STATE OF MICHIGAN

COURT OF APPEALS

ANTOINE LEE, Plaintiff-Appellee,	UNPUBLISHED August 28, 2012
v	No. 303217 Wayne Circuit Court
FARMERS INSURANCE EXCHANGE, Defendant-Appellant.	LC No. 09-020438-NF

Before: RONAYNE KRAUSE, P.J., and SAAD and BORRELLO, JJ.

PER CURIAM.

Defendant, Farmers Insurance Exchange, appeals the trial court's order that granted summary disposition to plaintiff, Antoine Lee. For the reasons set forth in this opinion, we affirm.

FACTS AND PROCEEDINGS

The parties do not dispute the material facts of this case. On March 2, 1978, plaintiff sustained serious injuries as a passenger in a vehicle involved in an accident. Because plaintiff had no insurance, and no other no-fault insurance applied to him, coverage for plaintiff's no-fault benefits was assigned to defendant, Farmers Insurance Exchange, through Michigan's Assigned Claims Facility. After the accident, plaintiff also received Medicare coverage to pay for his medical expenses. For many years, defendant also paid plaintiff amounts equal to his incurred medical expenses as part of his personal injury protection (PIP) benefits.

Recently, defendant declined to pay plaintiff for the incurred medical expenses that were already covered by Medicare. On August 18, 2009, plaintiff filed a complaint to recover these PIP benefits from defendant.[1] According to plaintiff, defendant failed to pay for medical expenses he incurred at Triumph Hospital between April 14, 2008 and May 14, 2008, at Harper Hospital between April 10, 2009 to April 22, 2009, and at Harper Hospital between January 7, 2009 to January 29, 2009. Plaintiff also claimed that defendant failed to pay various other

[1] Plaintiff also alleged that defendant is obligated to pay other expenses under the no-fault act. The parties settled those issues during the litigation and they are not raised on appeal.

incurred medical expenses in smaller amounts. Defendant does not dispute that plaintiff incurred those medical expenses as a result of the 1978 motor vehicle accident. Rather, defendant argues that all of the bills from those medical treatments were submitted to and paid by Medicare, and plaintiff should not receive a "windfall" of duplicate PIP payments when his medical expenses have already been paid. Defendant characterizes this as permitting plaintiff to "double-dip" from both Medicare and the assigned claims facility. Plaintiff takes the position that these medical expenses are allowable no-fault expenses that defendant is obligated to pay under the no-fault act, regardless whether his medical bills were paid by Medicare.

The parties filed motions for summary disposition and the trial court ruled that, as a matter of law, defendant must pay plaintiff the amount of his incurred medical expenses as PIP benefits, notwithstanding his Medicare coverage. Specifically, the court ruled that defendant must pay plaintiff $105,191.75 for the medical expenses incurred at Triumph Hospital, Harper Hospital, and facilities, plus interest. Pursuant to MCL 500.3148, the trial court also ordered defendant to pay $49,992.21 for plaintiff's attorney fees and $1,437.17 in costs. The parties agreed to stay execution of the judgment until defendant exhausts its appellate remedies.

I. DISCUSSION

A. STANDARDS OF REVIEW

Plaintiff moved for partial summary disposition pursuant to MCR 2.116(C)(9) and (C)(10). "This Court reviews de novo a trial court's decision on a motion for summary disposition." *Hastings Mut Ins Co v Safety King, Inc*, 286 Mich App 287, 291; 778 NW2d 275 (2009). As this Court explained in *Payne v Farm Bureau Ins*, 263 Mich App 521, 525; 688 NW2d 327 (2004):

> A motion for summary disposition pursuant to MCR 2.116(C)(9) tests the sufficiency of the defendant's pleadings, and is appropriately granted where the defendant has failed to state a valid defense to a claim. *Slater v Ann Arbor Public Schools Bd of Ed*, 250 Mich App 419, 425-426; 648 NW2d 205 (2002). A defense to a claim is invalid for the purposes of MCR 2.116(C)(9) "when the defendant's pleadings are so clearly untenable that as a matter of law no factual development could possibly deny the plaintiff's right to recovery." *Id.* A motion for summary disposition brought under MCR 2.116(C)(10) tests the factual sufficiency of the plaintiff's complaint. *Morris & Doherty, PC v Lockwood*, 259 Mich App 38, 42; 672 NW2d 884 (2003) (citation omitted). A motion for summary disposition is appropriately granted under MCR 2.116(C)(10) when, viewed in the light most favorable to the nonmoving party, the submitted evidence fails to establish a genuine issue of material fact, and the moving party is entitled to judgment as a matter of law. *Maiden v Rozwood*, 461 Mich 109, 120; 597 NW2d 817 (1999) (citations omitted).

