to mitigate damages.

A plaintiff who forgoes Medicare payments just to increase their damages is the same as a plaintiff who forgoes suitable employment to increase their lost-income damages. *Morris*, 459 Mich at 264-265. They're the same as a plaintiff who forgoes reasonable medical treatment just to increase their noneconomic damages. *Poikanen*, 226 Mich at 620-621.

Because Michigan's common-law duty to mitigate prohibits efforts to artificially inflate damages, the Court of Appeal correctly held that "the failure to seek payment from Medicare would not have been reasonable as a matter of law if the medical provider accepted Medicare." *Canty*, slip op., p. 8.

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[38] Again, Canty could submit his own claims. See 42 CFR 424.32(b) (claim form CMS-1490S is for "a patient to request payment for medical expenses"); 42 CFR 424.34; Medicare.gov, Filing a Claim, available at https://www.medicare.gov/providers-services/claims-appeals-complaints/claims (last accessed January 13, 2026).

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2. Canty saw non-Medicare-participating providers.

Canty's decision to see medical providers who do not participate in Medicare is (arguably)[39] different. Canty did not produce any evidence that his decision to see non-Medicare-participating providers was reasonable. See *Lowrey v LMPS & LMPJ, Inc*, 500 Mich 1, 9; 890 NW2d 344 (2016) ("[T]he rule is well established that a moving party may be entitled to summary disposition as a result of the nonmoving party's failure to produce evidence sufficient to demonstrate an essential element of its claim."). Nevertheless, the Court of Appeals held that expenses for medical services from non-Medicare-participating providers "might still be recoverable" and the trier of fact would have to decide whether it was reasonable for Canty to see those providers. *Canty*, slip op., p. 8 & n. 9.

Canty either ignores or misunderstands this part of the Court of Appeals' holding. He argues—repeatedly—about the "highly personal" choice of medical providers. (See Appellate Supplemental Brief, pp. 15, 18-19, 33-34). Because the Court of Appeals left the reasonableness of that choice for a jury to consider, it did not "override" Canty's right to choose a doctor or "dictate" the choice. (*Id.*, pp. 18-19). Rather, Mason can argue that Canty's decision to go to a non-Medicare-participating provider was

[39] In *Tousignant v Allstate Insurance Co*, 444 Mich 301; 506 NW2d 844 (1993), this Court held that, under MCL 500.3109a, an insured who coordinates no-fault coverage with an HMO plan must obtain medical services from the HMO plan—that, *Tousignant* explained, was part of the tradeoff for a lower no-fault insurance premium. *Id.* at 309-310. Like Section 3109a, the opt-out provision, MCL 500.3107d, is "in sections 3107 to 3110." MCL 500.3135(3)(c). And insureds who opt out because they have Medicare receive lower no-fault insurance premiums. So *Tousignant* indicates that an insured who opts out must, as a matter of law, see providers who participate in Medicare. *Tousignant*, 444 Mich at 307.

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unreasonable, Canty can argue that it was reasonable, and a jury will decide whether it was reasonable. *Rasheed*, 445 Mich at 124.

B. What happens if an insured who opts out of PIP coverage uses their Medicare coverage?

Canty fundamentally misunderstands the Medicare Secondary Payer Act. He says that Medicare will make a conditional payment "only if reimbursement is guaranteed" and he calls a conditional payment "illegal." (Appellant Supplemental Brief, p. 23-24). He also asserts that "Medicare will never be the primary insurer under these circumstances." (*Id.*, p. 29). None of that is true.

When a Medicare beneficiary is injured in a car accident, there are several **potential** "primary" plans—a no-fault insurer, an at-fault driver's liability insurer, or an uninsured at-fault driver. 42 USC 1395y(b)(2)(A)(ii). When the Medicare beneficiary opts out of PIP medical coverage, there isn't any no-fault coverage under the Medicare Secondary Payer Act. See 42 CFR 411.50 (defining no-fault insurance for the Medicare Secondary Payer Act). So there are two potential primary plans for a Medicare beneficiary who opted out of PIP medical coverage—an at-fault driver's liability insurer or an uninsured at-fault driver. 42 USC 1395y(b)(2)(A)(ii).

