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The Intersection of the Affordable Care Act and the Michigan No-Fault Automobile Insurance Act

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About the Author

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INTRODUCTION[1]

The Patient Protection and Affordable Care Act[2] (ACA) provides Americans with a broad range of rights and benefits regarding health insurance that they have never had under federal law. The people of Michigan, as do all Americans, need to be knowledgeable of these rights and benefits so they can make the best decisions regarding their health care and their purchase of health insurance going forward. However, it is also important to understand how the ACA intersects with Michigan state laws relating to health care. One such law is the Michigan No-Fault Automobile Insurance Act (hereinafter 'the MNFA").[3] For over 40 years, the MNFA has created a unique system of automobile insurance in Michigan that ultimately provides comprehensive health insurance coverage for the care, recovery and rehabilitation of people injured in motor vehicle accidents. The essential purpose of this article is to examine how the ACA and the MNFA intersect and what that means for the people of Michigan.

Although the ACA is over 2,000 pages long, there is not a single reference within those pages indicating how ACA coverage should operate in relation to auto no-fault insurance. Furthermore, the Michigan Legislature has not amended the MNFA or passed any other law providing guidance about the relationship between the MNFA and the ACA. Moreover, there is no case law addressing how these two laws relate to one another. Therefore, in order to properly and thoroughly examine the intersection between these two unique laws, it is necessary to first explain the basic principles and important concepts of each law. Accordingly, Section I of this article explains the basic principles of the ACA and the

[1]Note from author: I thank my firm and my family for tolerating the time it took me to write this article. I also greatly thank my father, George T. Sinas, my partner and mentor, Timothy J. Donovan, my brother, Thomas G. Sinas, and my former no-fault law professor and friend, Wayne J. Miller, for their great insight regarding various issues addressed in this article. Moreover, I greatly thank my fellow Wayne State University Law School alumni and State Bar of Michigan Health Law Section Member, Mercedes Varatesh Dordeski, for serving as the official editor of this article. I also thank juris doctorate candidate, Jonathan Homa, who helped with the research, citations and editing of this article.

[2] 42 U.S.C. 18001, *et seq*.

[3] MCL 500.3101, *et seq*.

rights and benefits the ACA provides with respect to health insurance. Section II explains the basic principles of the MNFA and the rights and benefits it provides to people who are injured in motor vehicle accidents. Section III then examines the intersection of the ACA and the MNFA and reaches the following conclusions:

- The coverage under the MNFA for the care, recovery and rehabilitation of motor vehicle accident victims is far broader than the coverage available to those victims under the ACA.
- No-fault insurance companies should not be entitled to set off the payment of no-fault benefits by the amounts available under ACA health insurance coverage, pursuant to the MNFA's mandatory governmental benefits set off provision that applies to uncoordinated and coordinated no-fault policies. Rather, no-fault insurance companies should only be able to set off the payment of no-fault benefits by the amounts actually paid under an injured person's ACA coverage when the person is insured under a coordinated no-fault insurance policy.
- The ACA affects the analysis of whether a person should buy uncoordinated or coordinated no-fault coverage. Ultimately, because of the ACA, more people may eventually purchase coordinated no-fault coverage instead of uncoordinated no-fault coverage.
- For various reasons, the ACA may help lessen the financial burdens and costs of the Michigan no-fault system. Therefore, because the cost of no-fault insurance is the major issue underlying the ongoing no-fault reform debate in Michigan, the ways in which the ACA may help lessen the financial burdens and costs of the no-fault system must be factored into that debate.

I. THE BASIC PRINCIPLES OF THE AFFORDABLE CARE ACT

A. THE CHOICE TO OBTAIN HEALTH INSURANCE UNDER THE ACA OR PAY THE APPLICABLE TAX PENALTY

While it is maligned by some as a massive government entitlement program, the ACA is largely a rejection of the concept of people obtaining health insurance through the government. With that being said, the ACA contains certain significant aspects of government funding of health insurance for some people. The most notable of these aspects is the funding of the expansion of Medicaid to allow those with income up to 133% of the federal poverty level to be eligible for the program. Also, while the ACA does not expand the eligibility requirements of Medicare, it expands some forms of care available under Medicare and decreases the out-of-pocket expenses for some types of medical services. Furthermore, the ACA also provides subsidies to those who purchase ACA policies with income between 133-400% of the federal poverty level. However, beyond those aspects of government funding, the ACA seeks to increase health care coverage in America by having Americans obtain their own health insurance through private health insurance companies.

With regard to the obligation of employers to provide health insurance, the ACA requires employers with 50 or more full-time employees to provide health insurance to their employees. Employers of less than 50 full-time employees are not obligated to purchase health insurance for their employees. The definition of full-time employee under the ACA means any employee who, with respect to any given month, works more than 30 hours on average per week.[4] Notably, the issue of whether a person constitutes a full-time employee can be disputed, depending upon the circumstances of the person's work schedule and actual time spent at work.

If a person does not have health insurance through his or her employer, assuming the person does not fall within the categories of exceptions explained further below, he or she will need to decide whether to purchase a qualified ACA "minimum essential" health insurance policy

[4] 26 U.S.C. 4980H.

that covers the person and his or her children. If the person fails to purchase ACA health insurance, he or she will be required to pay a penalty tax to the federal government. Notably, the tax penalty is the only consequence the ACA imposes on these people. There is no threat of criminal liability, imprisonment, or denial of any other liberties and freedoms to any person who fails to obtain health insurance.

The tax penalty for not purchasing health insurance is set forth in 26 U.S.C. 5000(A)(b) and specifically states in pertinent part:

> "If a taxpayer who is an applicable individual, or an applicable individual or whom the taxpayer is liable under paragraph (3), fails to meet the requirement of subsection (a) for 1 or more months, then, except as provided in subsection (e), there is hereby imposed on the taxpayer a penalty with respect to such failures in the amount determined under subsection(c) . . ."

The tax penalty in 2015 is the higher of the following: 2% of the person's household income, or $325 per family member for the year ($162.50 per child under 18). Notably, in 2015, the maximum penalty per family under the per-person method totals $975. In 2016, the tax penalty totals 2.5% of income or $695 per person, whichever calculation method is higher.

In *National Federation of Independent Business, et al v Sebelius*, the United States Supreme Court upheld the constitutionality of the ACA's tax penalty levied against those who fail to purchase health insurance under the ACA. [5] The Court reasoned that the tax penalty imposed under the ACA was within Congress' taxing power under Article 1, Sec. 8 of the United States Constitution. In reaching this holding, the Court made it clear that the tax penalty did not actually require or mandate the American people to purchase insurance. Rather, the tax penalty essentially presents people with this choice: either purchase health insurance or pay the tax penalty. In this regard, the United States Supreme Court specifically stated in pertinent part:

[5] 132 S. Ct. 2566 (2012).

> "By contrast, Congress's authority under the taxing power is limited to requiring an individual to pay money into the Federal Treasury, no more. If a tax is properly paid, the Government has no power to compel or punish individuals subject to it. We do not make light of the severe burden that taxation—especially taxation motivated by a regulatory purpose—can impose. But imposition of a tax nonetheless leaves an individual with a lawful choice to do or not do a certain act, so long as he is willing to pay a tax levied on that choice."[6]

Therefore, despite the claim that the ACA contains a "government mandate" to purchase health insurance, the United States Supreme Court has specifically recognized that the ACA does not actually require or mandate that the American people purchase health insurance. Rather, the ACA is simply presenting Americans with the choice of either purchasing health insurance or paying the tax penalty for not doing so. This will be an important point to remember for purposes of the discussion in Section III regarding whether ACA coverage is subject set off from the payment of no-fault benefits under the governmental benefit set off provision of the MNFA.

It is also very important to understand that the ACA explicitly exempts various people from having to pay the tax penalty if they do not purchase health insurance. Specifically, these people include the following:

1. Any person insured under an employer plan (including COBRA), with or without "grandfathered" status.[7]

2. People with uninsured periods of less than 3 months. [8]

3. Members of religious groups opposed to having health insurance coverage.[9]

4. Undocumented immigrants.[10]

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[6] *Id* at 2600.
[7] 26 U.S.C. 5000A(f)(1)(D).
[8] 26 U.S.C. 5000A(e)(4)(A).
[9] 26 U.S.C. 5000A(d)(2).

5. Incarcerated persons.[11]

6. Members of Indian tribes.[12]

7. Members of health care sharing ministries.[13]

8. People with family incomes below the tax filing threshold (i.e., $10,150 for an individual; $20,600 for a family in 2014).[14]

9. People without access to affordable insurance (i.e., in 2014, their premiums for available plans cost more than 8% of income, after accounting for employer contributions or premium tax credits.[15] Notably, the income threshold will be adjusted to reflect the rate of premium growth each year going forward).[16]

10. Family members of those with affordable employee-only employer- sponsored insurance (i.e., in 2014, their premium costs less than 8% of income) but unaffordable family coverage (premiums cost more than 8% of income).[17]

11. People who live in a state that is not expanding Medicaid and are uninsured because of the non-expansion of Medicaid.

12. People whose insurance policy was not renewed (canceled) and their replacement coverage is unaffordable.[18]

13. People who experience financial or domestic circumstances that prevent them from obtaining coverage, including, but not limited to, the following circumstances: homelessness; eviction in the last six months or a shutoff notice from a utility company, or bankruptcy filing in the past six months; domestic violence; unexpected increases in essential expenses because of caring for an

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[10] 26 U.S.C. 5000A(d)(3).
[11] 26 U.S.C. 5000A(d)(4).
[12] 26 U.S.C. 5000A(e)(3).
[13] 26 U.S.C. 5000A(d)(2)(B).
[14] 26 U.S.C. 5000A(e)(2).
[15] 26 U.S.C. 5000A(e)(1)(A).
[16] 26 U.S.C. 5000A(e)(1)(D).
[17] 26 U.S.C. 5000A(e)(1)(C).
[18] 26 U.S.C. 5000A(e)(1).

ill, disabled or aging relative; substantial recent medical debt from expenses in the last 24 months; disasters that substantially damaged personal property; awaiting a marketplace eligibility appeals decision (if appeal is successful), and certain children, ineligible for Medicaid, who receive medical support through a court order.[19]

Therefore, there is a wide variety of individuals in America who can fail or refuse to buy health insurance without being required to pay the tax penalty or face any other consequence or punishment.