This case also involves the interpretation of various statutes. "Issues of statutory interpretation are questions of law that [the Court of Appeals] reviews de novo." *Krohn v Home-Owners Ins Co*, 490 Mich 145, 155; 802 NW2d 281 (2011).

B. ANALYSIS

As discussed, since the accident in 1978, plaintiff has received Medicare coverage for his medical bills. Because no insurance policy covered plaintiff, defendant, as the assigned claims facility insurer, has also paid plaintiff no-fault PIP benefits for his incurred medical expenses. Thus, while most no-fault benefit recipients would use PIP benefits to cover medical bills, in this case, plaintiff's medical bills are paid by Medicare and plaintiff also receives checks from defendant for the cash value of the same medical expenses covered by Medicare. Defendant characterizes this as impermissible "double-dipping." It does appear that plaintiff may be receiving duplicative compensation. However, the Legislature has, specifically permitted recipients of assigned-claims no-fault benefits to receive duplicative compensation from Medicare by making the assigned-claims payment structure partially uncoordinated as to Medicare. Whether or not that is a wise policy choice, the trial court correctly ruled that defendant may not set off the Medicare payments.

Because plaintiff's accident occurred in 1978, it preceded the congressional enactment of the Medicare Secondary Payer provision of the Omnibus Budget Reconciliation Act of 1980, 42 USC 1395y(b)(2)(a), which prevents Medicare from acting as the primary payer for auto accident injuries.[2] The statute only applies to accidents that occurred after December 5, 1980. 42 CFR § 411.50. Thus, had plaintiff's accident occurred after December 5, 1980, defendant would be the primary payer for plaintiff's medical expenses pursuant to the Assigned Claims Facility statute, MCL 500.3171, *et seq*.

There is no dispute that plaintiff, who had no applicable no-fault coverage, would ordinarily be entitled to PIP benefits from defendant through the assigned claims plan.[3] Indeed,

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[2] The Medicare Secondary Payer provision in 42 USC 1395y(b) provides, in part:

> (2) Medicare secondary payer
>
> (A) In general
>
> Payment under this subchapter may not be made, except as provided in subparagraph (B), with respect to any item or service to the extent that--
>
> (i) payment has been made, or can reasonably be expected to be made, with respect to the item or service as required under paragraph (1), or
>
> (ii) payment has been made or can reasonably be expected to be made under . . . no fault insurance.
>
> In this subsection, the term "primary plan" means . . . no fault insurance, to the extent that clause (ii) applies.

[3] As our Supreme Court explained in *Thompson v DAIIE*, 418 Mich 610, 623; 344 NW2d 764 (1984):

defendant paid plaintiff PIP benefits for nearly three decades. Defendant now takes the position that it should no longer pay those PIP benefits, and presumably should never have paid those benefits, because plaintiff's medical expenses covered by Medicare should be subject to offset under MCL 500.3109(1), which provides: "Benefits provided or required to be provided under the laws of any state or the federal government shall be subtracted from the personal protection insurance benefits otherwise payable for the injury."

We need not address whether any offset would be appropriate under MCL 500.3109(1), however, because that statute, and the case law addressing that statute, contemplates a payee receiving benefits pursuant to some kind of *purchased* no-fault insurance policy. See *O'Donnell v State Farm Mut Auto Ins*, 404 Mich 524; 273 NW2d 829 (1979); *Jarosz v DAIIE*, 418 Mich 565; 345 NW2d 563 (1984); and *Crowley v DAIIE*, 428 Mich 270; 407 NW2d 372 (1987).

> No-fault benefits are payable when there is no insurance; this is accomplished through the assigned claims facility, which provides benefits when an owner or driver is not insured or cannot be identified. That facility provides a means of requiring persons who in fact contribute to the no-fault system to pay for those who do not, and functions like the Second Injury Fund by assessing all automobile insurers for the cost.

