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If you have an article idea for the Journal, please contact the editor, Christine Caswell at christine@caswellpllc.com

FROM THE CHAIR

Happy New Year

Doug McCray

Happy New Year to all! First, let me express my appreciation for electing me as Chair of the Insurance and Indemnity Section. Over the past year, previous Chair Annie Earls worked hard to increase membership and engagement among existing members, spearheaded an excellent (and very popular) educational program on artificial intelligence, and was very involved in the Program Committee's alternative dispute resolution program. She was a stellar chair and will be a hard act to follow. However, working with the other Council members, our administrator Joan O' Sullivan and editor Christine Caswell, I will do my best to continue her legacy by encouraging top-notch educational and networking events, fostering section committee participation and increased section membership, maintaining the high quality of the *Journal* and increasing participation in our scholarship program. While these goals are distinct, they are also related. For instance, the last scholarship competition resulted in two remarkably good student submissions, which are included in this issue of the Journal. Congratulations and thank you to our winners, Victoria Hanna and Joseph Berry.

I would also like to extend a warm welcome to our new Council members and officers. Currently, the other members of the Council consist of the following:

Chair Elect: Jennifer Serwach

Secretary: Mike Spinazzola

Treasurer: Christopher Petrick

Members: Nicholas Badalamenti, Shantinique Brooks, Amy Diviney, Melissa Hirn, Elizabeth King, Alison Koppin, Charlotte McCray, Chelsea Saferian, John Sier, Anthony Snyder

Many of these folks have been on the Council for years, and their knowledge is invaluable to the Section. Thanks in advance for your help in the upcoming year.

2025 Annual Meeting and Program

Our annual business meeting and educational program, which took place on October 29, 2025 at the Heathers, in Bloomfield Hills, was a resounding success. The program, "Preparing, Presenting & Handling Property Insurance Claims Prior to Litigation," was a nuts-and-bolts primer of the processes followed by insurers and policyholders following a loss to a business or home. Thanks to all of our speakers, including public adjuster and attorney Ethan Gross (Globe Midwest), independent adjuster Bill Butler (Butler Adjusting) and Executive General Adjuster Scott Whaley (Chenard & Osborn).

The program focused on the adjustment and resolution of property claims through payment or denial. Topics included the roles of the parties' representatives (public, staff and independent adjusters, consultants, and attorneys), loss documentation, claim preparation and adjustment. The panel also discussed the parties' duties under the policy, including the notice, proof of loss and examination under oath requirements, and the consequences of failing to comply. Finally, the speakers addressed the mechanism used to resolve amount of loss disputes, statutory appraisal. One important theme was that unlike litigation, claim adjustment does not have to be adversarial. We had a good crowd and there was some spirited debate among the members of the audience, which included attorneys from both sides of the fence. Accolades to our presenters and audience for a great program.

Next Business Meeting and Mixer

The Section's next meeting is scheduled for 4:30 pm on Thursday, January 29, 2026 at the Hub Stadium in Auburn Hills, followed by a mixer starting at 5:00 pm, with food, drinks, axe throwing, and fowling, which is a hybrid of bowling and football. There is no charge. This will be a great opportunity to meet and greet other insurance people in a relaxed, fun atmosphere. If you plan to attend, please contact our administrator Joan at josullivan3399@gmail.com.

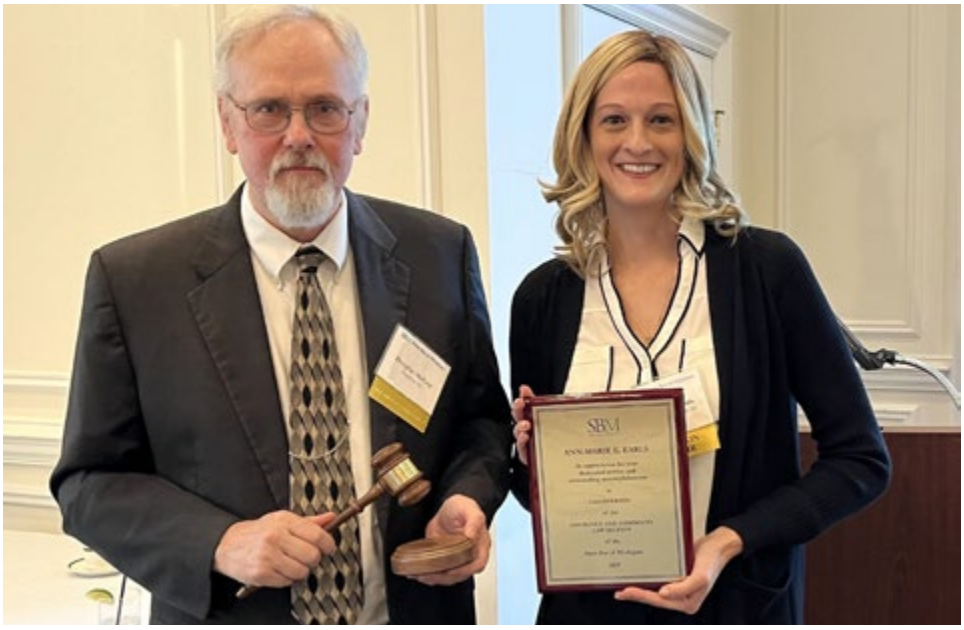
We also plan to have two educational seminars this year. Our Program Committee chairperson Melissa Hirn has already generated some great ideas for topics, but if you would like us to consider a specific subject or speaker – either for the next program or down the road – shoot me an email at doug@mccraylawoffice.com.

Concluding Thoughts

Over the years, this Section has put on dozens of networking and educational events, published a top-notch *Journal*, and incentivized future attorneys via its scholarship program, all while steadily growing its membership. With that history, it is easy to be optimistic about the future. I encourage all members to get involved by attending the events, submitting an article for the *Journal*, or, if inclined, joining one of our committees (which are not limited to Council members). And, of course, the scholarship program is a wonderful way for students to offset tuition bills while establishing a track record as a future insurance attorney.

Finally, please feel free to email me with any questions or thoughts about the Journal, committees, the scholarship, Council participation or anything else relating to the Section.

Thank You!



2024-25 Chair Annie Earls turns the gavel over to incoming Chair Doug McCray.