B. THE SCOPE OF HEALTH INSURANCE COVERAGE UNDER THE ACA

A qualified ACA "minimum essential" health insurance policy must provide "Essential Health Benefits"[20] (EHBs). EHBs include the following benefits and services:

1. **Ambulatory patient services –** These services include visits to a doctor's office, certain home-health care services and hospice care. However, these services are not required to be covered for more than 45 days per year.[21]

2. **Emergency services** - Emergency room visits and related emergency transportation costs are covered as EHBs. Furthermore, health insurers cannot penalize individuals for going out of network or for failing to obtain prior authorization for emergency services. [22]

3. **Hospitalization** - Health insurers must pay costs related to inpatient hospitalizations. However, an individual may have to pay 20% or more if he or she has not paid up to the applicable out-of-pocket cost sharing limit under his or her insurance policy. Surgeries, transplants and care in a skilled nursing facility also are included within this benefit category. However, health insurers

[19] 26 U.S.C. 5000A(e)(5).
[20] 42 U.S.C. 18022.
[21] 42 U.S.C. 18022(b)(1)(A).
[22] 42 U.S.C. 18022(b)(1)(B).

are not required to pay any more than 45 days at a skilled nursing facility.[23]

4. **Maternity and newborn care** - Policies must cover costs for prenatal care, delivery and care for the mother as well as postnatal care.[24]

5. **Mental health and substance abuse services** - All policies must provide coverage for both inpatient and outpatient services for mental health issues and substance abuse problems. However, these services may be limited to 20 days per year.[25]

6. **Prescription drugs** - At least one drug in every category and classification of federally approved drugs must be covered by ACA policies. This can be accomplished by the plan providing generic drug coverage.[26]

7. **Rehabilitative and habilitative services and devices** - Policies must provide 30 visits per year for either physical therapy, occupational therapy or chiropractor services, 30 visits for speech therapy and 30 visits for cardiac or pulmonary rehab.[27]

8. **Laboratory/Preventive services** – Certain preventive screening tests, including those for prostate exams and breast cancer screenings, must be provided free with no out-of-pocket cost to the person. A person may have to share the cost of other laboratory or preventive tests, depending on the terms of his or her policy. [28]

9. **Preventive and wellness services** - Policies must cover dozens of screenings to help prevent chronic disease. Among these services is testing for diabetes, colorectal cancer, high blood pressure, depression and HIV for those at risk. Furthermore, those who are

[23] 42 U.S.C. 18022(b)(1)(C).
[24] 42 U.S.C. 18022(b)(1)(D).
[25] 42 U.S.C. 18022(b)(1)(E).
[26] 42 U.S.C. 18022(b)(1)(F).
[27] 42 U.S.C. 18022(b)(1)(G).
[28] 42 U.S.C. 18022(b)(1)(H).

overweight must have access to dietary counseling, and smokers must have access to programs to help them stop smoking. [29]

10. **Pediatric dental and eye services** - Dental and vision care, previously not covered by many health policies, must be offered to children younger than 19. This benefit allows children to have their teeth cleaned twice a year and undergo X-rays and fillings. Children also must be able to get an eye exam and one pair of glasses or set of contact lenses a year.

EHBs are not further defined in the ACA. Rather, the ACA requires each state to select a *"benchmark plan"* to serve as a reference plan for the definition and scope of coverage for that state's EHBs. In a letter dated September 28, 2012, Governor Snyder informed the Department of Health and Human Services (HHS) that Priority Health's HMO plan has been selected as Michigan's benchmark plan for coverage years 2014 and 2015.[30] Accordingly, Priority Health's HMO plan forms Michigan's benchmark ACA plan for the years 2014 and 2015. The ACA requires Michigan to take its chosen benchmark plan *"as is."* In other words, the benchmark plan's covered services, quantitative limitations, and exclusions become the benchmark for all individual and small group health plans offered both inside and outside of the Insurance Marketplace in Michigan. However, it should be noted that the benchmark plan is a *"floor."* Therefore, it is possible for people to purchase more expensive health plans with more coverage and less limitations than those contained within the benchmark plan.

C. THE LEVELS OF COVERAGE AVAILABLE UNDER THE ACA

There are four different levels of qualified *"minimum essential"* health insurance policies that people can buy under the ACA. These four plan levels consist of the following:

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[29] 42 U.S.C. 18022(b)(1)(I).

[30] Letter from Rick Snyder, Governor of Michigan, to Kathleen Sebelius, Secretary of Health and Human Services (Sept. 28, 2012) (on file with Michigan.gov) (Discussing Michigan's benchmark essential health benefits plan), available at: https://www.michigan.gov/documents/lara/EHB_Gov_Benchmark_400142_7.pdf.

1. **Bronze Level Plans** - These plans must cover 60% of a person's health care costs.[31] The remaining 40% of health care costs must be paid by the person, subject to the personal/family cost sharing limit for EHBs explained further below. Bronze plans have the lowest premiums. The bronze plan may be a good choice for a person who does not expect to require a significant amount of health care throughout a given year.

2. **Silver Level Plans**- These plans must cover 70% of a person's health care costs, subject to the personal/family cost sharing limit for EHBs explained further below. [32] Silver plans offer additional help for those under 250% of the federal poverty limit. For these people, the silver plans offer reduced co-pays and other out-of-pocket expenses. The idea here is to help lower-income people pay for the silver level plan as opposed to have these people buy the bronze level plan simply because it is cheaper.

3. **Gold Level Plans** - These plans must cover 80% of a person's health care costs, subject to the personal/family cost sharing limit for EHBs explained further below.[33]

4. **Platinum Level Plans** - These plans must cover 90% of a person's health care costs, subject to the personal/family cost sharing limit for EHBs explained further below. [34] Despite that platinum plans have the highest premiums, these plans may be the wisest choice for a person who expects to receive a significant amount of health care throughout a given year.

It is very important to understand that the ACA provides limitations on the amount of out-of-pocket costs a person or family must pay in a given year for EHBs. This is known as the "cost sharing limit." In 2015, the current cost sharing limits are $6,600 per person and $13,200 per family. The cost sharing limit is adjusted each year by the "Premium Adjustment

[31] 42 U.S.C. 18022(d)(1)(A).
[32] 42 U.S.C. 18022(d)(1)(B).
[33] 42 U.S.C. 18022(d)(1)(C).
[34] 42 U.S.C. 18022(d)(1)(D).

Percentage," which is a standard amount determined and published each year. [35] Once a person/family has reached their yearly cost sharing limit for EHBs, their health insurance company must pick up 100% of covered benefits for the remaining portion of that given year. For example, if a family is insured under a bronze level plan, the family will need to pay 40% of their medical charges. However, once the family pays up to the cost sharing limit for a given year for EHBs, their health insurance company will become responsible to pay 100% of the family medical expenses for EHBs for the rest of that year.

Notably, money spent on health insurance premiums does not count toward the cost sharing limit.[36] Moreover, for those insured under an HMO, the services a person receives outside of his or her geographic area/network may cost more. In these situations, a person's cost-sharing for out-of-network services is not subject to the out-of-pocket maximum amount.[37] Additionally, some policies may have out-of-pocket limits that are lower than the maximum amount prescribed under the ACA. Therefore, when buying insurance, it is important for people to look at all associated costs, i.e., premiums, co-pays, deductibles and coinsurance, etc.

It should be further noted that the ACA allows people under the age of 30, as well as some people who face certain hardship exemptions, to purchase a special health insurance policy called "a catastrophic plan." [38] Catastrophic plans generally have lower premiums and higher deductibles. Marketplace catastrophic plans cover the full cost of three annual primary care visits and preventive services. However, these plans do not cover all EHBs available under a typical qualified "minimum essential" health insurance policy under the ACA. Additionally, people with catastrophic plans are not eligible for federal tax credits to lower their monthly premiums, regardless of their income level.[39] Catastrophic plans are offered based on the concept that people under the age of 30 are generally healthier and require less health care than people over the age of 30.

[35] 42 U.S.C. 18022(c)(1); 45 C.F.R. 156.130.
[36] 42 U.S.C. 18022(c)(3)(B).
[37] 45 C.F.R. 147.138(b)(3).
[38] 42 U.S.C. 18022(e).
[39] 26 U.S.C. 36B.

Notably, people under 30 avoid the tax penalty for not having insurance if they buy a catastrophic plan.

D. CONSUMER RIGHTS UNDER THE ACA

Prior to the ACA, there was no body of federal law governing private health insurance in America. The ACA now provides Americans with certain important rights that they have never had under federal law with respect to health insurance. These rights include, but are not limited to, the following:

1. **Ends discrimination for pre-existing conditions** - For all health insurance provided after January 1, 2014, the ACA prohibits health insurers from denying insurance coverage based on a pre-existing condition. Moreover, the ACA also prohibits charging a person a higher premium because of a preexisting condition. This is true even if the person has been turned down or refused coverage due to a pre-existing condition in the past. A person receiving care for a pre-existing condition will still need to pay any deductibles, copayments, and coinsurance his or her insurance plan requires. [40]

2. **Health insurance premiums can only be based on age and whether a person smokes tobacco** – Prior to the ACA, health insurance premiums could be based on a wide-variety of factors that varied in different states. However, under the ACA, premiums can only be based on the person's age and whether the person smokes tobacco.[41]

3. **Removes annual and lifetime limits on Essential Health Benefits (EHBs)** - Insurance companies cannot impose annual or lifetime spending on EHBs. However, insurance companies can still enforce these limits on spending for health care services that are not considered to constitute EHBs.[42]

[40] 42 U.S.C. 300gg-3(a).
[41] 42 U.S.C. 300gg.
[42] 42 U.S.C. 300gg-11(a)(1)(A) and 42 U.S.C. 300gg-11(b).

4. **Insurance plans must allow children to stay insured under their parents' policy until the age of 26** - Under the ACA, if a health insurance plan covers children of the insured persons, the plan must allow the children to be covered under the plan until they turn 26 years old. A person can join, remain, or return to a parent's plan even if the person is married, not living with his or her parents, attending school, financially independent, or, in most cases, eligible to enroll in an employer's plan.[43]

5. **Plain language benefits information** - Health insurance companies and group health plans are required to provide an easy-to-understand summary about a health plan's benefits and coverage. [44] This regulation is designed to help people better understand and evaluate their health insurance choices. The new forms include a short, plain language Summary of Benefits and Coverage, or SBC, and a uniform glossary of terms commonly used in health insurance coverage. All insurance companies and group health plans must use the same standard SBC form to help compare health plans.[45] The SBC form also includes details, called "coverage examples," which are comparison tools that allow people to see what the plan would generally cover in two common medical situations. A person also has the right to receive the SBC when shopping for or enrolling in coverage.[46]

6. **Providing better health insurance value for premium dollars through the 80/20 Rule** - The ACA requires health insurance companies to spend at least 80 cents of every premium dollar on expenses related to providing health care or improvements to health care. The other 20% of every premium dollar is supposed to cover a health insurance company's operating costs, overhead, claims handling expenses, etc. If a health insurance company fails to satisfy the 80/20 rule, it can be required to issue its members a

[43] 42 U.S.C. 300gg-14(a).
[44] 42 U.S.C. 300gg-15(a).
[45] 42 U.S.C. 300gg15(b).
[46] 42 U.S.C. 300gg15(b).

refund up to the amounts it failed to allocate to providing or improving health care under the rule.[47]

7. **Increased scrutiny of unreasonable premium increases** - The ACA prohibits health insurers from unreasonably increasing the cost of premiums. [48] A premium rate hike is unreasonable if, for example, it is based on faulty assumptions or unsubstantiated trends.[49] A rate hike can also be deemed unreasonable if it charges different prices to people who pose similar risks to the insurer. [50] The designated state regulator can approve or reject an unreasonable or excessive rate increase, if state laws give the regulator this authority. [51] The ACA provides grant money to each state to operate a rate review program. The operator of the rate review program in Michigan is the Insurance Commissioner and the Department of Financial and Insurance Services (DIFS).