Plaintiff qualified for PIP benefits through the assigned claims facility pursuant to MCL 500.3172(1), which provides, in part:

> A person entitled to a claim because of accidental bodily injury arising out of the ownership, operation, maintenance, or use of a motor vehicle as a motor vehicle in this state may obtain personal protection insurance benefits through an assigned claims plan if no personal protection insurance is applicable to the injury, no personal protection insurance applicable to the injury can be identified, the personal protection insurance applicable to the injury cannot be ascertained because of a dispute between 2 or more automobile insurers concerning their obligation to provide coverage or the equitable distribution of the loss, or the only identifiable personal protection insurance applicable to the injury is, because of financial inability of 1 or more insurers to fulfill their obligations, inadequate to provide benefits up to the maximum prescribed.

Thus, the Assigned Claims Facility represents the insurer of last priority. *Spencer v Citizens Ins Co*, 239 Mich App 291, 301; 608 NW2d 113 (2000).

Personal protection insurance benefits, commonly called "PIP" benefits, are defined in the Michigan no-fault act pursuant to MCL 500.3107, which states, in part:

> (1) Except as provided in subsection (2), personal protection insurance benefits are payable for the following:
>
> (a) Allowable expenses consisting of all reasonable charges incurred for reasonably necessary products, services and accommodations for an injured person's care, recovery, or rehabilitation.

Some case law has addressed situations in which no offset is required; significantly, however, this was because insurers were required under MCL 500.3109a to provide an option for their paying customers to elect whether or not to coordinate coverage. See *LeBlanc v State Farm Mut Auto Ins Co*, 410 Mich 173, 206-207; 301 NW2d 775 (1981) ("Since plaintiff in the instant case did not elect to coordinate his Medicare benefits with his no-fault benefits, payments made on his behalf by the Medicare program may not be subtracted from the no-fault benefits due under the no-fault policy issued to him by defendant."), cf *Tatum v Gov't Employees Ins Co*, 431 Mich 663, 670-671; 431 NW2d 391 (1988) (the defendant insurer was not entitled to a setoff because the defendant failed to offer the plaintiff the option of a coordinated no-fault policy). Notably, we have not found any published case law applying the offset under MCL 500.3109(1) to benefits paid pursuant to an assigned claim.

It is readily apparent from our Supreme Court's explanations of the above statutes that MCL 500.3109(1) and MCL 500.3109a are intertwined components of a single statutory scheme. In the case at bar, however, it is impossible for MCL 500.3109a to have any bearing: no insurer could have offered plaintiff a coordinated policy because plaintiff had no insurance at all. As our Supreme Court further explained, MCL 500.3109a "only applies to benefits payable to [a] person named in a no-fault policy, [his or her] spouse, and any relative of either domiciled in the same household." *Crowley*, 428 Mich at 278. None of those persons exist here, again given that plaintiff did not have a no-fault policy. Consequently, neither the offset reasoning set forth in *LeBlanc* nor the analysis pertinent to MCL 500.3109(1) applies to this case.

In contrast, MCL 500.3172 specifically applies to personal protection insurance benefits payable through assigned claims plans. MCL 500.3175(1), provides, in relevant part:

> The assignment of claims shall be made according to rules that assure fair allocation of the burden of assigned claims among insurers doing business in this state on a basis reasonably related to the volume of automobile liability and personal protection insurance they write on motor vehicles or of the number of self-insured motor vehicles. An insurer to whom claims have been assigned shall make prompt payment of loss in accordance with this act and is thereupon entitled to reimbursement by the assigned claims facility for the payments and the established loss adjustment cost, together with an amount determined by use of the average annual 90-day United States treasury bill yield rate, as reported by the council of economic advisers as of December 31 of the year for which reimbursement is sought . . . .

Critically, MCL 500.3172(2) states that PIP benefits paid by the assigned claims facility "shall be reduced to the extent that benefits covering the same loss are available from other sources," but further states that Medicare is not one of those "benefit sources." House Legislative Analysis, HB 4322, November 27, 1984, indicates that 1984 PA 426, which added the relevant setoff language in MCL 500.3172(2), granted assigned claims insurers a setoff against other benefits but explicitly contemplated not coordinating benefits with Medicaid or Medicare and making the assigned claims facility benefits primary over those government benefits. This is consistent with the plain language of the statute itself.