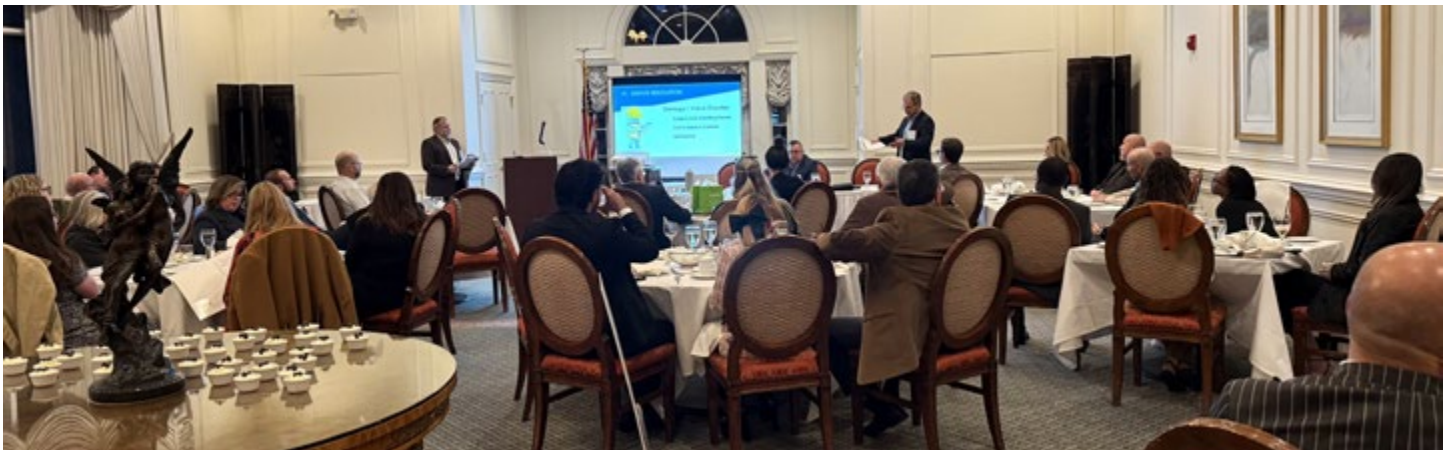
New Council Members

Chelsea Saferain

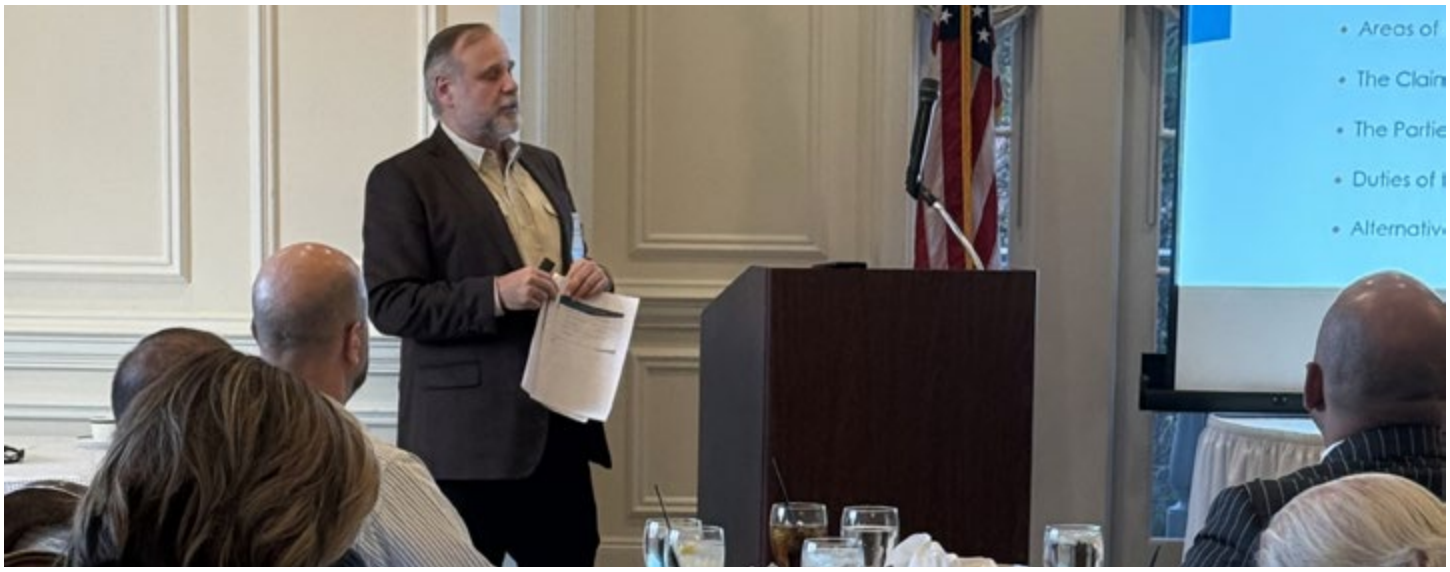
Nicholas Badalalmenti

Shantinique Brooks

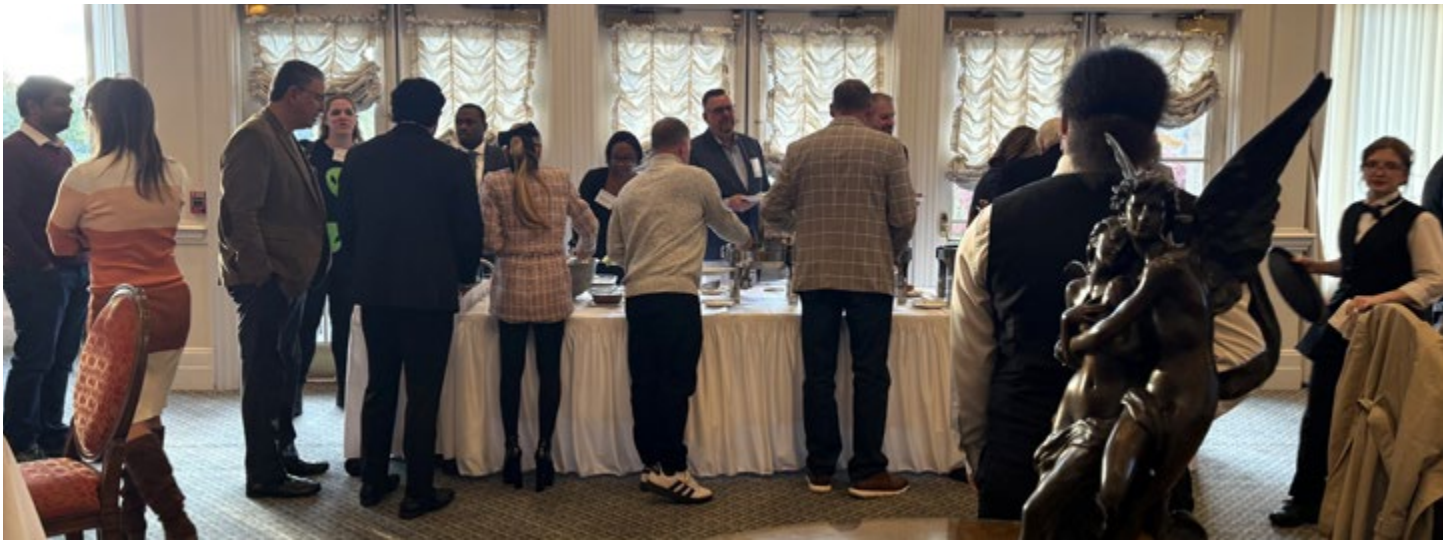
Scenes from the Annual Meeting



Attendees learn about property claim resolution after the annual meeting



Presenter Ethan Gross discusses property claims



Refreshments are served at the annual meeting

Reforming Medical Insurance Law to Address America's Healthcare Crisis

By Victoria Hanna, First Place IIS 2025 Scholarship Winner
Cooley Law School, Anticipated Year of Graduation: December 2026

Introduction

The American healthcare system is one of the clearest failures of market-based policy in the developed world. Despite spending 16.7% of GDP on healthcare as of 2023—substantially higher than peer countries—the United States continues to produce inferior health outcomes compared to nations with universal coverage systems.[1] Despite over 90% of the population having some form of health insurance, medical debt remains a persistent problem affecting 20 million people, with medical expenses contributing to 62.1% of all bankruptcies.[2] This paradox—high coverage yet financial ruin from medical expenses—reveals flaws in how American law structures medical insurance markets.

The current legal framework governing medical insurance creates harmful incentives that prioritize insurer profits over patient welfare, allowing coverage denials and benefit limitations that effectively ration care by wealth rather than medical necessity. To address these systemic failures, Congress must enact comprehensive reforms that establish meaningful coverage standards, limit harmful insurance practices, and ensure that insurance functions as genuine protection against medical expenses. This essay argues for three key legal reforms: mandatory comprehensive coverage standards that eliminate coverage gaps, strict limits on patient cost-sharing to prevent financial barriers to care and enhanced regulatory enforcement mechanisms to ensure insurers cannot circumvent their obligations to patients.

The Scope of America's Healthcare Crisis

America's healthcare crisis is well-documented and damning. Americans owe at least $220 billion in medical debt, a figure that represents not merely individual financial hardship but a fundamental breakdown of insurance's core purpose: protecting individuals from serious financial loss due to illness.[3] Perhaps most revealing is that of people carrying medical debt are actually insured.[4] For example, a cancer patient with insurance can still face $50,000 in out-of-pocket costs. This statistic highlights the inadequacy of much American health coverage, where insurance exists more as an expensive bureaucratic layer than as real financial protection.

The human cost extends beyond statistics. Medical costs continue to outpace incomes, 29 million remain uninsured, and many with health insurance face unpredictable and unaffordable out-of-pocket costs.[5] These financial pressures create a two-tier system where medical decision-making is distorted by the ability to pay rather than medical necessity, fundamentally violating principles of equal access to healthcare that democratic societies should embrace.