8. **Prohibits arbitrary withdrawals of insurance coverage** – The ACA prohibits health insurance companies from rescinding coverage simply because a member made an honest mistake or left out information on the health insurance application.[52] However, a health insurance company can cancel a person's coverage if the person knowingly made a false statement or intentionally provided incomplete information on his or her insurance application.[53] A health insurance company can also cancel a person's coverage if the person fails to issue timely payment of insurance premiums.[54] A health insurance company must give a notice of termination of coverage that includes the termination effective date and reason for termination.[55]

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[47] 45 C.F.R. 158.251(a)(1).
[48] 42 U.S.C. 300gg-94.
[49] 45 C.F.R. 154.205.
[50] 45 C.F.R. 154.205.
[51] 45 C.F.R. 154.210.
[52] 42 U.S.C. 300gg-42(a).
[53] 42 U.S.C. 300gg-42(b).
[54] 42 U.S.C. 300gg-42(b).
[55] 45 C.F.R. 156.270.

9. **No prior authorization required for emergency services in or out of network** - In cases of medical emergencies, an ACA plan must cover emergency medical care without regard to whether the provider is within a person's network. Moreover, the insurer generally cannot impose any co-payment or coinsurance greater than what the person would have to pay if the person treated within network.[56] However, a health insurer under the ACA must cover out-of-network emergency care only at the same level it would if the person were in-network. If the out-of-network provider charges more, the patient may have to pick up the balance.

10. **No co-pay or deductibles for certain preventative services** - As a way of encouraging people to receive preventative services, the ACA requires health insurance companies to pay the full costs of these services, which includes preventative services and tests such as: blood pressure tests, cholesterol tests, mammograms, colonoscopies, etc.

11. **Right to appeal decisions made by ACA health insurer** - The right to bring a private cause of action against the health insurer is not well established under the ACA. The ACA allows states to implement procedures by which people can appeal the decisions made by health insurers. In Michigan, people must appeal decisions made by health insurers through the appeal procedures set forth in the health insurance policy and/or through the external review procedures established under the Michigan Patient's Right to Independent Review Act (PRIRA).[57] Therefore, people are typically limited in their ability to have their health insurance grievances decided through the ordinary judicial process, i.e., discovery, trial by jury, etc.

Ultimately, the ACA empowers Americans with rights regarding health insurance that they have never had before under federal law. These substantive rights increase the scope of health insurance coverage available

[56] 42 U.S.C. 300gg-19a.
[57] MCL 550.1901, *et seq.*

to Americans and will presumably improve the quality of that coverage. It may be the case that these rights will result in more people having a better overall consumer experience with health insurance. This would be a welcomed change, especially for those who have had miserable experiences dealing with health insurance.

II. THE BASIC PRINCIPLES OF THE MICHIGAN NO-FAULT AUTOMOBILE INSURANCE ACT (MNFA)

A. THE GOALS AND OBJECTIVES OF THE MNFA

In Michigan, before the MNFA was enacted over 41 years ago, the damages caused by motor vehicle accidents were all subject to traditional tort law principles. Under these principles, people injured in motor vehicle accidents had to sue the at-fault driver in order to recover payment of their damages, including their medical expenses. If there was a dispute about fault, the injured person's medical bills would not be paid until the litigation was over. If the injured person was ultimately found to be at-fault, the person would not be entitled to recover medical expenses from his or her own automobile insurance, and there would often not be another source of insurance from which the injured person could recover adequate payment for his or her accident related medical expenses. This system was fraught with delays and led to many unfair and inadequate results, especially for those most catastrophically injured in motor vehicle accidents. The MNFA was enacted to provide a better way for Michigan to deal with the high costs and damages caused by motor vehicle accidents.

The MNFA compels owners or registrants of a motor vehicle intended to be operated on Michigan roads for more than 30 day to buy what is known as no-fault personal injury protection (PIP) coverage (hereinafter "no-fault coverage"). [58] In fact, the MNFA imposes criminal liability in the form of a misdemeanor punishable up to a year in jail against a vehicle owner or registrant who fails or refuses to insure his or her vehicle with no-fault coverage.[59] As explained further herein, no-fault

[58] MCL 500.3102(1).
[59] MCL 500.3102(2).

coverage provides payment for reasonably necessary medical and rehabilitation expenses incurred to treat motor vehicle accident victims, as well as payment of certain other economic losses sustained by those victims.

No-fault benefits are payable regardless of fault and are payable for "accidental bodily injury arising out of the ownership, operation, maintenance or use of a motor vehicle as a motor vehicle." [60] A person injured in a motor vehicle accident in Michigan can be denied no-fault coverage only in these six limited situations: (1) the person intentionally suffered his or her own injury[61]; (2) the person was injured in a motor vehicle accident involving an uninsured motor vehicle with respect to which the person was an owner or registrant[62]; (3) the person was injured while using a motor vehicle he or she knew or should have known was unlawfully taken[63]; (4) the person was not a resident of Michigan and did not have automobile insurance through an insurance company authorized to sell insurance in Michigan[64]; (5) the person was operating a motor vehicle that was insured under an insurance policy under which he or she was listed as an excluded driver[65]; (6) the injured person committed or was complicit in committing an act of fraud or misrepresentation in the procurement of the auto no-fault policy covering the person at the time of the accident. As long as those six limited situations do not apply, a victim of a motor vehicle accident occurring in Michigan will be entitled to recover payment of his or her medical expenses arising out of the ownership, operation, maintenance or use of a motor vehicle as a motor vehicle.

It should be further noted that motorcyclists are entitled to no-fault coverage only when injured in an accident that also involves a "motor vehicle" (e.g., a car hitting a motorcyclist). Under the MNFA, a motorcycle is not a motor vehicle. Rather, a motor vehicle is any vehicle "operated or

[60] MCL 500.3105(1).
[61] MCL 500.3105(4).
[62] MCL 500.3113(b).
[63] MCL 500.3113(a).
[64] MCL 500.3113(c).
[65] MCL 500.3113(d).

designed for operation upon a public highway by power other than muscular power which has more than 2 wheels." [66] If there is no involvement with a motor vehicle (e.g., a motorcyclist runs off the road because of his or her own doing), the motorcyclist will not be entitled to no-fault coverage.

Ultimately, Michigan's auto no-fault insurance system is based on the concept that driving a motor vehicle is inherently dangerous, and that just like how people buy their own health insurance to insure themselves against the risks of becoming sick or ill, people who operate motor vehicles should insure themselves against the risks of being injured while doing so. Furthermore, as explained by the Michigan Supreme Court in the landmark no-fault decision of *Shavers v Kelley*, et al, in replacing traditional tort law as the legal regime applicable to auto accidents in Michigan, "the goal of the no-fault insurance system was to provide victims of motor vehicle accidents assured, adequate, and prompt reparation for certain economic losses."[67]

B. UNDERSTANDING NO-FAULT PIP COVERAGE AND THE RELATED LIMITATIONS ON RECOVERING DAMAGES FROM THE AT-FAULT DRIVER

The MNFA provides broad and comprehensive coverage for the care, recovery and rehabilitation of all motor vehicle accident victims, regardless of whether those victims were at-fault for the accident. Specifically, under MCL 500.3107(1)(a), motor vehicle accident victims are entitled to pursue no-fault benefits called "allowable expense benefits," which are defined as "all reasonable charges incurred for reasonably necessary products, services or accommodations for the injured person's care, recovery, or rehabilitation." [68] Michigan courts have interpreted this language to provide coverage for much more than the victim's expenses for medical and rehabilitation services arising from his or her injuries. Rather, Michigan courts have made it clear that allowable expense benefits can

[66] MCL 500.3101(2)(h).
[67] 402 Mich 554, 578-579 (1978).
[68] MCL 500.3107(1)(a).

include, but are not limited to, payment for the following: in-home patient care service rendered either by family members or by commercial nursing companies[69]; handicap-accessible home accommodations[70]; handicap-accessible transportation accommodations[71]; medical mileage[72]; vocational rehabilitation services[73]; guardian/conservatorship services[74].

Under MCL 500.3107(1)(a), a no-fault insurer is obligated to pay a "reasonable charge" for an allowable expense benefit. Moreover, under MCL 500.3157, a medical provider's charge must not exceed the amount the provider customarily charges in cases not involving any form of insurance. Importantly, the MNFA does not contain any further definitions of a reasonable charge and does not contain any other limitations such as fee schedules, benefit formulas, etc. As a general proposition, the determination of whether a charge is "reasonable" is a question of fact to be decided through a trial.[75] Furthermore, Michigan courts have made it clear that the amounts customarily paid to hospitals by third-party payers, such as Workers Compensation, Medicare, Medicaid, Blue Cross Blue Shield, HMO's and PPO's, etc., are irrelevant to determining whether a medical providers charge is "reasonable" under the MNFA.[76] There is often not a perfectly clear answer as to whether a provider's charge satisfies the reasonable charge standard. Accordingly, this issue is frequently disputed between providers and no-fault insurance companies. It is true that the reasonable charge standard allows providers to seek payment for their auto-related medical services at a rate that is typically higher than the rates

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[69] *Douglas v Allstate*, 492 Mich 241 (2012).
[70] *Sharp v Preferred Risk Mutual Insurance Company*, 142 Mich App 499 (1985).
[71] *Admire v Auto-Owners*, 494 Mich 10 (2013).
[72] *Id.*
[73] *Kondratek v Auto Club Ins Ass'n*, 163 Mich App 634 (1987); *Tennant v State Farm*, 143 Mich App 419 (1985).
[74] *In Re Estate of Carroll*, 300 Mich App 152 (2013).
[75] *Nasser v ACIA*, 435 Mich 33 (1990) .
[76] *Johnson v Michigan Mutual Ins Co*, 180 Mich App 314 (1989) (amounts paid by Medicaid irrelevant); *Hofmann v Auto Club Ins Ass'n*, 211 Mich App 55 (1995) (amounts charged by private health insurance irrelevant); *Munson Medical Center v Auto Club Ins Ass'n*, 218 Mich App 375 (1996) (workers compensation fee schedules irrelevant); *Mercy Mt Clemens Corp v Auto Club Ins Ass'n*, 219 Mich App 46 (1996) (reimbursement rates from other forms of insurance irrelevant and inadmissible).

paid by many other forms of insurance. However, as will be explained further below in Section II. D, there are several ways in which providers receive payment for auto accident-related medical expenses in an amount that is less than the amount that would normally constitute a "reasonable charge" under the MNFA.

Importantly, there are no annual or lifetime monetary caps on the amount an injured person can recover for allowable expense benefits. As long as the injured person can demonstrate the ongoing need for the benefits, the person can claim allowable expense benefits for life. In this regard, the comprehensive medical coverage available under the MNFA is especially beneficial for the most catastrophically injured auto accident victims who require lifelong medical and rehabilitative services, such as those suffering severe brain injury or spinal cord injury.

Notably, other states that have auto no-fault insurance systems have low monetary caps for accident-related medical expenses which are easily exceeded in accidents resulting in serious injuries. When these caps are exceeded, accident victims become dependent upon Medicaid, Medicare or other tax-payer funded government insurance systems. Michigan's auto no-fault insurance system protects Medicaid and other tax-payer funded government insurance programs from being responsible for the enormous costs of treating and caring for those injured in motor vehicle accidents. Therefore, while auto insurance rates in Michigan are comparably higher than other states, it is a fact that Michigan's no-fault insurance systems provides the country's most complete coverage for the care, recovery and rehabilitation of those seriously injured motor vehicle accidents.