We appreciate the dissent's and defendant's frustration with the possible receipt by plaintiff, who had no insurance at the time of his 1978 accident, of more compensation than he has expended, at a cost to both taxpayers and insurance buyers. We further appreciate that this result may also be frustrating to no-fault insureds who might have benefits offset despite having paid for their insurance, while persons who paid nothing receive additional compensation. However anomalous the situation might seem, our Supreme Court has repeatedly instructed that our Court must enforce legislation as written rather than weigh its wisdom. See *O'Donnell*, 404 Mich at 541. Our reading of the applicable statutory law leads us to conclude that the Legislature has specifically permitted recipients of assigned-claims no-fault benefits to receive duplicative compensation from Medicare by making the assigned-claims payment structure partially uncoordinated as to Medicare. In so ruling, we express no opinion on the wisdom of this statutory scheme relative to its value as good or even wise public policy, rather we reach this result in accord with our obligation to enforce legislation as written.

Affirmed.

/s/ Amy Ronayne Krause
/s/ Stephen L. Borrello

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Before: RONAYNE KRAUSE, P.J., and SAAD and BORRELLO, JJ.

SAAD, J. (*dissenting*).

I respectfully dissent from the majority's decision to affirm the trial court's order granting summary disposition to plaintiff, Antoine Lee. For the reasons set forth below, I would reverse the trial court's order because defendant, Farmers Insurance Exchange, is entitled to summary disposition.

I. NATURE OF THE CASE

A preliminary observation is warranted in this case because of the outrageous nature of the result of the majority's ruling. This is a case in which plaintiff chose not to purchase any automobile insurance and, yet, remarkably, the majority rules that plaintiff properly has and will continue to make a profit every time he is treated by a doctor. That is, not only does Medicare pay for plaintiff's doctor bills—at taxpayers' expense—but, according to the majority, plaintiff may continue to accept a windfall of cash payments from Farmers for the same amount of money for those same medical expenses. No doubt, citizens who pay insurance premiums and taxes that support the Assigned Claims Facility (from which the money is paid via Farmers) would be offended to learn that someone who paid nothing into the no-fault system can actually profit at their expense and at the expense of the taxpayers who fund Medicare. And, when Farmers put an end to this decades-long folly, plaintiff filed this action to insist that he continue to receive something for nothing at others' expense, and the majority has accommodated his brazenness.

II. DISCUSSION

As the majority recognizes, plaintiff's medical bills are paid by Medicare and plaintiff also receives checks from defendant for the cash value of the same medical expenses covered by Medicare. I agree with Farmers that this is impermissible "double dipping" and would hold that

the Medicare benefits paid for plaintiff's medical expenses must be set off from the PIP benefits Farmers would otherwise pay for plaintiff's incurred medical expenses.

MCL 500.3109(1) provides: "Benefits provided or required to be provided under the laws of any state or the federal government shall be subtracted from the personal protection insurance benefits otherwise payable for the injury." On its face, this statute supports Farmers's position: When the accident occurred, Medicare was required to pay plaintiff's medical expenses because he qualified for Medicare coverage and MCL 500.3109(1) states that such benefits should be subtracted from any PIP benefits ordinarily payable by Farmers. The legislative intent and history of the statute also clearly militates in favor of a set off of plaintiff's Medicare benefits. As our Supreme Court explained in *Morgan v Citizens Ins Co of America*, 432 Mich 640, 648; 442 NW2d 626 (1989):

> The history of § 3109(1) indicates that the Legislature's intent was to require a set-off of those governmental benefits that *duplicated* the no-fault benefits payable because of the accident and *thereby* reduce or contain the cost of basic insurance. It is by the offsetting of duplicative benefits that § 3109(1) *thereby* reduce[s] or contain[s] the cost of basic insurance. It is not within the purpose of § 3109(1) to require the offset of governmental benefits that are not duplicative. [Internal quotation and citation omitted.]

Here, it is clear that the payment of PIP benefits to plaintiff was, indeed, duplicative, because plaintiff did receive and seeks to continue receiving payments for incurred medical expenses that were already paid by Medicare. It appears, therefore, that MCL 500.3109(1) should eliminate Farmers's responsibility to pay any duplicative amounts in PIP benefits to plaintiff.