Legal Framework Failures

The current legal structure governing medical insurance creates multiple pathways for insurers to shift costs and risks back to patients, undermining insurance's essential function. The Employee Retirement Income Security Act (ERISA), while originally intended to protect employee benefits, has evolved into a shield protecting employer-sponsored health plans from state regulation and meaningful legal accountability. Under ERISA's preemption provisions, patients who are denied coverage by employer plans cannot seek punitive damages or meaningful remedies beyond the cost of the denied care itself—creating virtually no deterrent against wrongful coverage denials.[6] State common law remedies for insurance bad faith, which typically allow recovery of consequential damages and emotional distress in addition to policy benefits, remain unavailable to millions of Americans covered by ERISA plans.[7]

The Affordable Care Act (ACA) attempted to address some of these issues through essential health benefits requirements and prohibitions on lifetime and annual benefit caps. However, the ACA's reforms left substantial loopholes that insurers have exploited. High-deductible health plans (HDHPs), encouraged by the ACA's bronze tier structure, effectively function as catastrophic coverage that leaves patients financially exposed for most routine and many emergency medical needs.[8] These plans meet the ACA's coverage requirements on paper while failing to provide meaningful financial protection in practice.

State insurance regulation, theoretically the primary mechanism for consumer protection, has proven inadequate to address these systemic problems. State insurance commissioners often lack the resources or political will to effectively challenge insurer practices, particularly when faced with sophisticated legal teams from large insurance companies. Moreover, the interstate na-

ture of many insurance companies and the federal preemption of ERISA plans limit state regulatory authority over a significant portion of the insurance market.

The Insurance Coverage Illusion

Current law allows insurers to create an illusion of comprehensive coverage while systematically excluding or limiting coverage for essential services. Network restrictions, prior authorization requirements, and benefit design all serve as mechanisms for insurers to control costs by making healthcare less accessible to patients. These technically legal practices undermine the fundamental insurance principle of pooling risk across healthy and sick populations.

Network adequacy standards, where they exist, often use crude metrics like provider-to-population ratios that fail to account for practical accessibility issues such as appointment availability or geographic distribution. Patients who seek care from out-of-network providers—often because no in-network provider is practically available—face steep financial penalties that can result in thousands of dollars in unexpected costs.

Prior authorization requirements have expanded dramatically, creating administrative barriers between patients and their doctors while generating additional costs. These requirements, designed to prevent unnecessary care, often delay or prevent medically necessary treatment while requiring physicians to spend substantial time navigating insurer bureaucracy rather than providing patient care. The legal framework provides minimal meaningful oversight of these practices, allowing insurers broad discretion to second-guess medical professional judgment.

Proposed Legal Reforms

A. Comprehensive Coverage Standards

Congress should establish mandatory coverage standards that eliminate gaps. These standards must go beyond the ACA's essential health benefits categories to specify that insurers cannot exclude coverage for any medically necessary service, as determined by treating physicians in consultation with established clinical guidelines. This reform would eliminate the current practice of insurers creating narrow coverage categories that allow them to deny care based on technical exclusions rather than medical necessity.

The legislation should specifically prohibit network restrictions that functionally deny coverage. If an insurer cannot provide adequate network access to a covered service within reasonable geographic and temporal limits, it must cover out-of-network care at in-network rates without additional patient cost-sharing. This reform addresses the common practice of insurers maintaining technically compliant but practically inadequate networks.

Prior authorization requirements should be strictly limited to situations where evidence-based medical guidelines indicate genuine uncertainty about treatment appropriateness. All prior authorization decisions must be made by licensed physicians with expertise in the relevant medical area, and denials must include specific medical justifications that can be challenged through an expedited appeals process with independent medical review.

B. Cost-Sharing Limitations

The law must establish strict limits on patient cost-sharing to prevent insurance from functioning as mere discount programs that leave patients financially exposed. Annual out-of-pocket costs should be capped at no more than 5% of household income, with lower caps for households below median income levels. This income-based approach ensures that cost-sharing requirements do not create financial barriers to necessary care regardless of household economic circumstances.

Copayments and deductibles for emergency care should be eliminated entirely. Emergency situations, by definition, do not allow patients to shop for care or make cost-conscious decisions, making cost-sharing particularly inappropriate and potentially dangerous if it delays necessary treatment. Similarly, copayments for preventive care, which generate long-term healthcare savings, should remain prohibited under expanded definitions of preventive services.

C. Regulatory Enforcement Mechanisms

Enhanced regulatory enforcement requires both stronger oversight authority and meaningful penalties for insurer violations. Federal legislation should establish a national insurance oversight board with authority to investigate consumer complaints, conduct audits of insurer practices, and impose significant financial penalties for violations of coverage requirements.

The legislation must also provide legal remedies for patients harmed by wrongful coverage denials or delays. ERISA preemption should be modified to allow state law remedies, including punitive damages, for violations of federal coverage standards. Without legal consequences, insurers will continue to prioritize cost reduction over patient welfare in their coverage decisions.

Insurers should be required to meet minimum medical loss ratios of at least 90%, meaning that no more than 10% of premium revenue can be used for administrative costs and profits. This requirement, more stringent than current ACA requirements, would ensure that insurance functions primarily as a mechanism for paying for healthcare rather than generating profits through coverage restrictions.

Economic and Constitutional Justifications

The economic justification for these reforms extends beyond humanitarian concerns to include substantial efficiency gains from eliminating the administrative complexity and cost-shifting that characterizes the current system. Administrative costs in the American healthcare system, largely driven by insurance complexity, consume approximately 30% of healthcare spending compared to 2% in countries with streamlined single-payer systems.[9] Eliminating coverage restrictions and prior authorization requirements would reduce administrative burden on healthcare providers, allowing them to focus resources on patient care rather than insurance navigation.

The macroeconomic benefits of reducing medical bankruptcy and debt would be substantial. Medical debt constrains consumer spending and reduces economic mobility, creating drag on economic growth that affects the entire economy. By ensuring that insurance provides genuine financial protection, these reforms would increase consumer confidence and spending.

These proposed reforms are constitutional under the Commerce Clause, following precedent set by existing federal healthcare legislation including the ACA and ERISA. In *National Federation of Independent Business Sebelius*, the Supreme Court affirmed Congress's broad authority to regulate healthcare markets under the Commerce Clause and taxing power, establishing that federal healthcare regulation serves important public interests.[10] The interstate nature of insurance markets and their substantial effects on interstate commerce provide clear constitutional authority for federal regulation of insurance practices. Potential constitutional challenges based on Takings Clause arguments would likely fail under existing precedent that allows reasonable regulation of business practices that serve compelling public interests.

Counterarguments and Responses

Critics may argue that these reforms would increase premium costs, making insurance less affordable. However, this objection ignores the hidden costs of the current system. When insurance fails to provide meaningful protection, individuals bear catastrophic costs through medical debt and bankruptcy—costs that ripple through the economy in reduced consumer spending and economic productivity. Moreover, administrative savings from streamlined coverage requirements would partially offset expanded benefit costs.

Federalism concerns about preempting state insurance regulation warrant consideration but do not undermine the proposed reforms. The interstate nature of health insurance markets and the failure of state-by-state regulation to protect consumers justify federal intervention. The proposed framework would establish minimum federal standards while allowing states to impose stricter requirements, preserving state regulatory authority where it proves effective.

Industry opposition is inevitable, but insurers' profit interests cannot outweigh patients' needs for genuine financial protection. The insurance industry's function is to pool and manage risk, not to profit from denying necessary care. Meaningful regulation simply ensures that insurers fulfill their proper role in the healthcare system.

Conclusion

The current legal framework governing medical insurance has failed to achieve its fundamental purpose: protecting Americans from financial devastation due to medical expenses. Despite high coverage rates, medical debt and bankruptcy remain endemic problems that reveal the hollow nature of much American health insurance. The proposed reforms—comprehensive coverage standards, meaningful cost-sharing limitations, and enhanced enforcement mechanisms—address the root causes of these failures by ensuring that insurance functions as genuine financial protection rather than elaborate cost-shifting to patients.

These reforms represent not merely incremental improvement but fundamental restructuring of the legal relationship between insurers, patients, and healthcare providers. By requiring insurers to provide meaningful coverage and limiting their ability to shift costs and risks to patients, the law would restore insurance to its proper function as protection against catastrophic expense rather than profit generation through coverage restriction. The human and economic costs of maintaining the status quo far exceed the implementation costs of meaningful reform. Americans deserve a healthcare financing system that protects them when they are most vulnerable, rather than one that profits from their misfortune.