Medicare will make a conditional payment if the potential primary plans aren't reasonably expected to pay within 120 days. 42 USC 1395y(b)(2)(B)(i); 42 CFR 411.21, .50. When Medicare makes a conditional payment, it has a lien on any recovery. 42 USC 1395y(b)(2)(B)(ii). If there's no recovery (e.g., a no-cause verdict), Medicare's conditional payment is the only payment and it extinguishes the plaintiff's debt to their medical provider. 42 USC 1395cc(a)(1)(A); 42 CFR 489.21(a). If there is a recovery, Medicare's conditional payment still extinguishes the plaintiff's debt to their medical provider, *Rybicki*, 792 F2d at 261, and Medicare's conditional

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payment does not reduce the award because Medicare has a lien. MCL 600.6303(1); *Greer v Advantage Health*, 305 Mich App 192, 212-213; 852 NW2d 198 (2014); *Sibley*, 431 Mich at 166 (holding that there's no reduction under MCL 500.3109(1) when the benefits are repaid under a lien).

In short, the system works efficiently when a Medicare beneficiary uses their Medicare coverage—the provider is paid and the patient's debt to the provider is resolved long before and regardless of the outcome of the litigation. It's a process consistent with the purpose and goals of the no-fault act. *Esurance Prop*, 507 Mich at 517; *Belcher*, 409 Mich at 240.

Canty expresses concern that his providers are not assured payment and may have to wait years for any recovery. (Appellant Supplemental Brief, pp. 23, 32). There's a simple answer to those concerns: submit the claim to Medicare and get the conditional payment. As explained below, risk only comes from **not** using Canty's Medicare coverage—a manufactured and improper attempt to inflate the damages.

C. A trap for the unwary: what happens if an insured who opts out of PIP coverage does not use their Medicare coverage?

While Canty and the MAJ's amicus brief focus on what happens if a plaintiff uses their Medicare coverage—Medicare makes a conditional payment and has a lien—they pay no attention to what happens if a plaintiff does not use their Medicare coverage. Leaving mitigation principles aside for the moment, forgoing Medicare coverage and a conditional payment is a trap for the unwary.

Consider a plaintiff like Canty—one who opted out of PIP benefits because they have Medicare coverage, but doesn't use their Medicare coverage after being injured in a car accident. Medicare won't pay a claim

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submitted a year after the date of service. 42 CFR 424.44. So, if the plaintiff doesn't prevail in their third-party case, they'll be personally responsible for the medical bills that are over a year old—they miss the opportunity for Medicare to pay for the medical services.

Winning the third-party case poses its own problems. Under the collateral-source statute, "collateral source benefits" include Medicare benefits. MCL 600.6303(4). Courts must reduce an award by any payable collateral-source benefits, unless the collateral source has a lien. MCL 600.6303(1), (4).[40] When a plaintiff doesn't use their Medicare coverage, Medicare does not make a conditional payment and there's no lien. So the plaintiff's recovery is reduced by any payable Medicare benefits. *Greer*, 305 Mich App at 210.

There's a simple way to avoid these unintended consequences—someone who opts out because they have Medicare coverage should use their Medicare coverage.

D. The Court of Appeals opinion doesn't shift any burdens.

Several times, Canty asserts that the Court of Appeals shifted the burden of proof on mitigating damages to him. It didn't.

A failure to mitigate is an affirmative defense. *Rasheed*, 445 Mich at 124. It stems from the plaintiff's duty or obligation to mitigate damages. *Morris*, 459 Mich at 263 ("'[I]t is incumbent upon the [plaintiff] to use such means as are reasonable under the circumstances to avoid or minimize the damages.'"), quoting *Shiffer*, 393 Mich at 197. So the Court of Appeals correctly stated that "[i]t is incumbent on a person who has been harmed by the commission of a tort to use such means that are reasonable under

[40] Again, the same is true for reductions under MCL 500.3109(1). *Sibley*, 431 Mich at 166.

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the circumstances to minimize or mitigate the amount of damages." *Canty*, slip op., p. 7.

A defendant can move for summary disposition on an affirmative defense. See, e.g., *Burton v Reed City Hosp Corp*, 471 Mich 745; 691 NW2d 424 (2005) (reinstating summary disposition based on the statute of limitations, which is an affirmative defense). And, here, Mason produced evidence that Canty didn't mitigate his damages—he didn't use his Medicare coverage.[41] That shifted the burden of production to Canty. *Lowrey*, 500 Mich at 7. But Canty didn't produce any evidence to explain why (1) he didn't use his Medicare coverage for his Medicare-participating providers, and (2) he saw non-Medicare-participating providers.

The Court of Appeals applied summary-disposition principles. *Canty*, slip op., pp. 3-4. It decided the first issue as a matter of law based on undisputed facts, which is appropriate. *Carter*, 350 Mich at 544-545; *Case*, 463 Mich at 7. And, though Canty failed to produce any evidence on the second issue, the court held that the second issue was a jury question.

Because the Court of Appeals didn't say anything that would shift the burden of production or persuasion at trial, Canty's argument on this point is misguided.