In addition to allowable expenses benefits, no-fault coverage also includes three other benefits: (1) work loss benefits; (2) replacement service benefits; and (3) survivor's loss benefits. Work loss benefits are available for up to three years after the accident and are payable for "loss of income from work an injured person would have performed . . . if he or she had not been injured."[77] Work loss benefits are payable at the rate of 85% of

[77] MCL 500.3107(1)(b).

gross pay, including overtime. However, the work loss benefit cannot exceed the legal monthly maximum, which is currently $5,392 per month.[78]

Replacement service benefits consist of reimbursement to the injured person for expenses incurred to obtain "ordinary and necessary" services that the injured person would have performed had the injury not occurred. This benefit is limited to $20 per day and is available for up to three years after the date of the accident. Replacement services are primarily meant to cover household services, such as typical housekeeping chores, yard work, snow removal, etc.[79]

Survivor's loss benefits are payable to the dependents of a person who dies in a motor vehicle accident. These benefits cover the decedent's "contributions of tangible things of economic value, not including services, that the dependents would have received" if the decedent had not died in the subject motor vehicle accident.[80] Survivor's loss benefits also include payment of replacement service benefits discussed above. Survivor's loss benefits are subject to the same monthly maximum that applies to work loss benefits.[81] These benefits primarily consist of the after-tax income of the person who died, the value of any fringe benefits lost as a result of the person's death, and the value of the household chores and services the decedent provided to the family.[82] Additionally, insurance companies are also required to pay, at minimum, $1,750 for funeral and burial expenses.[83]

In exchange for the right to recover no-fault benefits regardless of fault, the MNFA imposes significant limitation on a motor vehicle victim's right to recover damages from an at-fault driver, as long as the at-fault driver is either insured under a Michigan no-fault policy or is an out-of-state resident who is involved in an accident occurring in Michigan and insured by an insurance company certified to sell automobile insurance in Michigan.[84] Most significantly, the MNFA grants the at-fault driver

[78] *Id*; Mich Admin Code R 500.811.
[79] MCL 500.3107(1)(c).
[80] MCL 500.3108.
[81] *Id.*
[82] *Id.*
[83] MCL 500.3107(1)(a)(ii).
[84] MCL 500.3135(3).

immunity from liability for any medical expenses the injured person recovers through his or her no-fault coverage. [85] In this regard, the MNFA essentially abolishes the rights of the injured person to recover his or her medical expenses from the at-fault driver. However, the at-fault driver does not have immunity for medical expense liability if the at-fault driver was uninsured or intentionally inflicted the injury.[86] Ultimately, the tort immunity for medical expenses is an essential feature of the MNFA that eliminates the threat of a properly insured Michigan motorist becoming financially liable for the medical expenses of people he or she may mistakenly injure while operating a motor vehicle.

Furthermore, under the MNFA, an at-fault driver can only be sued for economic damages that are commonly referred to as "excess economic loss damages." These damages most frequently consist of the injured person's income loss that is not otherwise covered by no-fault work loss benefits. In this regard, if a motor vehicle accident victim loses income in excess of the applicable monthly maximum amount, or loses income beyond the three year work loss benefits that are payable under the MNFA, the victim can pursue that excess income loss from the at-fault driver.[87] Additionally, if an accident victim dies, the at-fault driver can be held liable for the loss of the household services the victim provided to his or her dependents in excess of those services that are covered as survivor's loss benefits.[88] However, under current case law, if the accident victim does not die, the at-fault driver cannot be held liable for the loss of the household services the victim provided to his or her dependents in excess of those services covered as replacement service benefits.[89] Ultimately, beyond these damages, an at-fault driver faces virtually no other financial liability for the injured person's economic damages sustained as a result of the accident.

The MNFA also expressly limits an injured person's right to recover noneconomic damages from the at-fault driver. Noneconomic damages cover losses that affect a person's quality of life, such as pain and suffering,

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[85] *Id.*
[86] *Id.*
[87] *Id.*
[88] *Id.*
[89] See *Johnson v Recca,* 492 Mich 169 (2012).

disability, incapacity, mental anguish, shock, humiliation, embarrassment, loss of society and social pleasures, etc. Under the MNFA, an injured person can only recover noneconomic loss damages from the at-fault driver if that person sustains an injury that constitutes one or more of the following: (1) serious impairment of body function; (2) permanent serious disfigurement; or (3) death.[90] Essentially, by imposing these limits, the MNFA prevents the at-fault driver from being sued for noneconomic loss damages in situations involving relatively minor injuries. Under traditional tort law principles, even if a person sustained minor injuries in a motor vehicle accident, the person would have a right to sue the at-fault driver for noneconomic damages. In this regard, the threshold injury requirement under the MNFA ultimately eliminates the ability to sue the at-fault driver for noneconomic loss damages in cases involving minor injuries.

The MNFA further limits the liability of the at-fault driver for noneconomic damages by prohibiting the injured person from suing the at-fault driver for noneconomic damages, if the injured person's comparative fault is greater than 50%.[91] In other words, this rule prohibits an injured person from suing another driver when the injured person is determined to be more at-fault for the accident than the other driver.

These significant limitations on an injured person's rights to recover damages from the at-fault driver are a fundamental part of the MNFA. In this regard, these limitations form the basis of the "quid pro quo" that is necessary to balance the costs of providing comprehensive medical and rehabilitation coverage for motor vehicle accident victims regardless of fault.

C. UNCOORDINATED VS. COORDINATED NO-FAULT PIP COVERAGE

Under the MNFA, a person can buy either uncoordinated no-fault coverage or coordinated no-fault coverage. There are significant substantive and practical differences between these two coverages. If a person purchases uncoordinated no-fault coverage, the person's no-fault insurance company is obligated to pay no-fault benefits even though

[90] MCL 500.3135(1).
[91] MCL 500.3135(2)(b).

similar benefits may be payable to the person under another health insurance policy. On the other hand, if a person purchases coordinated coverage, the person's no-fault insurer is only obligated to pay those expenses and benefits that are not paid by other applicable health or accident insurance coverage. In other words, a coordinated no-fault PIP policy is secondary to other sources of private health insurance plans. In light of the fact that the premium charged for a coordinated benefits policy is less than the premium for an uncoordinated policy, the majority of Michigan motorists have purchased (either knowingly or unknowingly) coordinated no-fault coverage.

The statute permitting coordinated no-fault policies is MCL 500.3109a, which specifically states:

> "An insurer providing personal protection insurance benefits under this chapter may offer, at appropriately reduced premium rates, deductibles and exclusions reasonably related to other health and accident coverage on the insured. Any deductibles and exclusions offered under this section are 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."

Notably, pursuant to the language of MCL 500.3109a, no-fault benefits payable to an injured person under a coordinated policy are coordinated with other health coverages only when the injured person is the person named in the policy, the spouse of the insured or any relative of either domiciled in the same household.

It should be further noted that the current language of MCL 500.3109a was the result of a recent amendment to the MNFA passed by the Michigan Legislature in December 2012. The original version of MCL 500.3109a provided that insurance companies "shall offer at appropriately reduced premium rates, deductibles and exclusions reasonably related to other health and accident coverage." In other words, under the original version of MCL 500.3109a, insurance companies were required to offer coordinated no-fault policies. However, under the amended version,

insurance companies are no longer technically required to offer coordinated no-fault policies. It should be noted that, at the time of this article, there is no indication that any major no-fault insurance company has stopped offering coordinated no-fault coverage. In fact, because it is cheaper than uncoordinated coverage, most Michigan motorists who have health insurance continue to buy coordinated coverage.

People who are insured under a coordinated no-fault policy and who are also members of HMOs are confronted with special rules if they seek treatment outside of the HMO network. In *Tousignant v Allstate Ins Co*, the Michigan Supreme Court held that if the service or treatment is available within the HMO and the patient seeks the service or treatment outside of the HMO without following proper procedures to obtain HMO approval, the no-fault insurer is not obligated to pay for any of the cost of the service or treatment obtained outside of the HMO.[92] Notably, this rule only applies where the specific medical service is available within the HMO policy. If the service is not available under the HMO policy, the no-fault insurer is not released from its obligation to pay for treatment, so long as the treatment is otherwise payable as an allowable expense benefit. In this regard, following the *Tousignant* decision, in *Sprague v Framers Ins Exchange*, the Michigan Court of Appeals held that the patient's no-fault insurance company was obligated to pay the full cost of chiropractic treatment that was deemed "reasonably necessary" under MCL 500.3107(1)(a) and was not otherwise available through the patient's HMO. [93]

No-fault insurers have attempted to extend the concepts established in *Tousignant* and *Sprague* to patients who have health insurance coverage with preferred provider plans (PPOs). In other words, if a patient has health insurance that will pay the full cost of a particular service if rendered by a participating provider, a coordinated no-fault insurer may attempt to deny payment of all or some of the medical expenses that the patient incurs by treating with a non-participating provider. As of the present date, there is no specific appellate court that has specifically approved of this approach. Nevertheless, one should assume that the same

[92] 444 Mich 301 (1993).
[93] 251 Mich App 260 (2002).

reasoning that applies to HMOs under *Tousignant* and *Sprague* may also apply to PPOs.

D. THE WAYS IN WHICH MEDICAL PROVIDERS ARE PAID DISCOUNTED REIMBURSEMENT RATES FOR AUTO ACCIDENT-RELATED MEDICAL TREATMENT

As explained above, the MNFA requires no-fault insurers to pay a "reasonable charge" for allowable expense benefits. The reasonable charge standard under the MNFA allows providers to seek payment for their auto-related medical services at a rate that is typically higher than the rates paid by many other forms of insurance. However, the reality is that there are many situations in which medical providers are paid discounted rates of reimbursement payment for auto accident-related treatment.

In particular, a medical provider who has agreed to accept discounted reimbursement rates under a participating provider contract with a particular health insurance company is typically limited to recovering those discounted rates for auto-accident related medical treatment the provider renders to people insured with the health insurance company. One example of this occurring is in situations involving coordinated no-fault coverage. Under the Court of Appeals' decision in *Dean v Auto Club Ins Ass'n*, a medical provider who provides treatment to a person insured under coordinated no-fault policy will be paid based on the discounted reimbursement rates established in the injured person's health insurance plan, and the provider is typically prohibited from balance billing the no-fault insurer for the additional amount that would be payable based on the reasonable charge standard under the MNFA.[94] Therefore, considering that most people in Michigan have coordinated no-fault coverage, the *Dean* doctrine leads to a significant number of instances when providers receive payment for accident-related medical treatment in an amount that is less than would be payable as a "reasonable charge" under the MNFA.

Another example of medical providers being paid for auto accident-related medical treatment based on discounted participating provider health insurance reimbursement rates arises when the injured person is

[94] 139 Mich App 266 (1984).

insured under an uncoordinated no-fault policy but is also insured with a health insurance company through which the person's medical provider has contracted to accept discounted reimbursement rates. The Michigan Court of Appeals decision in *Bombalski v Auto Club Ins Ass'n* stands for the proposition that in these situations, the person's no-fault insurer only has to pay for the medical provider's services based on the discounted reimbursement rates applicable under the injured person's health insurance coverage, even though the person is covered under an uncoordinated no-fault policy.[95] As of the date of this article, *Bombalski* has not been overturned or distinguished by any subsequent published case. Ultimately, the *Bombalski* doctrine is another significant example of how medical providers often receive payment for accident-related medical treatment in an amount that is less than would be payable as a "reasonable charge" under the MNFA.