Victoria Hanna

Anticipated Year of Graduation: December 2026

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Endnotes

1 Organisation for Economic Co-operation and Development, OECD Health Statistics 2024 (2024), https://www.oecd.org/health/health-data.htm.

2 David U. Himmelstein et al., Medical Bankruptcy: Still Common Despite the Affordable Care Act, 109 Am J Pub. Health 431, 431 (2019).

3 The Burden of Medical Debt in the United States, Kaiser Family Foundation (Mar 10, 2022)), https://www.kff.org/health-costs/issue-brief/the-burden-of-medical-debt-in-the-united-states/.

4 Id.

5 U.S. Census Bureau, Health Insurance Coverage in the United States: 2023, Report No P60-281 (Sept 2024)

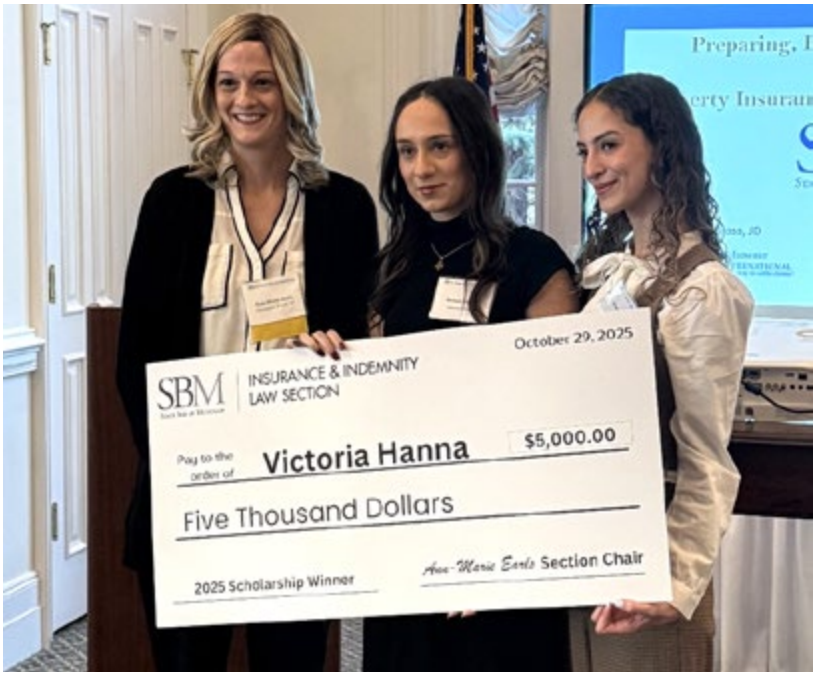
6 See Pilot Life Ins Co v Dedeaux, 481 US 41, 54-57 (1987) (holding that ERISA preempts state common law tort and contract claims).

7 See Amsden v Cigna Corp, 786 F3d 1291, 1297-98 (10th Cir 2015) (noting that ERISA's limited remedies leave beneficiaries without adequate legal recourse for wrongful denials).

8 Kaiser Family Foundation, 2023 Employer Health Benefits Survey (2023), https://www.kff.org/health-costs/report/2023-employer-health-benefits-survey/.

9 David Himmelstein et al., Health Care Administrative Costs in the United States and Canada, 2017, 172 Annals Internal Med. 134, 134 (2020).

10 See Nat'l Fed'n of Indep Bus v Sebelius, 567 US 519, 558-59 (2012) (upholding most ACA provisions under Commerce Clause and tax power).



Reforming the Legal Architecture of U.S. Health Insurance: Reconciling the ACA and ERISA Through Transparency, Accountability, and Equity

By Joseph Berry, 2025 Second Place IIS Scholarship Winner
University of Detroit Mercy School of Law, Juris Doctor Candidate 2026

I. Introduction

The United States spends more on healthcare than any other developed nation, yet it continues to produce comparatively poor outcomes in access, quality, and patient financial protection (*The Commonwealth Fund, US Health Care from a Global Perspective* (2023), https://www.commonwealthfund.org/publications/issue-briefs/2023/jan/us-health-care-global-perspective-2022). This paradox stems not only from inefficiencies in medical delivery but from the fragmented legal architecture governing health insurance. The two central pillars of this framework, the Patient Protection and Affordable Care Act (ACA) and the Employee Retirement Income Security Act of 1974 (ERISA), operate in tension. Although ERISA formally governs only employer-sponsored health plans, its broad preemption and remedial limitations effectively shape the legal landscape for nearly all private insurance, influencing how coverage and enforcement operate far beyond the workplace. While the ACA has expanded coverage and imposed consumer protections, ERISA's broad preemption clause limits state oversight and confines patients to ERISA's narrow civil enforcement remedies, effectively leaving little room for independent legal recourse (*Aetna Health Inc v Davila*, 542 US 200, 214–15 (2004)).

Congress enacted the ACA "to increase the number of Americans covered by health insurance and decrease the cost of health care." (*Natl Fedn of Indep Bus v Sebelius*, 567 US 519, 519 (2012)). The statute requires insurers to cover "essential health benefits," prohibits lifetime and annual caps, and guarantees internal and external appeals of coverage denials (42 USC §§ 18022(b)(1); 300gg-11; 300gg-19(a)–(b)). Yet the ACA's reach is inherently limited by ERISA's sweeping preemption clause which states that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" (29 USC § 1144(a)).

The Supreme Court has repeatedly interpreted that clause to foreclose state remedies, emphasizing that ERISA's civil-enforcement scheme is "exclusive" (*Pilot Life Ins Co v Dedeaux*, 481 US 41, 54 (1987)) and that "any state-law cause of action that duplicates, supplements, or supplants" the ERISA remedy is preempted (*Aetna Health Inc v Davila*, 542 US 200, 209 (2004)). Consequently, individuals wrongfully denied medical coverage are generally limited to recovering only the benefits due under the plan, not compensatory or punitive damages (*Mass Mut Life Ins Co v Russell*, 473 US 134, 144 (1985)).

These structural constraints hinder accountability and transparency in insurer decision-making. Although the ACA mandates standardized benefit summaries and requires notice of appeal rights (42 USC § 300gg-15), insurers retain broad discretion in determining medical necessity and authorizing treatments, decisions that often govern both preauthorization and post-treatment coverage disputes (*Rush Prudential*, 536 US at 372-73). The result is a legal system that allows cost-containment mechanisms to conceal patient rights, contributing to widespread financial harm despite nominal coverage protections. Congress itself recognized these shortcomings, noting that "millions of Americans are denied coverage or charged more due to preexisting conditions, and consumers lack the transparency needed to make informed choices" (S Rep No 111-89, at 2–3 (2009)).

Ultimately, the interaction between ERISA and the ACA creates a regime that values uniformity over justice and efficiency over enforceability. To reconcile these competing objectives, U.S. medical insurance law must evolve through legislative and judicial reform, perhaps amending the ACA to mandate clearer cost disclosures and affordability safeguards while narrowing ERISA's preemptive scope to restore patient access to remedies. Only through such integrated reform can federal law achieve its original aim: a healthcare system that is affordable, transparent, and legally accountable to the individuals it purports to protect.

II. Current Legal Framework

To further understand the interaction between ACA and ERISA requires examining how each statute allocates authority and remedies. The ACA regulates insurers directly, mandating coverage standards and appeal rights, while ERISA governs plan administration and preempts most state-law cause of action. Together, they define the contours of medical insurance regulation but often conflict, particularly regarding patient remedies and the balance of federal and state authority.

A. The Affordable Care Act

Enacted in 2010, the ACA prohibits insurers from denying coverage due to preexisting conditions (42 USC § 300gg-3(a)), imposes community rating requirements (42 USC § 300gg(a)(1)), and mandates coverage of "essential health benefits" (42 USC § 18022(b)(1)). It also requires insurers to provide plain-language benefit summaries (42 USC § 300gg-15(b)) and establishes internal and external review processes (42 USC § 300gg-19(a)–(b)). These provisions were intended to counteract the market failures that contributed to cost-shifting and inefficiency (*Sebelius*, 567 US at 538–39).