E. Conclusion: Forgoing Medicare coverage after opting out of PIP medical coverage is contrary to the purpose of the no-fault act and the common law.

The no-fault act is "'designed to provide sure and speedy recovery of certain economic losses resulting from motor vehicle accidents.'"

[41] AT Apx. p.114a-p.122a, Medical Bills; AT Apx. pp. 10-20, Participating Insurers.

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Esurance Prop, 507 Mich at 517, quoting *Belcher*, 409 Mich at 240. For most, it does that through PIP benefits. Those who opt out exchange PIP medical coverage for Medicare coverage. Perhaps obviously, they should use that Medicare coverage. It ensures payment and mitigates loss. It achieves the goals of the no-fault act and the public policy behind the common-law duty to mitigate damages. *Shiffer*, 393 Mich at 198; *Marquis*, 444 Mich at 655.

The Court of Appeals correctly held that the common-law duty to mitigate applies to Canty's claims. It correctly held the duty to mitigate required Canty to use his Medicare coverage with his Medicare-participating providers. And, though Canty didn't produce any evidence on the issue, it held that whether it was reasonable for Canty to see non-Medicare-participating providers was a question of fact. It didn't err.

No one should accrue medical bills and forgo Medicare coverage simply to increase their damages claim. It's inefficient, unnecessarily risky, and costly for the entire system. Simply put, there's no good reason for Canty to forgo Medicare coverage. This Court should deny leave to appeal or affirm.

Issue 2

This Court asked, "whether the fee schedules in MCL 500.3157 apply to a tort action under MCL 500.3135(3)(c)." *Canty*, 25 NW3d at 132. The answer is, yes. Because that's the answer that the Court of Appeals reached, this Court should either deny leave or affirm.

A. Statutes have to be read together and taken as a whole.

Whether the fee schedules apply in a third-party action is an issue of statutory interpretation. A court's role in construing statutory language

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is to ascertain the Legislature's intent. *Mich Ass'n of Home Builders v Troy*, 504 Mich 204, 212; 934 NW2d 713 (2019).

When interpreting statutory language, courts must read the statute as a whole and in its grammatical context, giving each and every word its plain and ordinary meaning unless otherwise defined. *In re Receivership of 11910 South Francis Rd*, 492 Mich 208, 222; 821 NW2d 503 (2012). Statutory language should not be isolated but must be read with reference to the entire act. *State Conservation Dep't v Seaman*, 396 Mich 299, 309; 240 NW2d 206 (1976). Courts must avoid an interpretation that would render any part of the statute surplusage or nugatory. *Esurance Prop*, 507 Mich at 508-509. And "[i]dentical language should certainly receive identical construction when found in the same act." *People ex rel Simmons v Munising Tp*, 213 Mich 629, 633; 182 NW 118 (1921); *Empire Iron Min P'ship v Orhanen*, 455 Mich 410, 426; 565 NW2d 844 (1997).

B. The allowable expenses recoverable in a third-party action are subject to the fee-schedule statute.

Again, the Legislature abolished tort liability arising from automobile accidents with certain exceptions. See MCL 500.3135; *Johnson*, 492 Mich at 175. One of the exceptions allows third-party claims for allowable expenses:

> (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. [*Id.*]

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After the 2019 amendments, this exception has two parts—one for those who have PIP coverage, the other for those who opted out:

- Those with PIP coverage can recover allowable expenses "as defined in sections 3107 to 3110 **...** in excess of any applicable limit under section 3107c or the daily, monthly, and 3-year limitations contained in those sections." *Id.*

- Those who opt out can recover allowable expenses "as defined in sections 3107 to 3110 **...** without limit for allowable expenses." *Id.*

Either way, the allowable expenses are "as defined in sections 3107 to 3110." *Id.*

Section 3107 defines certain PIP benefits, which, in relevant part, includes allowable expenses:

> (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 include medical treatment and rehabilitation. *Id.*; see *Nasser v Auto Club Ins Ass'n*, 435 Mich 33, 49; 457 NW2d 637 (1990).

Section 3107 expressly incorporates "the exceptions and limitations in this chapter." MCL 500.3107, as amended by 2019 PA 21 and 2019 PA 22. The term "this chapter" means Chapter 31 of the Insurance Code of 1956, which is MCL 500.3101 through MCL 500.3179.

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The fee-schedule statute, MCL 500.3157, is in Chapter 31. And the fee schedule applies to allowable expenses—a physician, hospital, clinic, or other person's treatment or rehabilitative occupational training. MCL 500.3157(2).