It should also be noted that no-fault insurance companies frequently utilize medical bill auditing to limit the payments of auto accident-related medical treatment. The no-fault insurers defend this practice as a way of gathering medical billing data to help determine the reasonable charge for a particular service in a given geographic location. Furthermore, in *AOPP v ACIA*, the Michigan Court of Appeals held that it is not necessarily illegal under the MNFA for a no-fault insurer to utilize a medical bill auditing methodology that limits the payment of medical expenses to the amount paid to 80% of the other medical providers in a given area.[96] Moreover, the holding in *AOPP* was not overturned by a majority vote when it was appealed to the Michigan Supreme Court.[97] Therefore, no-fault insurers continue to frequently use medical bill auditing to limit the rates of payment to medical providers. Medical bill auditing is often criticized because the audit companies do not provide a clear explanation about how their audits are calculated or clearly define the sets of data upon which their audits are based. Many providers believe that audits cause them to receive significantly discounted rates of reimbursement from no-fault insurers.

[95] 247 Mich App 536 (2001).
[96] 257 Mich App 365 (2003).
[97] 472 Mich 91 (2005).

Another example of providers receiving payment for accident-related medical treatment based on discounted reimbursement rates arises in situations commonly known as "Silent PPOs." In these situations, a medical provider signs a contract with a health insurance PPO under which the provider agrees to accept discounted rates of reimbursements in exchange for provider to be included as a preferred provider within the PPO. However, the contract goes further to state that the medical provider will also accept discounted rates of reimbursements from any other payor that contracts with the PPO. Without the knowledge of the medical provider, the PPO then contracts with a no-fault insurance company to be included as a payor under the PPO network. The no-fault insurance company then argues that with respect to accident-related medical treatment the provider renders to people insured through the no-fault insurance company, the no-fault insurer only has to pay the discounted rates of reimbursement established under the PPO. At this time, there is no appellate case law addressing the legal propriety of a no-fault insurance company using a Silent PPO arrangement to discount the payment of accident-related medical treatment. Therefore, there is currently significant controversy and legal uncertainty about this issue.

In sum, the "reasonable charge" standard does not guarantee that medical providers will be paid for accident-related medical treatment at a higher rate of reimbursement compared to other forms of private health insurance coverage. Rather, there are several ways in which providers rendering auto accident-related medical treatment end up being paid much less than the amount that would constitute a "reasonable charge" amount under the MNFA.

E. GOVERNMENTAL BENEFIT SET OFFS UNDER MCL 500.3109(1)

Under MCL 500.3109(1), a no-fault insurer is entitled to set off its payment of no-fault benefits by the amounts the injured person receives for governmental "benefits provided or required to be provided" under federal and state laws in relation to his or her injuries. Specifically, MCL 500.3109(1) states:

> "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."[98]

The objective of the governmental benefit set off is to eliminate duplicative recovery of benefits provide by state or federal governments to help keep down the cost of no-fault insurance. It should be further noted that if a benefit is deemed to be subject to set off under MCL 500.3109(1), the set off applies to both coordinated and uncoordinated policies. Therefore, no-fault insurers have a strong incentive to argue that any particular benefit provided by or under the laws of a state or the federal government is subject to set off under MCL 500.3109(1). In this regard, the issue of whether ACA coverage is subject to mandatory set off treatment under MCL 500.3109(1) is a very significant issue that cannot be properly analyzed without a proper understanding of the case law related to this relatively complicated issue.

Within the first decade of the MNFA, the Michigan Supreme Court decided a number of relatively straightforward cases regarding whether certain government provided or mandated benefits were subject to set off under MCL 500.3109(1). In *Workman v DAIIE*, the Michigan Supreme Court held that Medicaid benefits could not properly be considered a governmental benefit for purposes of MCL 500.3109(1). [99] The Court held that under the Medicaid statute, Medicaid benefits are only payable to individuals who are "medically indigent." The Court reasoned that an auto accident victim who is entitled to no-fault PIP benefits is not "medically indigent" and, therefore, has no legal right to receive Medicaid benefits. Therefore, the Court held that the no-fault insurer could not claim a set off for the Medicaid benefits that would have been payable to the injured person if he did not have no-fault coverage.

In *O'Donnell v State Farm Ins Co*, the Michigan Supreme Court held that Social Security survivors loss benefits payable under §202 of the Federal Social Security Act were proper governmental benefit set-offs

[98] MCL 500.3109(1).
[99] 404 Mich 477 (1979)

against no-fault survivor's loss benefits payable under MCL 500.3108 of the MNFA.[100] In reaching its holding, the Court reasoned that Social Security survivor's loss benefits and Michigan no-fault survivor's loss benefits were both payable as a result of the decedent's fatal car accident and both benefits served the same purpose. Therefore, the Court held that Social Security survivor's loss benefits were properly deductible under MCL 500.3109(1).

In *Mathis v Interstate*, the Michigan Supreme Court, relying heavily upon its reasoning in *O'Donnell*, held that workers' compensation benefits payable as a result of the same accident were duplicative of certain no-fault benefits, and, therefore, were properly deductible against no-fault work loss benefits under MCL 5003109(1).[101] Notably, there is not any in-depth discussion in *Mathis* as to whether workers' compensation should be considered a government benefit. It appears that the Court assumed that workers' compensation benefits were subject to MCL 500.3109(1) simply because they are mandated to be provided under State law.

In *Thompson v DAIIE*, the Michigan Supreme Court also relied upon *O'Donnell* and held that Social Security disability benefits payable to the dependents of the injured person were properly deductible from the injured person's no-fault work loss benefits.[102] In reaching this holding, the Court characterized the Social Security disability benefits received by the injured person's wife and minor children as a substitute or replacement for the injured father's income which would have inured to their specific benefit if the father was not injured. Therefore, the Court held that under MCL 500.3109(1), the social security disability benefits received by the family members were properly subject to set off from the payment of injured father's no-fault work loss benefits.

Despite the relatively straightforward holdings of the foregoing cases regarding governmental benefits, it soon became evident that it is not always clear whether a particular benefit is a governmental benefit and

[100] 404 Mich 524 (1979)
[101] 408 Mich 164 (1980)
[102] 418 Mich 610 (1984)

ultimately subject to mandatory set off treatment under MCL 500.3109(1). Simply because something is paid by a governmental source or paid under the powers of a state or the federal government does not necessarily mean it is subject to set off under MCL 500.3109(1). Therefore, the Michigan Supreme Court ultimately established a specific test to determine whether a particular benefit should be subject to set off under MCL 500.3109(1).

1. Government Benefit Set offs Under the Two-Part Test Established in *Jarosz v DAIIE*

In *Jarosz v DAIIE*,[103] the Michigan Supreme Court made it clear that a no-fault insurer cannot set off the payment of no-fault benefits under MCL 500.3109(1) simply because the subject government benefit is deemed to be "provided or required to be provided under the law of any or the federal government." Rather, the Court recognized that if an injured person is receiving government benefits that bear no relationship to the injured person's no-fault benefits, the government benefits would not be subject to set off under MCL 500.3109(1). Specifically, the Court stated in pertinent part:

> "Certainly not all '[benefits] provided or required to be provided under the laws of any state or the federal government' must be subtracted from no-fault personal protection insurance benefits otherwise due. Some governmental benefits bear no relationship whatever to no-fault benefits or to the reason no-fault benefits are paid. Benefits bearing no such relationship are not subject to set off. Our task is to find a formula by which governmental benefits which are required to be set off under § 3109(1) can be distinguished from those which are not."[104]

Accordingly, the Court established a two-part test to determine whether a particular government benefit is subject to set off from the payment of no-fault benefits under MCL 500.3109(1). Specifically, the Court held that in order for government benefits to be subject to set off under MCL 500.3109(1), the benefits must be: "1) benefits which serve the same purpose as no-fault benefits, and 2) benefits which are provided or

[103] 418 Mich 565 (1984).
[104] *Id* at 573 (1984).

required to be provided as a result of the same accident. If both criteria are met, the governmental benefit can be said to be duplicative and thus subject to setoff under § 3109(1)."[105]

Jarosz involved a complicated set of facts regarding the Social Security retirement benefits at issue, but the Court ultimately applied its two-part test and concluded that the retirement benefits failed both parts of the test. With respect to the first part of the test, the Court reasoned that even though the retirement benefits may have served the same general purpose as no-fault benefits (i.e. wage payments to the injured person), the benefits did not serve the same particular purpose as no-fault work loss benefits. In this regard, the Court reasoned that the purpose of the retirement benefits was not to pay the plaintiff disability benefits. Rather, the purpose of the retirement benefits was to supplement the plaintiff's income because of his age and income level after the accident. Therefore, the Court concluded that the plaintiff's retirement benefits did not serve the same specific purpose as the plaintiff's no-fault work loss benefits. With respect to the second part of the test, the Court concluded that the retirement benefits were not payable as a result of the same accident. In reaching this conclusion, the Court reasoned that the plaintiff's entitlement to the retirement benefits was triggered as a result of his age and income level and not as a result of him being injured in an accident.[106]

There have been several other cases in which Michigan courts have applied the *Jarosz* two-part test in order to determine whether a particular benefit is subject to set off from the payment of no-fault benefits under MCL 500.3109(1). The Michigan Court of Appeals decision in *Perkins v Riverside Ins Co* [107] is an example of the precision with which Michigan courts have applied the *Jarosz* test. In *Perkins*, the Michigan Court of Appeals held that the Michigan State Police pension benefits, which were payable to the widow of a Michigan State Police Trooper who was killed in an off-duty automobile accident, were not governmental benefits subject to set off from the payment of survivor's loss benefits, pursuant to MCL 500.3109(1). In reaching its holding, the court applied the *Jarosz* test and

[105] *Id* at 580.
[106] *Id* at 582-583.
[107] 141 Mich App 379 (1985).

held that the decedent's pension benefits did not serve substantially the same purpose as the plaintiff's no-fault survivor's loss benefits. In this regard, the court reasoned that the retirement pension benefits were technically payable to the decedent's family as a part of the decedent's retirement benefits through his employment with the Michigan State Police and were not payable because the decedent died in a motor vehicle accident. In reaching its holding that these pension benefits failed the *Jarosz* test, the court in *Perkins* stated in pertinent part:

> "We agree with the trial court's analysis. No-fault survivors benefits are designed to replace the loss of income or wages that decedent would have enjoyed had he continued his employment. . . No-fault survivors benefits thus duplicate workers' compensation benefits . . . and social security survivors loss benefits . . . Contrary to the defendant's argument on appeal, however, we find that the State Police pension is intended to protect the decedent's retirement contributions and is not intended to replace decedent's wages. MCL 28.107(4); MSA 3.337(4) clearly refers to the pension as a retirement benefit. Under that provision, a spouse is entitled to a pension computed as if the deceased had retired the day preceding his or her death. Further, the pension is referred to as a "retirement allowance" payable to the widow until death only if the trooper had accrued at least 10 years of service . . . the Michigan State Police pension does not duplicate no-fault survivors loss benefits intended to replace income loss. We thus affirm the trial court's refusal to consider Nadine Perkins' pension to reduce her no-fault benefits."[108]