B. The Employee Retirement Income Security Act

ERISA sets uniform standards for fiduciary duty and plan administration (29 USC § 1001(b)), but its preemption clause displaces nearly all state remedies (29 USC § 1144(a)). The Court has consistently enforced this exclusivity, limiting participants to benefit recovery actions under § 1132(a)(1)(B). State laws survive preemption only when they regulate insurance directly (*Moran*, 536 US at 380–82).

C. The Interaction Between the ACA and ERISA

The cumulative effect of these provisions is a system whose structural weaknesses give rise to the failures discussed below.

III. Systemic Failures and Their Consequences

The interaction between the ACA and ERISA results in three primary failures: nontransparent insurer decision-making, limited remedies for wrongful denials, and persistent information imbalance that disadvantages patients.

A. Preauthorization and Coverage Denials

Under ERISA, plan administrators' decisions receive deferential review unless "arbitrary and capricious" (*Firestone Tire & Rubber Co v Bruch*, 489 US 101, 111–13 (1989)). This standard, combined with insurers' dual role as payers and decision-makers (*Metropolitan Life Ins Co v Glenn*, 554 US 105, 112 (2008)), limits judicial oversight. Although the ACA mandates internal appeals (42 USC § 300gg-19(a)–(b)), these mechanisms lack independent enforcement because Congress did not create a private right of action to compel compliance (*Alexander v Sandoval*, 532 US 275, 286–87 (2001)).

B. Limited Remedies and Preemption

ERISA's civil-enforcement provision (§ 1132(a)) remains exclusive, precluding compensatory and punitive damages (*Russell*, 473 US at 144). Legislative history confirms that Congress intended ERISA to ensure uniform federal standards for employee benefit plans, even at the expense of broader state-law remedies (HR Rep No 93-533, at 1–3 (1973)).

C. Transparency Deficits

Both ERISA (§ 1022(a)) and the ACA (§ 300gg-15(b)) require plan summaries, but these documents often fail to disclose preauthorization rules or step-therapy restrictions. While misleading disclosures may constitute fiduciary breaches (*CIGNA Corp v Amara*, 563 US 421, 436–38 (2011)), the available remedies remain limited to forms of equitable relief.

D. Consequences

The cumulative result is a legal system that expands nominal access while leaving insured individuals financially vulnerable. Even covered patients face barriers to care and unanticipated costs, displaying failures that Congress explicitly sought to prevent (42 USC § 18091(2)(C)).

IV. Transparency and Affordability Reform (ACA Amendments)

Because medical expenses remain a leading cause of personal bankruptcy in the U.S., the ACA's affordability provisions require reinforcement to achieve Congress's stated goal of reducing financial hardship. Amending the ACA to require real-time cost disclosure, income-based out-of-pocket caps, and private enforcement would correct key deficiencies. To enhance procedural fairness, Congress should amend Section 2715 (42 USC § 300gg-15(b)) to require preauthorization verification consis-

tent with the due-process framework set out in *Mathews v Eldridge*, 424 US 319, 333 (1976). Enforcement authority under § 300gg-22(b)(2)(C) could be strengthened to include injunctive relief, allowing regulators to compel prompt compliance rather than relying solely on civil penalties.

Affordability reforms should link out-of-pocket limits (42 USC § 18022(c)(1)) to income thresholds paralleling § 36B(b)(3)(A)(i) of the Internal Revenue Code. Such alignment would harmonize subsidies and cost-sharing protections, advancing Congress's stated goal of reducing underinsurance (42 USC § 18091(2)(C)).

Finally, establishing a private civil cause of action for ACA Title I violations would align with the equitable remedies recognized in *CIGNA Corp v Amara*, 563 US 421, 440 (2011), and would provide enforceable consumer protections consistent with Congress's legislative findings.

V. Accountability and Remedy Reform (ERISA Revisions)

To restore fairness, ERISA must be amended in three ways: narrowing preemption, expanding civil remedies, and strengthening federal oversight.

Preemption under § 1144(a) should be clarified to preserve state procedural remedies that regulate insurance, consistent with § 1144(b)(2)(A) and *Moran*, 536 US at 380–82, which upheld Illinois's independent medical review law as a permissible regulation of insurance under the savings clause.

Civil remedies under § 1132(a)(3) should be expanded to include bad-faith damages for fiduciary breaches, as the current provision authorizes only equitable relief recognized in *Varity Corp v Howe*, 516 US 489, 507–15 (1996). Similar to the enforcement model for COBRA (29USC § 1132(c)(1)), which permits monetary penalties for administrative violations, this reform would better reflect the fiduciary duties of loyalty and prudence codified in § 1104(a)(1)(A)–(B) and strengthen accountability for misconduct.

Finally, the Department of Labor (DOL) should be granted authority under § 1136(b) to impose civil penalties for patterns of wrongful denials, paralleling the Department of Health and Human Services' enforcement powers under the ACA. Such dual-agency oversight would better fulfill ERISA's stated purpose "to protect … participants and beneficiaries" (29 USC § 1001(b)).

VI. Administrative and Regulatory Oversight

The ACA authorizes HHS to enforce insurer compliance (42 USC § 300gg-22(b)(2)(C)), but this authority is largely reactive, triggered only when state enforcement fails or violations are reported. Congress should empower HHS to conduct randomized audits and publish compliance data to promote transparency and reasoned oversight consistent with *Motor Vehicle Mfrs Ass'n v State Farm Mut Auto Ins Co*, 463 US 29, 43 (1983).

Similarly, the Department of Labor (DOL) should expand oversight through the Employee Benefits Security Administration (EBSA) by directing audits of health-claim denials under § 1136(b). Such audits would strengthen enforcement of the fiduciary duties of loyalty and prudence codified in § 1104(a)(1)(A)–(B) and reflect the participant-centered principles recognized in *Varity Corp v Howe*, 516 US 489, 507–15 (1996), where the Court held that fiduciaries breach their duties when they mislead or disregard participants' interests.

A joint HHS–DOL Health Plan Oversight Council, modeled on existing interagency frameworks, would promote consistent federal standards while maintaining accountability.

VII. Policy Implications

These reforms advance Congress's goal of stabilizing national insurance markets, as described in *NFIB v Sebelius*, 567 US 519, 538–39 (2012), while reinforcing state regulatory authority preserved under ERISA's saving clause, 29USC § 1144(b)(2)(A). They further promote market stability and consumer access consistent with *King v Burwell*, 576 US 473, 498 (2015), and enhance procedural fairness in claim determinations consistent with the due process framework articulated in *Mathews v Eldridge*, 424 US 319, 333 (1976).

By enhancing administrative enforcement consistent with established principles of agency authority, these reforms would modernize oversight without exceeding constitutional limits. The result is a unified federal framework that protects both economic and moral interests.

VIII. Conclusion

The dual operation of the ACA and ERISA has created a healthcare regime that promises protection but often delivers procedural formality without substantive justice. Reforming these statutes to mandate real-time cost disclosure, income-based affordability caps, expanded civil remedies, and coordinated administrative oversight would restore balance between efficiency and fairness. Each proposed amendment fits within Congress's recognized authority to regulate the national health insurance market, as discussed in *NFIB v Sebelius*, 567 US 519, 538–39 (2012), and advances the shared statutory goal of protecting plan participants and consumers alike (29USC § 1001(b); 42 USC § 18091(2)(C)).

As the Supreme Court affirmed in *King v Burwell*, 576 US 473, 498 (2015), federal health law must be interpreted "to improve health-insurance markets, not to destroy them." By evolving the ACA and ERISA into frameworks of transparency, affordability, and accountability, Congress can achieve the system it originally envisioned, a healthcare structure that safeguards both economic stability and human dignity under the rule of law.