In summary, section 3135(3)(c) incorporates section 3107, which, in turn, incorporates the limitations in section 3157. So, yes, under the plain statutory text, the fee schedules in MCL 500.3157 apply to a tort action under MCL 500.3135(3)(c).

C. Arguments to exclude the fee schedule from third-party claims only fight the plain statutory text.

Canty and Judge Mariani's partial dissent argue that the statutory exception for a third-party claim doesn't incorporate section 3107(1) and, if it does, that provision only applies to PIP benefits, not damages in a third-party action. They're wrong on both points.

1. The argument that the Legislature meant subsection 3107(1)(a) when it wrote "sections 3107 to 3110" is wrong.

The third-party exception refers to allowable expenses "as defined in section 3107 to 3110." MCL 500.3135(3)(c). It does not carve out 3107(1); it does not limit the definition to section 3107(1)(a).

The recent statutory history refutes Canty and Judge Mariani's arguments. See *Ray v Swager*, 501 Mich 52, 80; 903 NW2d 366 (2017) ("[C]ourts must pay particular attention to statutory amendments …" (internal quotation omitted)). The amendments that the Legislature made and didn't make in 2019 confirm its intent for the fee schedule to apply in third-party cases. See *Wallen v Dep't of Corrections*, 443 Mich 240, 248; 505 NW2d 519 (1993) ("It is a well-known principle that the Legislature is

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presumed to be aware of, and thus to have considered the effect on, all existing statutes when enacting new laws.").

The Legislature amended section 3107(1) when it amended section 3157. 2019 PA 21; 2019 PA 22. It added "[s]ubject to the exceptions and limitations in this chapter" in section 3107(1) when it added the fee schedule in section 3157. *Id.* The Legislature also amended section 3135(3)(c) at the same time. *Id.* Most significant here, the Legislature did **not** change the phrase, "Damages for allowable expenses … as defined in sections 3107 to 3110 …." MCL 500.3135(3)(c), as amended by 2019 PA 21 and 2019 PA 22.

Because the Legislature amended section 3107(1) to incorporate the limitations in chapter 31, the Legislature could have narrowed the reference in section 3135(3)(c); it could have amended it to specifically reference only section 3107(1)(a). But it didn't. This Court must presume that was intentional. *Wallen*, 443 Mich at 248.

Of course, the Legislature is capable of specifically referencing section 3107(1)(a) when it wants to. It did so many times. See MCL 500.2111f(3); MCL 500.3107c(1), (6); MCL 500.3107d(1), (3), (6); MCL 500.3109a(2); MCL 500.3142(3); MCL 500.3148(4); MCL 500.3172(7).

All of those specific references to section 3107(1)(a) were added in the 2019 reforms—the same time sections 3107, 3135(3)(c), and 3157 were amended. "'[C]ourts cannot assume that the Legislature inadvertently omitted from one statute the language that it placed in another statute, and then, on the basis of that assumption, apply what is not there.'" *People v Peltola*, 489 Mich 174, 185; 803 NW2d 140 (2011), quoting *Farrington v Total Petroleum, Inc*, 442 Mich 201, 210; 501 NW2d 76 (1993). Because the Legislature specifically referenced section 3107(1)(a) in other statutes, this

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Court cannot assume the Legislature inadvertently omitted it from section 3135(3)(c).

Canty and Judge Mariani's position is, essentially, that the Legislature made a mistake. It added "[s]ubject to the exceptions and limitations in this chapter" to section 3107(1) without changing the broad reference to section 3107 in the third-party-claim exception. This Court cannot assume the Legislature made a mistake nor attempt to correct it by judicial fiat. See *Brucker v Chisholm*, 245 Mich 285, 292; 222 NW 761 (1929) ("If this was a mistake, clerical or otherwise, the Legislature which will soon be in session can correct it. We must decline so to do."); *Bronk v Standard Mfg Co*, 141 Mich 680, 684; 105 NW 33 (1905) ("The reason why the courts may not correct the mistake in legislative action … is that in its own sphere each department of government is supreme and independent.").

2. The MAJ's argument that the word "defined" overcomes the express reference to "sections 3107 to 3110" is wrong.

The MAJ's amicus brief offers a different argument; one that neither Canty nor Judge Mariani made. It emphasizes the word "defined" in section 3135(3)(c)—"Damages for allowable expenses, work loss, and survivor's loss as **defined** in sections 3107 to 3110 …." MCL 500.3135(3)(c) (emphasis added). That, it argues, allows this Court to pluck section 3107(1)(a) free from the language in section 3107(1)—and, presumably, the provisions on work loss in section 3107(1)(b) and survivor's loss in section 3108(1).