Another example of the precise application of the *Jarosz* test is the Michigan Court of Appeals decision in *Gier v Auto Owners*. In *Gier,* the Michigan Court of Appeals considered whether the $255 lump sum U.S. social security death benefit payable under the Social Security Act could be set off against the no-fault funeral and burial expense benefit available under MCL 500.3107(1)(a).[109] The Court applied the *Jarosz* test and determined that the death benefit was not a proper governmental set off because it neither served the same purpose as the no-fault funeral and

[108] *Id* at 339-340 (citations omitted).
[109] 244 Mich App 336 (2001).

burial expenses, nor was it triggered by the same event. In this regard, the Court stated:

> "In this case the two benefits are not triggered by the same event. The no-fault payment is triggered by the funeral and burial of the decedent; proof of expenses incurred by the recipient is required. The lump sum payment, on the other hand, is triggered by the death of an insured person who leaves eligible survivors; no funeral or burial is required, and the payment would be made even if there were no remains to be buried . . .These two payments do not serve the same purpose; therefore, under *Jarosz*, defendant may not decrease this liability by subtracting $255 from its obligation."[110]

On the other hand, in *Moore v ACIA*, the Court of Appeals held that benefits paid under the Railroad Unemployment Insurance Act (RUIA) were subject to set off as a government benefit under the *Jarosz* test.[111] The court reasoned that pursuant to the RUIA, these benefits passed the *Jarosz* test because they were payable as a result of the motor vehicle accident and substituted for wages the plaintiff would have made if he was not injured. In reaching this holding, the court in *Moore* rejected the plaintiff's argument that these benefits were no different from regular state unemployment compensation benefits, which are payable only due to loss of employment and not specifically triggered because of a person's injury.

The case law discussed above establishes that in precisely applying the *Jarosz* test, Michigan courts have closely examined the government benefit at issue and analyzed the specific reason and/or purpose of that benefit. It is not necessarily enough for a governmental benefit to become payable at the same time as another seemingly similar no-fault benefit. Rather, a specific comparison must be made between the nature of the particular government benefit and no-fault benefit at issue. Ultimately, under the *Jarosz* test, a governmental benefit is only subject to set off under MCL 500.3109(a) when it can be determined that the governmental benefit

[110] *Id* at 340-341.
[111] 173 Mich App 308 (1988).

serves the same essential purpose as the no-fault benefit and is payable directly as a result of the subject motor vehicle accident.

2. Avoiding the Governmental Benefit Set off under MCL 500.3019(1) for Uncoordinated No-Fault Coverage, Pursuant to the *Leblanc* Hybrid Benefit Doctrine

There have been situations in which a benefit has been determined to be both a government benefit under MCL 500.3109(1) and "other health and accident coverage" under MCL 500.3109a. *LeBlanc v State Farm* was the first case that addressed this situation.[112] In *Leblanc*, the Michigan Supreme Court recognized a distinction between governmental benefits, which are subject to set off under MCL 500.3109(1), and other types of benefits payable by the government, but which are more accurately characterized as "health and accident coverage" within the meaning of MCL 500.3109a. In making this distinction, the Court held that because Medicare benefits are, in fact, "other health and accident coverages" within the meaning of MCL 500.3109a, they may be subject to set off only if the injured person is covered under a coordinated no-fault policy. In so holding, the Court stated:

> "§3109(1) . . . is clearly addressed to governmental benefits. . . . In contrast to §3109(1) is the later enacted §3109a which more specifically speaks to other health and accident coverage. Coverage, a word of precise meaning in the insurance industry, refers to protection afforded by an insurance policy, or the sum of the risks assumed by a policy of insurance. . .
>
> . . .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

[112] 410 Mich 173 (1981).

subtracted from the no-fault benefits due under the no-fault policy issued to him by defendant."[113]

Based on this analysis, the Court in *Leblanc* recognized that there can be a hybrid or combo benefit that constitutes a governmental benefit within the meaning of MCL 500.3109(1), and constitutes "other health and accident coverage" within the meaning of MCL 500.3109a. The Court reasoned that these types of benefits can only be treated as a set off if the injured person was covered under a coordinated no-fault policy. Therefore, if a person paid a higher premium to purchase uncoordinated no-fault coverage and is eligible to receive other collateral benefits, the characterization of a benefit as "other health or accident coverage" under MCL 500.3109a immunizes the benefit from set off under MCL 500.3109(1).

It is important to note that in 1980, after *Leblanc* was decided, the United States Congress passed the Omnibus Budget Reconciliation Act that clearly provides that Medicare is always secondary whenever payment has been made or can reasonably be expected to be made under a liability or auto no-fault policy.[114] Furthermore, on April 5, 1983, the Health Care Financing Administration (HCFA) published final regulations making it clear Medicare benefits are secondary to no-fault insurance policies. In any event, even though Medicare must never pay primary for auto accident-related medical treatment covered by no-fault insurance, the holding in *Leblanc* remains relevant with respect to its discussion of situations where a benefit satisfies both the governmental benefit test under MCL 500.3109(1) and the other health and accident coverage test under MCL 500.3109a.

Since deciding *LeBlanc*, the Supreme Court has confirmed the viability of the hybrid benefit doctrine on a number of occasions. In *Tatum v Government Employees Insurance Company*, the Michigan Supreme Court held that military medical benefits payable to a member of the armed services, who also purchased an uncoordinated no-fault policy, could not be set off under MCL 500.3109(1) as a governmental benefit.[115] The Court reasoned that because these benefits were also "health and accident coverage" within the meaning of MCL 500.3109a, they could not be subject

[113] *Id* at 204-207.
[114] 42 USC §1395y(b)(2)(A)(ii)
[115] 431 Mich 663 (1988).

to set off under *LeBlanc*, unless the plaintiff had purchased a coordinated no-fault policy. Therefore, because the plaintiff was covered under an uncoordinated no-fault policy, the military medical benefits, which might otherwise be considered a governmental benefit, were immunized from set off.

In *Profit v Citizens Ins Co*, the Michigan Supreme Court held that Social Security disability benefits were properly set off as a governmental benefit under MCL 500.3109(1), where the injured person had purchased an uncoordinated no-fault policy.[116] In so holding, the Court reasoned that the Social Security disability benefits were not "other health and accident coverage" within the meaning of MCL 500.3109a. Therefore, there was no issue as to whether the benefits could be set off where a person purchases an uncoordinated policy, pursuant to the *Leblanc* hybrid benefit doctrine. Importantly, however, in reaching this holding, the Supreme Court explicitly refused to overrule the *Leblanc* hybrid benefit doctrine. Therefore, *Profit* serves as further proof of the continued viability of the *Leblanc* hybrid benefit doctrine.

Two years after *Tatum,* the continued viability of the *Leblanc* hybrid benefit doctrine was further confirmed by the Michigan Supreme Court in *DeMeglio v ACIA*[117]. In *Demeglio*, the Court held that no-fault benefits required to be provided under the laws of Pennsylvania to a Pennsylvania resident injured in a Michigan motor vehicle accident were subject to set off from the payment of no-fault benefits under MCL 500.3109(1). In so holding, the Court specifically recognized the *Leblanc* hybrid benefit doctrine and did not disavow it in anyway. Rather, similar to its holding in *Profit,* the Court determined that the hybrid-benefit doctrine did not apply to the given case, because the Pennsylvania no-fault benefits were "benefits" for purpose of MCL 500.3109(1), but did not constitute "other health and accident coverage" for purposes of MCL 500.3109a.

[116] 444 Mich 281(1993).
[117] 449 Mich 33 (1995).

Ultimately, it is clear that the *Leblanc* hybrid benefit doctrine remains viable and must be applied by Michigan courts so that in situations where a particular government benefit is determined to fall under both MCL 500.3109(1) and MCL 500.3109a, the benefit is only subject to set off from the payment of no-fault benefits when the injured person has coordinated no-fault coverage.

F. CONSUMER RIGHTS AND REMEDIES UNDER THE MNFA

Under the MNFA, motor vehicle accident victims and their medical providers have a clearly established right to bring a private civil cause of action in state court to recover benefits wrongfully denied by a no-fault insurer.[118] Notably, there is a very strictly enforced "one-year-back" rule which provides that an action seeking to recover no-fault benefits can do so only with respect to expenses incurred within one year from date the lawsuit was filed.[119] Therefore, patients and their providers must exercise due diligence to make sure that suit is filed within one year from the date the unpaid expense was incurred. This stringent one-year limitation makes dealing with coordinated PIP policies more problematic. In this regard, precious time can be wasted waiting for responses from the person's health insurance company, which then puts the person or provider in a precarious position with regard to the one-year-back rule. This is one reason why some people choose to avoid purchasing coordinated no-fault policies.

It should be noted that the person or provider bringing the action can recover penalty sanctions against the no-fault insurer, but these sanctions are limited to penalty interest and attorney fees.[120] Attorney fees are only recoverable when there has been an unreasonable denial or delay in paying benefits. A person who has been denied benefits can file suit immediately and does not need to go through any review process that is typically required in health insurance disputes. In this regard, the MNFA provides

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[118] MCL 500.3145(1). For the right of medical providers to bring their own private cause of action, see *Lakeland Neurocare Ctrs v State Farm Mut Auto Ins Co*, 250 Mich App 35, 36-37 (2002) and *Wyoming Chiropractic Health Clinic, PC v Auto-Owners*, 308 Mich App 380 (2014), leave denied by Michigan Supreme Court (May 28, 2015).

[119] MCL 500.3145.

[120] MCL 500.3142 and MCL 500.3148.

injured people the right to initiate a lawsuit against their no-fault insurers to protect and enforce their rights through the judicial system. However, it should be noted that even though people can take immediate action to initiate a lawsuit against their no-fault insurance company, the MNFA does not impose any specific duties on no-fault insurers to handle claims in good faith. Therefore, one of the biggest weaknesses of the Michigan no-fault system is that the relationships between no-fault insurers and their insureds are often adversarial and contentious.

III. THE INTERSECTION OF THE ACA AND THE MNFA

A. MICHIGAN NO-FAULT COVERAGE IS FAR BROADER THAN ACA COVERAGE

Some people believe that because of the ACA, Michigan no-fault coverage is no longer needed to cover the care, recovery and rehabilitaiton of motor vehicle accident victims. This is clearly not the case. Even though the ACA provides for relatively broad forms of health insurance coverage, the Michigan benchmark ACA plan contains significant limitations regarding various types of medical products, services and accommodations that are critically important for a motor vehicle accident victim's care, recovery, or rehabilitation, especially for the most catastrophically injured. Some notable examples of products, services and accommodations that are available to auto accident victims under the MNFA but are not available to any extent under Michigan's benchmark ACA plan, include, but are not necessarily limited to, the following:

- long-term/custodial nursing home care (including family-provided attendant care);
- habilitative services[121];

[121] The ACA allows the states to define the term "habilitative services." The Michigan Insurance Commissioner has defined habilitative services as "*health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities.*" The Michigan Insurance Commissioner has determined that habilitative

- alternative therapies such as massage therapy and acupuncture;
- guardianship and conservator services;
- case management services;
- medical mileage;
- handicap-accessible transportation accommodations;
- handicap-accessible housing accommodations;

Furthermore, there are substantial limitations within Michigan's benchmark ACA plan for services that are frequently needed for the care, recovery or rehabilitation of seriously injured motor vehicle accident victims and that are covered without quantitative limitations under the MNFA. These services and their respective limitations under Michigan's benchmark plan include, but are not necessarily limited to, the following:

- hospice services (skilled nursing, subacute, inpatient rehabilitation and hospice facility) limited to 45 days per year;
- home health care services limited to 45 days;
- skilled nursing facility (skilled nursing, subacute, inpatient rehabilitation and hospice facility) limited to 45 days per year;
- mental/behavioral health outpatient services (i.e., outpatient mental health services) limited to 20 days per year;
- mental/behavioral health inpatient services (i.e., outpatient mental health services) limited to 20 days per year;
- outpatient rehabilitation service (i.e., rehabilitative medicine services) limited to 30 visits per year;

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services encompasses many types of services, including but not limited to applied behavioral analysis (ABA) for the treatment of autism spectrum disorder. ABA is defined by Michigan law as "*the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.*"

- chiropractic care (i.e., rehabilitative medicine services) limited to 30 visits per year.