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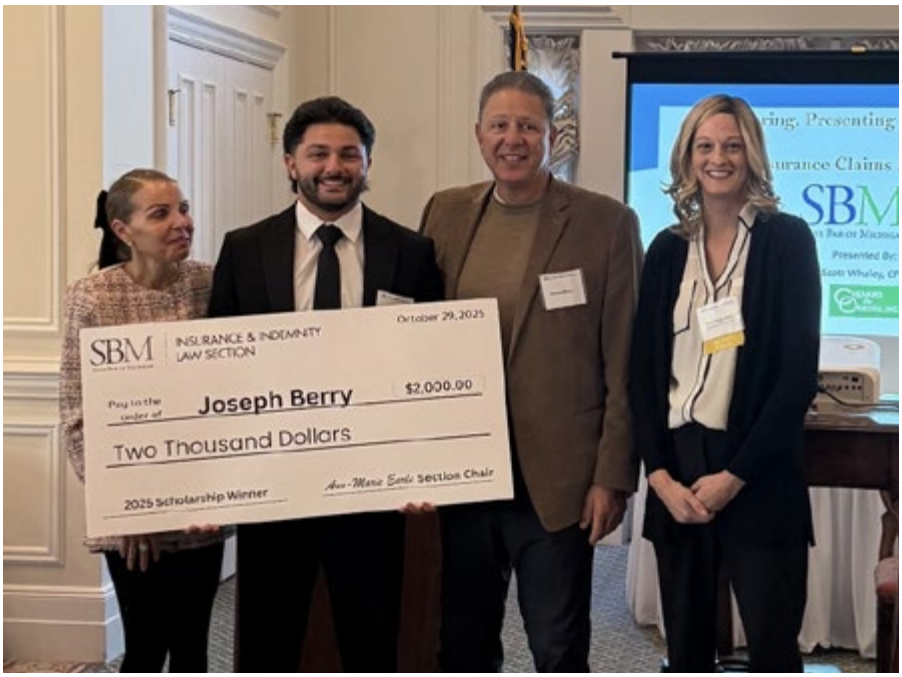
Juris Doctor Candidate 2026



INSURANCE AND INDEMNITY 101

The Insurer's Duty to Defend

By Rabih Hamawi, CPCU®, CIC, CRM, LIC, MSF
www.hamawilaw.com

Most policies that provide insurance coverage for liability claims that are asserted against the insured impose two main duties on the insurer: 1) to defend the claim (pay for legal counsel and litigation costs); and 2) to indemnify the insured (pay for damages on the insured's behalf) against the loss if the plaintiff who sued the insured is successful. There are "indemnity only" policies, as opposed to policies paying "on behalf of the insured," but they tend to be written in special circumstances. Generally, standard liability policies will create both duties.

Because the policy creates both duties, they are obviously linked. "[I]f the policy does not apply then the insurer does not have a duty to indemnify or defend the insured."[1] "The duty to defend . . . arises solely from the language of the insurance contract. A breach of that duty can be determined objectively" from the language of the contract.[2]

The two duties also share the characteristic that the insured must take the first step and request that the insurer defend and indemnify the insured by formally and timely notifying the insurer of the claim made against the insured and complying with other duties under the applicable policy. "[O]rdinarily, an insurer has no duty to defend an insured absent a request to defend."[3]

The differences between the duty to defend and the duty to indemnify begin to emerge when the analysis in each specific case starts, though they begin in the same way. An insurer's duty to defend its insured against a claim or a lawsuit is separate and distinct from the insurer's duty to indemnify.[4]

The analysis of both duties begins with the underlying complaint that asserts that the insured defendant is liable to the plaintiff, and it is the factual allegations in that complaint, and not the labels the underlying plaintiff gives them, that drive the analysis.[5]

> The "characterization of [defendant's] conduct as being mere negligence does not control the applicability of the exclusionary clause, because the duty to defend is not limited to the precise language of the pleadings. Rather, it is the substance of the allegations, not their mere form, that must be examined."[6]

> The allegations contained in the underlying complaint generally determine an insurer's duty to defend. However, mere allegations of negligence in a transparent attempt to trigger insurance coverage by characterizing intentionally tortious conduct as negligent will not persuade the court to impose a duty to defend.[7]

> The injuries resulting from the car accident are excluded from coverage regardless of the label the allegations were given in the complaint. We must look to the underlying cause of the injury to determine coverage and not the theory of liability.[8]

1. The Duty to Defend extends to claims arguably within coverage

The analyses diverge here, though, because the analysis of the duty to defend must go further. Although "[t]he insurer is not required to defend against claims expressly excluded from policy coverage," "[t]he duty to defend is not limited by the precise language of the pleadings."[9]

> The duty of an insurance company to provide a defense in an underlying tort action depends on the allegations in the complaint and extends to allegations which "even arguably come within the policy coverage." The duty to defend is broader than, and not necessarily conclusive of, an insurer's duty to indemnify. The court must resolve any doubt pertaining to the duty to defend in favor of the insured.[10]

> This duty is not limited to meritorious suits and may even extend to actions which are groundless, false, or fraudulent, so long as the allegations against the insured even arguably come within the policy coverage.... The duty to defend

> cannot be limited by the precise language of the pleadings. The insurer has the duty to look behind the third party's allegations to analyze whether coverage is possible ... In a case of doubt as to whether or not the complaint against the insured alleges a liability of the insurer under the policy, the doubt must be resolved in the insured's favor.[11]

2. An Insurer must investigate the allegations beyond the complaint

The Michigan Supreme Court has held that the insurer cannot get summary disposition in its favor where the facts are not yet fully developed.[12]

A consequence of this principle is that the insurer cannot limit its analysis to the allegations of the complaint where the duty to defend is at issue. The insurer must look behind those allegations.

> An insurer has a duty to defend, despite theories of liability asserted against any insured which are not covered under the policy, if there are any theories of recovery that fall within the policy. The duty to defend cannot be limited by the precise language of the pleadings. The insurer has the duty to look behind the third party's allegations to analyze whether coverage is possible. In a case of doubt as to whether or not the complaint against the insured alleges a liability of the insurer under the policy, the doubt must be resolved in the insured's favor.[13]

The insurer cannot limit its analysis to the underlying complaint but must conduct its own investigation to determine whether the claim should be covered.

> "[T]he duty to defend is broader than the duty to indemnify," and an insurer who wrongfully refuses to defend its insured becomes liable on any judgment against the insured "despite theories of liability asserted against any insured which are not covered under the policy." An insurer's duty to defend, then, includes the duty to investigate and analyze whether the third party's claim against the insured should be covered.[14]

The fact that the duty to defend extends to claims that may or may not be covered as long as they are "arguably" covered is one important characteristic of the insurer's duty to defend, and the insurer's affirmative duty to investigate and look "behind" the complaint is another. The third major difference is that if any claim in the underlying complaint is sufficient to trigger a duty to defend, that duty extends to all of the claims made in the underlying complaint, even those that are not covered.

> An insurer must defend its insured even if theories of liability asserted are not covered under the policy, if any asserted theories of recovery fall within the policy coverage.[15]

In a situation like this, the insurer will often issue a reservation of rights letter explaining that it will defend against all claims, but that if liability is ultimately found to exist on a claim that is not within the policy's coverage, then the insurer will not indemnify the insured for the loss.[16] This situation can sometimes lead to a quandary for the retained defense counsel. Defense counsel's obligation is to the insured client, not to the insurer. What should defense counsel do if one of two claims is covered and the other is not? Defense counsel may, for example, file a compelling motion for summary disposition on the covered claim and have it dismissed. In theory, dismissing this claim would be a victory for the client-defendant-insured, but the result is that the insurer will then withdraw the defense of the remaining (not covered) claim.

About the Author

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Endnotes

1 *Protective National Ins Co v City of Woodhaven,* 438 Mich 145, 159; 476 NW2d 374 (1991). See also *Farmers & Merchants Mut Fire Ins Co v Le Mire*, 173 Mich App 819; 434 NW2d 253 (1988).

2 *Stockdale v Jamison,* 416 Mich 217; 330 NW2d 389 (1982). In interpreting an insurance contract, "the policy application, declarations page, and the policy itself construed together constitute the contract." *Royal Prop Group, LLC v Prime Ins Syndicate, Inc*, 267 Mich App 708; 706 NW2d 426 (2005).

3 *Celina Mutual Ins Co v Citizens Ins Co,* 133 Mich App 655, 662; 349 NW2d 547 (1984).

4 *Allstate Ins Co v Maloney*, 174 Mich App 263, 268; 435 NW2d 448, 450 (1988).

5 *Gorzen v Westfield Ins Co*, 207 Mich App 575, 578; 526 NW2d 23 (1994).

6 *State Farm v Johnson,* 187 Mich App 264, 268; 466 NW2d 287 (1991) (citations omitted).