First, the meaning of "defined" isn't as narrow as the MAJ frames it. "[D]efine" means "[t]o state or explain explicitly," "[t]o fix or establish (boundaries or limits)," and "[t]o set forth the meaning of (a word or

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phrase)." Black's Law Dictionary (12th ed, 2024). Including limitations like the fee schedule is within the concept of defining allowable expenses.

Second, the MAJ's argument would make the express incorporation of sections 3109 and 3110 surplusage. If the MAJ were correct, the Legislature would have only referenced sections 3107 to 3108 to define allowable expenses, work loss, and survivor's loss. This Court cannot ignore the express inclusion of sections 3109 and 3110; it cannot render them surplusage. *Esurance Prop*, 507 Mich at 508-509 ("'Courts must … avoid an interpretation that would render any part of the statute surplusage or nugatory.'"), quoting *O'Connell v Dir of Elections*, 316 Mich App 91, 98; 891 NW2d 240 (2016). Also, this Court has already explained that section 3109 applies in third-party cases. *Tebo*, 418 Mich at 368.

Accordingly, the MAJ's emphasis on "defined" is misplaced. The Legislature could not have intended "defined" to have the narrowing effect that the MAJ aims to give it.

3. The argument that 3107(1) only applies to first-party PIP benefits is wrong.

Canty and Judge Mariani's fallback position—section 3107(1) only applies to PIP benefits, not damages in a third-party action—also isn't supported by the statutory text.

Allowable expenses are as subset of PIP benefits. *Johnson*, 492 Mich at 173 ("PIP benefits are payable for four general categories of expenses and losses: survivor's loss, allowable expenses, work loss, and replacement services."). So the argument that only PIP benefits are "[s]ubject to the exceptions and limitations in this chapter" doesn't advance Canty's position. MCL 500.3107(1), as amended by 2019 PA 21 and 2019 PA 22. Because allowable expenses are PIP benefits, they are

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""[s]ubject to the exceptions and limitations in this chapter." MCL 500.3107(1), as amended by 2019 PA 21 and 2019 PA 22.

Judge Mariani suggested that it could make sense to treat PIP benefits and tort damages differently. (*Canty*, slip op., p. 3 n. 2 (Mariani, J., dissenting). It also makes sense to treat them the same.

Canty's claim is an exception to the abolition of automobile-negligence claims. The exception isn't for "economic damages." It's for specific categories (PIP benefits) permitted under the no-fault act—allowable expenses, work loss, and survivor's loss. MCL 500.3135(3)(c). So it's not surprising that the statutory requirements for those items—here, allowable expenses—apply for third-party claims, too.

Again, "[a] key goal of the 2019 no-fault reforms was to drive down premiums for all operators of automobiles in Michigan." *Andary*, 512 Mich at 269. First-party benefits aren't the only component of no-fault insurance premiums. No-fault policies must include residual liability coverage. MCL 500.3009; *Belcher*, 409 Mich at 240. Containing residual-liability exposure through the fee-schedules serves the purpose of the 2019 reforms to lower premiums.

Guesswork about policy implications don't favor either argument. The Court of Appeals majority correctly resolved this issue based on the statutory text. And the plain terms of the statutes incorporate the fee schedule for third-party claims under section 3135(3)(c).

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D. Conclusion: The Court of Appeals majority correctly held that the fee schedule applies in third-party cases.

Section 3135(3)(c) adopts the definition of "allowable expenses" from MCL 500.3107 to MCL 500.3110. Section 3107(1) makes allowable expenses "[s]ubject to the exceptions and limitations in this chapter." The fee schedule in MCL 500.3157 applies to allowable expenses and it's in "this chapter"—Chapter 31 of the Insurance Code of 1956. All efforts to break that statutory chain simply fight the plain statutory language.

The Court of Appeals majority correctly followed the plain statutory language. Because it didn't err, this Court should deny leave to appeal, or affirm.

Conclusion and Relief Requested

The Court of Appeals correctly rejected Canty's attempt to inflate his damages. The no-fault act requires anyone who opts out of PIP medical coverage to have Medicare coverage. Absent reasonable justification (which Canty never provided), they should use their Medicare coverage. Doing so assures payment and contains costs—it effectuates the purpose of the no-fault act.

The Court of Appeals also correctly concluded that the fee schedule applies in third-party cases. It followed the plain language of the statutes. The Legislature could have easily narrowed the reference in section 3135(3)(c) to reference only section 3107(1)(a). It didn't. Courts cannot override that choice. Policy arguments against applying the fee schedule in third-party cases should be directed to the Legislature.

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Because the Court of Appeals didn't err, this Court should deny leave to appeal or affirm.

Respectfully submitted,

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