Therefore, given the aforesaid limitations regarding the types and quantities of services available under Michigan's ACA benchmark plan, the coverage available under the MNFA for the care, recovery and rehabilitation of the injuries sustained by motor vehicle accident victims is far broader than the coverage available under the ACA. Accordingly, Michigan no-fault coverage will continue to be necessary for the care, recovery and rehabilitation of seriously injured motor vehicle accident victims, especially those who require extensive rehabilitative therapies, long-term nursing care, handicap-accessible housing and transportation accommodations, or other specialized services such as vocational rehabilitation services, case management services and guardian and conservator services.

It must be also emphasized that, as explained above, there are several categories of individuals who are not required to buy ACA policies. Therefore, if any of these people without health insurance are injured in a Michigan motor vehicle accident, no-fault coverage remains their primary source of coverage for auto-related medical treatment (i.e., assuming they are not otherwise disqualified from no-fault coverage under the relevant disqualification provisions of the MFNA).

Moreover, while the ACA expanded the Medicaid eligibility requirements, Medicaid cannot be held responsible for auto-related treatment. Thus, Michigan no-fault coverage remains the primary source of medical insurance for Medicaid beneficiaries in the event they are seriously injured in a motor vehicle accident. The same is true with respect to Medicare beneficiaries.

It is also important to note that ACA health insurance policies only cover a certain percentage of a person's medical costs. Therefore, if a person, who is insured under a bronze ACA policy that only pays 60% of medical costs, is injured in a motor vehicle accident, he or she will still need to find a way to pay the other 40% of the medical costs related to his or her motor vehicle accident injuries. However, it should be noted that, as

explained above, the person's out-of-pocket expenses for Essential Health Benefits (EHBs) will be capped each year pursuant to the person's cost-sharing limit for EHBs, i.e., in 2015, $6,350 per person and $12,700 per family. In any event, no-fault coverage is necessary to help pay an injured person's out-of-pocket costs that are not covered under his or her ACA health insurance coverage.

Additionally, the other benefits available under no-fault coverage (replacement services, work loss benefits, and survivor's loss benefits) are obviously not covered under the ACA. Therefore, no-fault coverage is needed to continue to provide these benefits to motor vehicle accident victims.

B. ACA Coverage Should Only be Subject to Set off Under Coordinated No-Fault Policies

One of the most significant issues regarding the intersection of the ACA and MNFA is whether ACA coverage should be set off from the payment of no-fault benefits payable under coordinated no-fault coverage, or whether the set off should also apply to no-fault benefits payable under uncoordinated no-fault coverage. Some commentators have suggested that no-fault benefits are subject to mandatory set off under MCL 500.3109(1), regardless of whether the person is insured under an uncoordinated or coordinated no-fault policy.[122] For the reasons explained below, this article disagrees with that position and ultimately concludes that ACA coverage does *not* constitute a governmental benefit under MCL 500.3109(1), and, even if it does, the amounts paid under an ACA policy are only subject to set off from the payment of no-fault benefits in situations involving coordinated no-fault coverage.

1. ACA Coverage is not Subject to Set off Under MCL 500.3109(1) because ACA Coverage is not "Provided or Required to be Provided" by the Laws of any State or the Federal Government

[122] Miller, The Affordable Care Act's Uncertain Impact on Michigan's No-Fault Act, 93 Mich B J 20, (March 2014).

A benefit can only be subject to set off under MCL 500.3109(1) if it is deemed to be "...provided *or* required to be provided under the laws of any state or the federal government . . ." [123] As explained above, in *National Federation of Independent Business, et al v Sebelius*, the United States Supreme Court explained that the ACA does not actually require or mandate Americans to buy health insurance. The ACA simply presents people with the choice to either buy a qualified ACA health insurance policy or pay the applicable tax penalty. Based on this reasoning, it is clear that benefits payable under ACA policies are not actually "required to be provided" by the federal government.

Moreover, ACA health insurance coverage is not being "provided . . .under the laws of any state or the federal government." Rather, ACA coverage is being provided by private health insurance companies. Obviously, there are laws and regulations that apply to ACA health insurance coverage, but that is also the case with any other form of private health insurance. For example, in order for Blue Cross to provide health insurance coverage to the people of Michigan, it must follow certain state laws and regulations regarding health insurance. However, there is no precedent establishing that private health insurance is subject to MCL 500.3109(1) simply because there are laws that regulate how health insurance companies operate and provide health insurance coverage. Accordingly, ACA coverage should not be deemed to be "provided...under the laws of any state or the federal government" for purposes of MCL 500.3109(1). Notably, this analysis would be different if the ACA actually created a system of health insurance in which the federal government sold its own health insurance policies and/or administered its own benefits. If this was the case, ACA health insurance coverage would be provided by the government in ways similar to how the government provides health insurance coverage through Medicaid, Medicare, TRICARE military health insurance, etc. However, the system of private health insurance established under the ACA is a direct rejection of that type of government involvement in health insurance. Therefore, ACA coverage is obviously distinguishable from these other forms of government provided health insurance coverage.

[123] Emphasis added.

Based on the foregoing, ACA coverage is not "required to be provided by or provided under the laws of any state or the federal government" for purposes of MCL 500.3109(1). Therefore, ACA coverage should not be subject to set off under MCL 500.3109(1).

2. ACA Coverage is not Subject to Set off Under MCL 500.3109(1) Because it Fails the *Jarosz* Test

Even if it is determined that ACA coverage is provided or required to be provided under the laws of the federal government, ACA coverage is not subject to set off under MCL 500.3109(1) because it fails the *Jarosz* two-part test explained above. The *Jarosz* test provides that benefits can only be subject to set off under MCL 500.3109(1) if the benefits (1) serve the same purpose as the no-fault benefit at issue; and (2) are provided or are required to be provided as a result of the same accident. The case law discussed above indicates that in applying this test, Michigan courts have closely examined the specific benefit at issue and inquired about the specific reason and/or purpose for the payment of that benefit. For example, in *Perkins*, the court determined that the benefits at issue were technically payable as a part of the decedent's retirement benefits available to him and his family at the time of his death. The benefits were not available to the family because the decedent was killed in an accident. Therefore, the court in *Perkins* determined that these benefits failed the *Jarosz* test. Furthermore, in *Gier*, the court concluded that the social security death benefits at issue failed the *Jarosz* test because the benefits were payable upon the event of the person dying, whereas the funeral and burial expense benefits under the MNFA were payable once the charges were actually incurred for the decedent's funeral and burial services.

Pursuant to *Jarosz* and its progeny, the payment of benefits under an ACA health insurance policy does not serve the same specific purpose as the payment of no-fault benefits under a Michigan no-fault insurance policy. Benefits under an ACA policy are paid pursuant to the private health insurance company's contractual obligation to provide health insurance for the general health and well-being of the insured person. On the other hand, no-fault benefits are paid as part of Michigan's compulsory auto insurance system that seeks to provide comprehensive coverage for the care, recovery and rehabilitation of motor vehicle accident victims,

while, at the same time, immunizing at-fault drivers from financial liability for an injured person's medical expenses. Therefore, benefits paid under an ACA policy fail the *Jarosz* test because the purpose of the payment of those benefits is fundamentally different and distinct from the purpose underlying the payment of no-fault benefits.

Furthermore, benefits paid under an ACA policy fail the *Jarosz* test because the payment of those benefits is not triggered by the same event. Benefits are payable under an ACA policy for medical treatment a person requires regardless of the events and/or reasons that cause the person to require the treatment. However, under the MNFA, allowable expenses benefits are payable only when a person requires medical treatment for "accidental bodily injury arising out of the ownership, operation, maintenance or use of a motor vehicle as a motor vehicle."[124] In other words, no-fault benefits become payable strictly when a person sustains injury while engaged in a particular activity (i.e., using a motor vehicle), whereas benefits under an ACA policy become payable whenever a person needs medical treatment. Therefore, the payment of benefits under an ACA policy is not triggered by the same event that triggers the payment of no-fault benefits.

3. ACA Coverage is not Subject to Set off Under MCL 500.3109(1) Under the *LeBlanc* Hybrid Benefit Doctrine

Even if ACA coverage passes the *Jarosz* test and is also determined to be "provided or required to be provided under the laws of any state or the federal government" for purposes of MCL 500.3109(1), it remains the case that ACA coverage should only be subject to set off in situations involving coordinated no-fault coverage. This is because of the *Leblanc-Tatum* hybrid benefit doctrine discussed above. Under this doctrine, if a benefit is determined to be a governmental benefit under MCL 500.3109(1) and "other health and accident coverage" under MCL 500.3109a, the benefit can only be set off against the payment of no-fault benefits in situations involving coordinated no-fault coverage. There is no question that ACA health insurance coverage constitutes "other health and accident coverage"

[124] MCL 500.3105(1).

under MCL 500.3109a. Therefore, even if ACA coverage constitutes a governmental benefit for purposes of MCL 500.3109(1), under the *LeBlanc-Tatum* hybrid benefit doctrine, ACA benefits should only be subject to set off in situations involving coordinated no-fault coverage.

In sum, pursuant to the foregoing reasons, ACA coverage should only be subject to set off in situations involving coordinated no-fault coverage. If the opposite result was reached, there would be great confusion about the amount insurance companies could set off their payment of no-fault benefits in a variety of situations. With regard to a person who has uncoordinated no-fault coverage but failed to purchase health insurance under the ACA, would the no-fault insurance company be entitled to set off the payment of no-fault benefits by an amount that would have been payable under an ACA policy? If so, would the amount of the set off equal the amounts that would have been payable to the injured person under a bronze, silver, gold or platinum ACA plan? For people under 30, would the set off amount be the equivalent of the amounts payable under a catastrophic health insurance plan, given that is the only type coverage people under the age of 30 are required to buy under the ACA to avoid the tax penalty? Also, would the set off apply to no-fault benefit claims brought by children whose parents failed to purchase health insurance for their family? If so, what would be the amount by which the no-fault insurer would be allowed to set off the payment of the injured child's benefits? Would the set off apply to a person who chooses to pay the tax penalty under the ACA as opposed to buying health insurance? Would the set off not apply to no-fault claims brought by the wide-variety of people who do not have any obligation to purchase health insurance under the ACA? These points of confusions can be avoided by Michigan courts correctly holding that it is only in situations involving coordinated no-fault coverage when a no-fault insurance company is entitled to claim a set off against the payment of no-fault benefits by the amounts actually paid under the injured person's ACA health insurance policy.