Notwithstanding what appears to be plainly set forth in MCL 500.3109(1), however, our courts have ruled, in some contexts, that Medicare benefits are not subject to the mandatory offset. Though the majority avoids any analysis of *LeBlanc v State Farm Mut Auto Ins Co*, 410 Mich 173; 301 NW2d 775 (1981), it is clear that both plaintiff and the trial court primarily relied on *LeBlanc* in concluding that Medicare benefits may not be offset under MCL 500.3109(1). I agree with the majority that *LeBlanc* is not dispositive, but its discussion is instructive in reaching the conclusion that Farmers should prevail.

In *LeBlanc*, our Supreme Court considered "whether MCL 500.3109 and 500.3109a . . . can be construed to allow a no-fault insurer to set off for Medicare benefits . . . ." *Id*. at 188. As noted, the Court in *LeBlanc* also interpreted MCL 500.3109a, which provides:

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

In other words, under MCL 500.3109a, the no-fault act requires insurers to allow policyholders to elect coordinated coverage at a lower premium rate, thereby making the policyholder's other insurer primarily responsible for certain expenses that arise from the accident—usually medical expenses—and renders the no-fault carrier secondarily responsible for those expenses.

In *LeBlanc*, the plaintiff sustained injuries in an accident involving a vehicle. *Id*. at 187. The plaintiff was over 65 years old at the time of the accident, and was already eligible to receive Medicare benefits under the Social Security Act. *Id*. The plaintiff had also purchased an uncoordinated no-fault insurance policy through State Farm. *Id*. Medicare paid for most of the plaintiff's medical expenses and State Farm paid the balance, but State Farm refused to pay the plaintiff for the Medicare-reimbursed hospital and other medical expenses. *Id*. at 187-188. According to State Farm, the Medicare payments had to be subtracted from the plaintiff's no-fault benefits under MCL 500.3109(1). *Id*. at 188.

Specifically, State Farm argued in *LeBlanc* that Medicare benefits are "government benefits" subject to the set off provision in MCL 500.3109(1), and, therefore, do not qualify as "other health and accident coverage" in MCL 500.3109a. *Id*. at 201. The Supreme Court disagreed with this rationale and ruled that the terms in each statutory section are not interdependent. *Id*. The Court also rejected State Farm's argument that Medicare benefits are "government benefits" and cannot be private benefits under MCL 500.3109a, simply "because they are provided pursuant to federal law, are administered by agencies of the federal government, and are funded by federal tax schemes." *Id*. at 201-202. The Court reasoned that, while MCL 500.3109(1) indisputably refers to "government" benefits, government benefits are not excluded in MCL 500.3109a. *Id*. at 202. In other words, Medicare may qualify as "other health and accident coverage" because, in MCL 500.3109a, the Legislature did not limit the source of such coverage in any way and did not use the word "private" to describe "other coverage." *Id*. at 202-203. Thus, the *LeBlanc* Court ruled that "participants in the Medicare program qualify for permissive coordination of benefits under [§] 3109a, rather than for mandatory coordination of benefits under [§] 3109(1) . . . ." *Id*. at 203.

Importantly, the central holding in *LeBlanc* is not that Medicare is excluded from the set off in MCL 500.3109(1), but that it is *included* as "other health and accident coverage" in the coordination section, MCL 500.3109a. *Id*. at 205. The Court summarized its holding as follows:

> Medicare constitutes "other health and accident coverage" within the meaning of [§] 3109a of the no-fault act. Thus, payments made to health care providers pursuant to the Medicare program for expenses arising out of the same accident for which no-fault benefits are also payable may be subtracted from payable no-fault benefits at the option of the insured. Since plaintiff in the instant case did not elect to coordinate his Medicare benefits with his no-fault benefits, payments made on his behalf by the Medicare program may not be subtracted from the no-fault benefits due under the no-fault policy issued to him by defendant. [*Id*. at 206-207.]

Again, because the plaintiff in *LeBlanc* had an uncoordinated no-fault policy with State Farm, and because Medicare is a source of "other health and accident coverage" under MCL

500.3109a, State Farm was required to offer a less expensive coordinated policy or pay the plaintiff benefits that, in essence, duplicated his Medicare coverage.