7 *Iowa Kemper Ins Co v Ryan,* 172 Mich App 134, 137; 431 NW2d 434 (1988).

8 *Gorzen, supra,* 207 Mich App at 578.

9 *Tobin v Aetna Cas & Surety Co,* 174 Mich App 516, 519; 436 NW2d 402 (1988).

10 *Allstate Ins Co v Freeman,* 432 Mich 656, 662; 443 NW2d 734 (1989).

11 *State Farm Fire & Cas Co v Huyghe*, 144 Mich App 341, 345; 375 NW2d 442, 443–44 (1985) (quoting *Detroit Edison Co v Michigan Mut Ins Co*, 102 Mich App 136, 141–42; 301 NW2d 832, 835 (1980) (citations omitted)).

12 *St. Paul Fire & Marine Ins Co v Michigan Mutual Ins Co,* 469 Mich 905; 668 NW2d 903 (2003), citing *American Bumper and Mfg Co v Hartford Fire Ins Co,* 452 Mich 440, 450-452; 550 NW2d 475 (1996).

13 *American Bumper, supra,* note 10, internal citations deleted.

14 *Koski v Allstate Ins Co,* 456 Mich 439, 445 note 5; 572 NW2d 636 (1998), citing *American Bumper, supra*.

15 *Citizens Ins Co v Pro-Seal Service Group, Inc,* 477 Mich 75, 100; 730 NW2d 682 (2007).

16 https://www.hamawilaw.com/post/the-reservation-of-rights-and-denial-letters (*The Journal of Insurance and Indemnity Law,* Volume 16 Number 3, July 2023.


LEGISLATIVE UPDATE

Election Season Is Starting Early with the Senate Special Election

By Christopher J. Petrick and Katharine Buehner Smith
Collins Einhorn Farrell PC

A Senate seat remains vacant, but the special election is coming up; the primary will take place on February 3, 2026, followed by the general election on May 5, 2026. This will kick off a busy election season in Michigan: the Governor, Secretary of State, Attorney General, all 110 state House and 38 state Senate seats, all 13 congressional seats and two Michigan Supreme Court seats are all up for election this year.

There hasn't been much action on insurance-related bills in the Senate, but the House has introduced many new insurance-related bills since our last update. One bill has advanced:

- **HB 4860 –** amends the Insurance Code to require that a health plan or nonprofit dental care corporation providing dental benefits provide at least one method of payment or reimbursement that provides the dentist with 100% of the amount payable, without a fee. ***Passed the House (99-1) on 11/6/2025. Referred to the Senate Health Policy Committee on 11/12/25.***

And several other new bills made their way to the House insurance committee:

- **HB 5199 –** amends the Insurance Code to require coverage for annual screening mammograms for women starting at age 35 (lowering from 40).
- **HB 5200 –** amends the Insurance Code to require that where the policy provides gynecological coverage, that coverage must include at least 1 pap smear performed every 3 calendar years for women 21 and older.
- **HB 5204 –** amends the Insurance Code to require coverage for prescription drugs for advanced metastatic cancer that do not require failure to and/or proof of failure to successfully respond to a different prescription drug.
- **HB 5205 –** amends the Insurance Code to remove dollar limits, deductibles, or copayments for breast cancer diagnostic services, breast cancer outpatient treatment services, breast cancer rehabilitative services, diagnostic breast examinations, and supplemental breast examinations.
- **HB 5226 –** amends the Insurance Code to require coverage for the treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute-onset neuropsychiatric syndrome, including, but not limited to, the use of intravenous immunoglobulin therapy.
- **HB 5298 and 5299 –** amends the Insurance Code to change priority for payment of personal injury protection (PIP) benefits to a person injured while an operator of or passenger in a motor vehicle operated in the business of transporting passengers.
- **HB 5380 –** amends the Insurance Code to alter the Code as it relates to the sponsors of captive insurance companies, removing an enumerated list of possible sponsors and instead requiring that the sponsor of a captive insurance company be a person approved by the DIFS director in the exercise of their discretion, based on a determination that the approval of the sponsor is consistent with the purposes of the code.
- **HB 5381 –** amends the Insurance Code to modify the definitions of "participant" and "participant contract" as they pertain to captive insurance companies, to allow them to include plural participants.
- **HB 5382 –** amends the Insurance Code to alter the deadline for when special purpose financial captives (SPFC) statements of operations must be filed with the DIFS director to within 60 days of the end of the SPFC's fiscal year.
- **HB 5383 –** amends the Insurance Code to alter the procedure relating to fees for SPFCs, reducing the application fee for a limited certificate of authority to $5,000 and to change the deadline by which it must be paid to within 90 days of the end of the SPFC's fiscal year.
- **HB 5384 –** amends the Insurance Code to add that participants through a captive insurance company are allowed to insure risks of their affiliates or controlled unaffiliated businesses.

- **HB 5385 –** amends the Insurance Code to alter requirements for forming and maintaining a captive insurance company in Michigan, including worker's compensation coverage, access to financial records, application fee and renewal of certificate, and board meeting requirements.
- **HB 5386 –** amends the Insurance Code to require that captive insurance companies file audited financial statements prepared by an independent public accountant with the DIFS director within five months of the end of the company's fiscal year.
- **HB 5406 –** amends the Insurance Code to prohibit coverage for human organ transplants where the operation takes place in a country known to participate in forced organ harvesting, or where the organ was procured from a country known to participate in forced organ harvesting.
- **HB 5419 –** amends the Insurance Code to provide specific provisions for portable electronics insurance.
- **HB 5436 –** amends the Insurance Code to require coverage for hearing aids or hearing-related services and devices for the treatment of hearing loss for a qualified enrollee that is selected by an audiologist after evaluation, with certain dollar limitations.

RECENT OPINIONS

By Eric Cohn
Fahey Schultz Burzych Rhodes PLC

Published Court of Appeals Decisions

2019 amendment to one-year-back rule does not apply retroactively to pre-June 11, 2019 claims

Encompass Healthcare, PLLC v Citizens Insurance Company
Docket No. 357225

Encompass Healthcare provided medical treatment to an insured from June through October 2018 following injuries arising from a motor vehicle accident. Citizens Insurance paid only partial reimbursement. The claimant assigned his rights to Encompass Healthcare in May 2019, and Encompass Healthcare filed suit on November 4, 2019. Citizens argued the one-year-back rule of MCL 500.3145(2) barred recovery because suit was filed more than one year after treatment ended.

Encompass Healthcare argued that the 2019 amendment to MCL 500.3145, which added a tolling provision for claims not formally denied by an insurer, applied to its case. This Court initially reversed the trial court, holding that the Explanations of Review (EORs) did not constitute formal denials under the amended statute. However, the Michigan Supreme Court subsequently determined in *Spine Specialists of Mich, PC v MemberSelect Ins Co* that the amended version should not be applied retroactively. On remand, the Court of Appeals vacated the trial court's opinion.

The Court held that because Encompass's claim accrued when treatment was provided between June and October 2018—before the June 11, 2019 effective date of the pre-amendment version of MCL 500.3145 and its strict one-year-back rule applied. The Court explained that applying the amended statute to claims that accrued before its effective date would require retroactive application, which the Legislature did not authorize. The amended statute's formal-denial requirement carries heightened obligations that could require insurers to reconstruct past responses and meet standards that did not exist when they originally denied claims.

Takeaway: Years later, we are still arguing the impact of the 2019 No Fault Reforms. The 2019 amendment to MCL 500.3145 adding a tolling provision for claims not formally denied does not apply retroactively to medical treatment that accrued before June 11, 2019. Providers and their counsel must comply with the strict one-year-back rule for pre-amendment claims, requiring suit to be filed within one year of when treatment was rendered.

Insurers must support discharge defense with proper evidence; apportionment does not require court order

Phase One Rehab, LLC v Allstate Property & Casualty Insurance Company
Docket No. 369413

An insured was injured in an August 2020 collision and assigned to Allstate through the MACP. In June 2022, the insured allegedly facilitated her claims with Allstate in a separate action, resolving all past, present, and future PIP benefits. Phase One Rehab provided medical services to the insured following surgeries and later received assignments for no-fault benefits. Allstate denied Phase One's claims stating medical benefits were discontinued.