C. THE ACA MAY RESULT IN MORE PEOPLE PURCHASING COORDINATED NO-FAULT COVERAGE

Because coordinated coverage allows an insurance company to pay for an auto accident victim's medical treatment on a secondary basis, it cost less than uncoordinated coverage. Because coordinated coverage costs less, many people end up buying it. However, throughout the years, it has been arguably a better decision for Michigan motorists to buy uncoordinated no-fault coverage. The ACA changes the analysis of whether a person should buy uncoordinated or coordinated no-fault coverage. Ultimately, because of the ACA, more people may purchase coordinated no-fault coverage instead of uncoordinated no-fault coverage.

Perhaps the most significant way in which the ACA may influence more people to buy coordinated no-fault coverage is simply because the ACA will increase the number of people who have private health insurance. Prior to the ACA, if a person did not have private health insurance, he or she would not be eligible to buy coordinated no-fault coverage. Therefore, if a person can now obtain private health insurance under the ACA, he or she can now also buy coordinated no-fault coverage. It should be expected that the vast majority of these people will decide to buy coordinated no-fault coverage simply because it costs less than uncoordinated coverage.

The decision of whether to buy uncoordinated or coordinated no-fault coverage is also significantly affected by the ACA's prohibition on health insurance policies containing any lifetime or annual caps on services that constitute Essential Health Benefits (EHBs). Prior to the ACA, there were no laws prohibiting health insurance companies from including annual or lifetime monetary caps within their health insurance policies. For example, health insurance policies could contain a provision stating that the health insurance company is not liable to pay any more than $1,000,000 (or less) for a person's medical needs throughout the entire time the person is insured under the policy. Therefore, if a person was insured under a coordinated no-fault policy and required extensive medical care for injuries sustained in a motor vehicle accident, the person might not have enough coverage remaining under his or her health insurance policy if he or she happened to become ill or develop another life-threatening

disease, such as cancer, at any point in the future. The threat of exhausting health insurance coverage prior to the ACA provided a very compelling reason for people to buy uncoordinated coverage as opposed to coordinated coverage. However, due to the ACA's prohibition on lifetime and annual caps on EHBs, there is significantly lower risk that a motor vehicle accident victim insured under a coordinated no-fault policy will actually face the problem of exhausting health insurance coverage the person may otherwise need in the future. This reduced risk may make coordinated no-fault coverage more appealing to those who have been previously inclined to purchase uncoordinated no-fault coverage.

It is also worth noting that because the ACA empowers people with significant rights regarding health insurance matters, people may experience more straightforward and fairer treatment from their health insurance company. If people have better experiences dealing with health insurance companies under the ACA, it may help further influence them to buy the less expensive coordinated no-fault coverage instead of the more expensive uncoordinated no-fault coverage.

Based on the foregoing, it is clear that the ACA changes the analysis of whether a person should buy uncoordinated or coordinated no-fault coverage. Ultimately, because of the ACA, more people may eventually purchase coordinated no-fault coverage instead of uncoordinated no-fault coverage.

D. The ACA May Help Lessen the Financial Burdens and Costs of Michigan's No-Fault System

Despite the MFNA's broad scope of coverage for motor vehicle accident victims, there is a seemingly perpetual debate raging in the Michigan Legislature about whether the MNFA should be reformed. At the heart of that debate is whether the MNFA must be reformed in order to ease the financial burdens and costs of Michigan's no-fault system. The cost of auto insurance and the financial reality of the Michigan no-fault system are very complicated issues that this article does not attempt to fully analyze. However, there are some notable observations that can be made regarding how the ACA may help lessen the financial burdens and costs of Michigan's no-fault system.

At the outset, it should be noted that there is nothing within the ACA that should increase the financial burdens of Michigan's no-fault system. In this regard, the ACA does not result in any new cost shifts to no-fault insurance coverage. The ACA also does not further elevate no-fault insurance to any higher order of insurer priority. Furthermore, the ACA does not limit health insurance coverage beyond which was typically provided by health insurance companies prior to the ACA.

There actually appear to be several ways in which the ACA may help lower the financial burdens and costs of Michigan's no-fault system. First, ACA health insurance coverage is generally broader than the coverage that was typically available under health insurance policies prior to the ACA. Notably, the ACA increases the scope and extent of health insurance coverage by guaranteeing coverage for Essential Health Benefits (EHBs) without any annual or lifetime caps, as well as imposing the cost sharing limit that caps the amount people must pay for out-of-pocket medical costs. Thus, many people with coordinated no-fault coverage now have better health insurance coverage under the ACA that covers a greater amount of treatment and services than were covered under their health insurance plans prior to the ACA. In these cases, the potential liability of the coordinated no-fault insurer that pays secondary to the health insurance company is directly diminished as a result of the person's expanded health insurance coverage under the ACA.

Moreover, as explained above, the ACA may result in more people obtaining coordinated no-fault coverage, as opposed to uncoordinated no-fault coverage. In these situations, if these people are injured in a motor vehicle accident, they will now turn to their health insurance company first for all of their medical treatment and no-fault insurance will only have to pay in the secondary position. Furthermore, under the *Dean* doctrine discussed above, these people's medical providers have to accept the discounted rates of reimbursement under the person's ACA policy and are not be able to bill the no-fault insurer for the differential amount that would be payable as a reasonable charge under the MNFA.

The ACA may also lessen the financial burdens of the no-fault system by effectively limiting the right of medical providers to be paid under the "reasonable charge" standard under the MNFA. Based on the growing

health insurance market under the ACA, it is anticipated there will be more instances of medical providers contracting with health insurance companies to accept discounted reimbursement rates. As explained above, under the *Bombalski* doctrine, when a medical provider renders auto accident-related medical treatment to a person insured with a health insurance company through which the provider has agreed to accept discounted rates, the provider will only be able to receive payment from the person's no-fault insurance company based on those discounted rates, even if the injured person is insured with uncoordinated no-fault coverage. Therefore, if the ACA impacts the health care industry in such a way that results in more discounted reimbursement rate contracts existing between providers and health insurance companies, there will be more opportunities for no-fault insurers to pay for auto accident-related medical treatment based on those discounted rates.

Another interesting way the ACA could ease the financial burdens and uncertainties of Michigan's no-fault insurance system is based on the ACA increasing the viability of the no-fault PIP "buyout" for the less seriously injured person (i.e., non-catastrophic injury). A buyout is when the no-fault insurer pays the injured person a lump sum of money in exchange for the person forever releasing the no-fault insurer for any future liability for no-fault benefits. No-fault insurance companies are typically interested in finding ways to buyout people's no-fault coverage, because buyouts give the insurance companies certainty about their financial exposure and allow the companies to remove the claims from their books. On the other hand, many no-fault attorneys have been very wary about representing a person in a no-fault buyout deal. This is because no-fault coverage is too broad and significant for a person to forgo forever. Furthermore, prior to ACA, the person would have a difficult time finding additional health insurance coverage because of the preexisting condition exclusion he or she would likely face as a result of his or her auto accident injuries. Therefore, many no-fault attorneys have typically refused to represent people on buyouts because of malpractice concerns and other complications that could arise as a result of that representation.

The ACA helps limit the potential complications that can arise from a no-fault buyout. The major reason for this is that the ACA prohibits health insurers from denying health insurance coverage based on a preexisting

condition. Therefore, if an injured person receives a buyout from his or her no-fault coverage and has enough money to afford an ACA policy, he or she will be able to obtain that health insurance coverage. It would be advisable for the person to put the money from the buyout into a trust account or health-care set aside account to ensure the money will be available for health insurance in the future. Furthermore, it must be emphasized that a buyout of no-fault benefits is much more complicated if the injured person is insured through Medicare or Medicaid. In that situation, Medicare or Medicaid could attempt to deny future coverage by arguing that the buyout compromised its interest by elevating it to the primary pay position. It is not clear whether it would be proper for Medicare or Medicaid to deny future coverage on this basis. Accordingly, the buyout option must be pursued very cautiously when the injured person is covered under Medicare or Medicaid. In sum, carefully crafted buyouts of no-fault benefits for less seriously injured people could help ease some of the financial burdens and uncertainties of Michigan's no-fault system.

Ultimately, before the debate about reforming the MNFA rages on any further, a specific analysis should be conducted by the Department of Financial and Insurance Services regarding how the ACA may impact Michigan's auto insurance rates. Notably, in the landmark no-fault decision, *Shavers v Attorney General*, the Michigan Supreme Court held that because of the compulsory nature of the Michigan no-fault insurance system, due process protections within the United States Constitution and Michigan Constitution require that auto insurance rates in Michigan to be "fair and equitable."[125] In this regard, the Court in *Shavers* specifically stated:

> "In choosing to make no-fault insurance compulsory for all motorists, the Legislature has made the registration and operation of a motor vehicle inexorably dependent on whether no-fault insurance is available at fair and equitable rates. Consequently, due process protections under the Michigan and United States Constitutions (Const 1963, art 1, § 17; US Canst, AM XIV) are operative."[126]

[125] 402 Mich 554 (1978).
[126] *Id* at 599.

The Court in *Shavers* further indicated that the Legislature, the Judiciary and the Insurance Commissioner all share in the responsibility of making sure auto insurance rates are "fair and equitable." Ultimately, the assessment of how the ACA may impact auto insurance rates is a necessary part of our government's constitutional obligation to make sure the people of Michigan are able to buy auto insurance at fair and equitable rates. This point is especially relevant today, considering the extremely high costs of auto insurance in cities like Detroit.

It should also be noted that pursuant to MCL 500.3109a, the insurance commissioner is obligated to make a specific determination of whether the premiums for coordinated no-fault coverage are being "appropriately reduced," in comparison to the cost of uncoordinated no-fault coverage. Therefore, in addition to the due process constitutional concerns, there is also a specific statutory requirement that obligates the Insurance Commissioner to assess whether the rates of coordinated no-fault policies are being appropriately reduced in light of the scope and extent of health insurance coverage available under the ACA.

CONCLUSION

Since the MNFA was enacted in 1973, whether they have known it or not, the people of Michigan have been covered under a unique and comprehensive form of health insurance for one of the most perilous hazards we face in our daily life – motor vehicle accidents. This coverage assures that when the people of Michigan are driving in their cars, if something goes wrong, there will be comprehensive coverage for any product, service or accommodation that is reasonably necessary for their care, recovery and rehabilitation. With the passage of the ACA, the people of Michigan are now insured under a relatively broad form of health insurance that establishes more consumer rights in relation to health insurance than have ever existed before in America. The coexistence of these two insurance systems is seemingly good for the health and well-being of the people of Michigan. However, it is incumbent upon Michigan courts to correctly hold that no-fault benefits can only be set off by amounts paid under a person's ACA coverage when the person is insured under a coordinated no-fault policy. Furthermore, it is incumbent upon the Insurance Commissioner to conduct a detailed assessment of the various ways in which the ACA may bring down the cost of auto insurance in Michigan. Last, but certainly not least, it is incumbent upon Michigan legislators to factor the ACA into the ongoing debate about whether to reform the MNFA.