In my view, the trial court erred by relying on *LeBlanc* because the facts and circumstances differ in this case.[1] Here, plaintiff did not have a no-fault policy of insurance, let alone an uncoordinated policy under which he may have contracted to receive medical payments from both Medicare and a no-fault insurer. Further, this case does not involve MCL 500.3109a. Indeed, no insurer *could* offer plaintiff a less expensive coordinated policy as required by MCL 500.3109a, because he elected to pay for no coverage at all. Also, as our Supreme Court later recognized in *Crowley v DAIIE*, 428 Mich 270; 407 NW2d 372 (1987), MCL 500.3109a only applies to benefits payable to a person named in a no-fault policy, a spouse or a household resident, and none of those factors apply to plaintiff who, again, did not have a no-fault policy. Stated simply, plaintiff is not within the class of people eligible for the coordination of benefits under MCL 500.3109a and, contrary to the trial court's holding, the reasoning in *LeBlanc* does not apply.

Moreover, the *LeBlanc* Court's reasoning with regard to the application of the two statutory sections in the context of Medicare coverage was necessarily premised on the fact that the plaintiff qualified for Medicare on the basis of his age and, like many other elderly residents, used Medicare as his primary source of health insurance. In that context, the Court could reasonably read MCL 500.3109a to require insurers to provide voluntary coordination of benefits at a reduced cost, without automatically excluding the possibility of coordination with Medicare by applying MCL 500.3109(1). But here, again, plaintiff did not pay for no-fault insurance and he also did not have other health or accident benefits. Rather, plaintiff received Medicare coverage only because of the auto accident. This distinction is decisive, as our Supreme Court explained in an opinion released three years after *LeBlanc*, *Jarosz v DAIIE*, 418 Mich 565; 345 NW2d 563 (1984).

In *Jarosz*, the plaintiff could no longer work after he sustained injuries in an accident on June 27, 1977. *Id*. at 569. At the time of that accident, Mr. Jarosz was 64 years old and qualified for social security old age benefits. *Id*. Mr. Jarosz's no-fault insurer, DAIIE, claimed that, pursuant to MCL 500.3109(1), it could set off part of his social security benefits from the amount of work loss benefits DAIIE would otherwise owe. The Supreme Court described the issue as follows: "The specific question we are required to decide in this case is whether the social security old-age benefits Mr. Jarosz is receiving are the kind of governmental benefits the Legislature intended to be subtracted from no-fault benefits. In answering that question, we take this occasion to delineate a standard or test by which such benefits may be identified in future cases." *Id*. at 573. The Court quoted with approval *O'Donnell v State Farm Mut Auto Ins*, 404 Mich 524; 273 NW2d 829 (1979), for its observation that "'[t]he history of § 3109(1) indicates that the Legislature's intent was to require a setoff of those government benefits that duplicated

[1] For similar reasons, plaintiff's reliance on *Kilburn v Progressive Michigan Ins Co*, unpublished opinion per curiam of the Court of Appeals, issued March 29, 2007 (Docket No. 272379) is also misplaced.

the no-fault benefits payable because of the accident and thereby reduce or contain the cost of basic insurance.'" *Id*. at 574, quoting *O'Donnell*, 404 Mich at 544. To effectuate this intent, the *Jarosz* Court explained:

> We conclude that the correct test is: state or federal benefits "provided or required to be provided" must be deducted from no-fault benefits under § 3109(1) if they:
>
> 1) Serve the same purpose as the no-fault benefits, and
>
> 2) Are provided or are required to be provided as a result of the same accident. [*Jarosz*, 418 Mich at 577.]

If the benefits received satisfy the above test, they are "duplicate" benefits and are subject to the set off in MCL 500.3109(1). *Id*. at 579-580.

In describing how the test should apply, the *Jarosz* Court observed that, for the first part of the test, courts should inquire whether "the federal or state law that provides the governmental benefits or requires them to be provided must specifically base payment of benefits upon the happening of an event, and an automobile accident must qualify as such an event." *Id*. at 581-582. And, "[f]or purposes of the second criterion of our two-part test, the benefits received must be contingent upon the occurrence of the same automobile accident." *Id*. at 582.

The Court ruled that Mr. Jarosz's social security benefits did not serve the same purpose as the no-fault work loss benefits and the triggering event to receive the social security benefits was his age, 65, not because Mr. Jarosz was disabled as a result of the accident. *Id*. at 582-583. Accordingly, because the benefits did not "duplicate" the no-fault work loss benefits, DAIIE was not entitled to the offset in MCL 500.3109(1). *Id*. at 584-585.

Here, plaintiff received Medicare coverage for his medical expenses specifically because he was disabled in the auto accident and Medicare covered the medical expenses for which he seeks reimbursement from Farmers. The Medicare payment "duplicates" the no-fault benefit plaintiff seeks and it must be set off under MCL 500.3109(1). It is telling that, at the motion hearing, plaintiff agreed to limit his demand from Farmers to only those amounts actually paid by Medicare for his medical expenses, which clearly indicates plaintiff's intent to recover amounts that exactly duplicate plaintiff's Medicare coverage. This kind of double recovery is plainly contrary to MCL 500.3109(1).

This position is consistent with the Supreme Court's analysis in *O'Donnell*, in which our Supreme Court also explained:

> One of the most important principles of statutory interpretation is that the words of the statute should be construed in light of the Legislature's intent. See, e.g., *Moore v Department of Military Affairs*, 398 Mich 324; 247 NW2d 801 (1976). The history of § 3109(1) indicates that the Legislature's intent was to require a set-off of those government benefits that duplicated the no-fault benefits payable because of the accident and thereby reduce or contain the cost of basic insurance. [*O'Donnell*, 414 Mich at 544.]

That the set off under MCL 500.3109(1) applies here is the only result in keeping with the intent of the Legislature and sound public policy. Plaintiff has received Medicare coverage as a result of his disabling car accident, yet he has also received and seeks to continue receiving from the assigned claims facility duplicate cash payments for bills already paid by Medicare. Indeed, it is clear that plaintiff, by taking advantage of both government programs, is collecting more than had he actually paid for health and no-fault insurance.[2] Our courts have repeatedly recognized that MCL 500.3109(1) was specifically drafted for purposes of "maintaining or reducing premium costs for all insureds through the elimination of duplicative benefits recovery." *LeBlanc*, 410 Mich at 191, quoting *O'Donnell*, 404 Mich at 544-545. Further, it is anathema to the concept of justice to permit someone to recover cash payments that duplicate free federal social insurance benefits from an assigned claims insurer when he did not pay into the no-fault system.

I would hold that, as a matter of law, Farmers is entitled to set off the amounts paid by Medicare for plaintiff's accident related injuries for any PIP benefits otherwise payable as specifically contemplated in MCL 500.3109(1).[3] Further, because Farmers was not obligated to

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[2] Defendant's point is fundamentally correct that plaintiff is seeking to "double dip" from two government programs, Medicare and the assigned claims facility, which requires coverage of claims by insurers doing business in Michigan, but also permits those insurers to recover such costs from the state. MCL 500.3175(1), provides, in relevant part:

> The assignment of claims shall be made according to rules that assure fair allocation of the burden of assigned claims among insurers doing business in this state on a basis reasonably related to the volume of automobile liability and personal protection insurance they write on motor vehicles or of the number of self-insured motor vehicles. An insurer to whom claims have been assigned shall make prompt payment of loss in accordance with this act and is thereupon entitled to reimbursement by the assigned claims facility for the payments and the established loss adjustment cost, together with an amount determined by use of the average annual 90-day United States treasury bill yield rate, as reported by the council of economic advisers as of December 31 of the year for which reimbursement is sought . . . .

[3] I would reject plaintiff's claim that Medicare is exempt from any set off because of the language in MCL 500.3172(2). That section states that PIP benefits paid by the assigned claims facility "shall be reduced to the extent that benefits covering the same loss are available from other sources," but further states that Medicare is not one of those "benefit sources." This section is unrelated to the set off provision, MCL 500.3109(1), and in no way prohibits the consideration of Medicare benefits under § 3109(1). MCL 500.3172(2) simply recognizes that benefits may be available from sources other than an assigned claims insurer and that the insurer is entitled to seek reimbursement for those benefits from applicable third parties.

pay plaintiff PIP benefits for the reasons set forth above, I would hold that the trial court erred in awarding plaintiff attorney fees and costs pursuant to MCL 500.3148.

/s/ Henry William Saad