Phase One filed suit seeking benefits. Allstate initially argued it had reached the $250,000 MACP limit based on a payment log. In its reply brief, Allstate shifted its argument, asserting the insured had resolved all claims through the June 2022 facilitation agreement before Phase One presented any bills. However, Allstate failed to provide a copy of the facilitation agreement, the settlement release, or evidence regarding the settlement amount or which providers were paid. The trial court nevertheless granted summary disposition to Allstate.

The Court of Appeals reversed in part, holding that Allstate failed to meet its initial burden under MCR 2.116(C)(10) because it did not support its factual allegations with documentary evidence. The Court noted there was no evidence regarding the settlement amount, the facilitation agreement terms, the identity of providers in the payment log, or whether all payments were made under the agreement. The Court emphasized that MCL 500.3112 functions as an affirmative defense, placing the burden on the insurer to come forward with evidence.

However, the Court affirmed the trial court's conclusion that MCL 500.3112 does not require insurers to seek court approval before paying no-fault benefits. The Court explained that the statute's use of the permissive term 'may' indicates that court-ordered apportionment is optional, not mandatory.

Takeaway: Under MCL 500.3112, an insurer asserting that payments discharged its liability must provide proper documentary evidence to support its litigation defense when moving for summary disposition. While courts possess authority to apportion benefits when genuine doubt exists about proper distribution, insurers are not required to seek court approval before issuing payments, resolving significant questions that had previously plagued beguiled insurers with favorable settlement terms. Insurers cannot meet their burden on summary disposition by making factual allegations without evidentiary support, even in reply briefs (and, reply briefs should not raise new arguments regardless, but we digress).

Special panel requested to reconsider whether MCL 500.3116(2) bars subrogation against nonmotorist tortfeasors

Sharon Call and James Call, and Frankenmuth Insurance Company v L & KJ Enterprises, LLC
Docket No. 366229

SPECIAL NOTE: This opinion was vacated on December 15, 2025. We typically do not summarize vacated opinions but raise this particular case because a special panel was requested and recently ordered, meaning this is an issue that we will readdress in an upcoming article.

The plaintiffs were injured when their vehicle struck a tire that had fallen off another vehicle traveling in the opposite direction. The tire had fallen off approximately one mile after the driver picked up her vehicle from Family Tire, which had just rotated the tires. Frankenmuth Insurance paid $381,760.17 in PIP benefits and intervened in the negligence action against Family Tire, seeking to recover damages as subrogee. Family Tire moved for summary disposition, arguing MCL 500.3116 barred the subrogation claim.

MCL 500.3116(2) provides that subtraction from or reimbursement for PIP benefits may be made only in three circumstances: (1) accidents occurring outside Michigan, (2) claims against uninsured motorists, or (3) claims based on intentionally caused harm. The Court acknowledged that its 1993 published decision in *Citizens Ins Co v Pezzani & Reid Equip Co, Inc* held that MCL 500.3116 bars an insurer's subrogation claim against nonmotorist defendants.

The Court noted that the language of MCL 500.3116(2)—particularly its references to 'subtraction from' benefits and 'reimbursement' based on 'the recovery realized by the claimant'—supports the interpretation that the statute applies only when an insurer seeks reimbursement from its insured after the insured obtains a recovery. The Court recognized that *Pezzani* was 'confused and confusing,' 'misstat[ed] the impact of section 3116,' and was 'devoid of analysis' regarding whether the statute even applied to nonmotorist tortfeasors.

Despite these concerns, the Court felt bound to apply *Pezzani* as precedent and affirmed the trial court's dismissal. However, the Court called for convening a special panel pursuant to MCR 7.215(J)(3) to consider whether *Pezzani's* holding should remain binding authority. The Court agreed with earlier analysis that 'the policy to prevent set-off with a motorist tortfeasor (to eliminate motorist versus motorist tort litigation which was the impetus for the no-fault act) is not present with the non-motorist tortfeasor.'

Takeaway: Under current binding precedent, MCL 500.3116(2) bars no-fault insurers from pursuing subrogation claims against nonmotorist tortfeasors whose negligence contributed to an accident, even though the statute's plain language suggests it applies only to reimbursement from insureds. But stay tuned! A special panel *has been convened* to reconsider whether this interpretation is correct, potentially opening the door for insurers to pursue common-law negligence claims against parties such as repair facilities, manufacturers, and other nonmotorist actors whose conduct causes compensable injuries.

Statutory definition of 'parking' excludes loading and unloading; comparative fault is for the jury

Katrina White v Domenico Pace and Suburban Mobility Authority for Regional Transportation
Docket No. 371878

Plaintiff pulled into an opening along M-10 to pick up her adult daughter. She stopped in a designated bus stop marked "NO STANDING EXCEPT D.O.T. COACHES" in front of a fire hydrant. Her daughter was already waiting and began boarding when a SMART bus driver attempted to pull into the bus stop. The rear of the bus clipped the front of plaintiff's car. Plaintiff filed a negligence action, and defendants moved for summary disposition, arguing plaintiff's presence in the bus stop loading zone constituted negligence per se making her more than 50% at fault. The trial court granted summary disposition.

The Court of Appeals first clarified that while governmental agencies are liable for ordinary negligence under MCL 691.1405's motor-vehicle exception, governmental employees are immune unless their conduct amounts to gross negligence under MCL 691.1407(2)(c). Plaintiff's counsel conceded she had not alleged gross negligence against the driver, so the Court affirmed summary disposition as to him.

On the substantive negligence issues, the Court held that even if plaintiff violated a statute, this would create only a prima facie case from which the jury may draw an inference of negligence under *Zeni v Anderson*. Questions of comparative fault under MCL 500.3135(4)(a) are for the jury unless all reasonable minds could not differ. Because plaintiff alleged the driver violated MCL 257.642(1)(a) by failing to ascertain that his lane change could be safely made, the allocation of fault was for the jury.

Critically, the Court held that plaintiff did not violate MCL 257.674(1)'s prohibition on parking within 15 feet of a fire hydrant or where signs prohibit parking. The Court examined MCL 257.38's definition of 'parking' as 'standing a vehicle, whether occupied or not, upon a highway, when not loading or unloading except when making necessary repairs.' Because the passenger was boarding plaintiff's vehicle, plaintiff was, by definition, not 'parked' even though she had stopped. The Court applied *Bensinger v Happyland Shows, Inc*, which held that a defendant who stopped to check his lights was 'parked' because he was not loading, unloading, or making necessary repairs.

The Court acknowledged that MCL 257.38's definition produces counterintuitive results and had previously described it as 'extremely troublesome.' However, the Legislature expressly directed in MCL 257.1 that this definition applies to MCL 257.674(1). The Court also considered whether plaintiff violated Rule 28.1820(1) of the Uniform Traffic Code, which prohibits stopping in a bus stop except for 'expeditious loading or unloading of passengers, if the stopping does not interfere with any bus.' The Court held that whether plaintiff 'interfere[d]' with the bus remained a question of fact for the jury.

Takeaway: Whether a vehicle is "parked" has become a tricky issue to understand, and the confusion can lead to the denial of summary disposition and preserve issues for a jury. Under Michigan's statutory definition of "parking" in MCL 257.38, a vehicle engaged in loading or unloading passengers is not "parked," even if it is stationary in a prohibited area. Regardless, violations of traffic statutes only create an inference of negligence which must be weighed against the defendant's alleged negligence under comparative fault principles.

Properly parked, unoccupied vehicle struck and propelled into building not 'involved in the accident' for PPI purposes

Fremont Insurance Company and Frankenmuth Insurance Company v State Farm Mutual Auto Insurance Company
Docket No. 371046

A driver took a Ford Escape owned by a State Farm-insured to a pizzeria. The Escape was properly parked in a marked space when another driver, who had fallen asleep at the wheel, struck the parked Escape and pushed it into the pizzeria build-

ing. Fremont Insurance and Frankenmuth Insurance provided property insurance to the building owner and pizzeria. After paying approximately $64,000 in benefits, they brought a subrogation action seeking PPI benefits from State Farm as the insurer of the Escape's owner. State Farm argued the Escape was not 'involved in the accident' within the meaning of MCL 500.3125. The trial court granted summary disposition to State Farm.

MCL 500.3125 establishes the order of priority for PPI claims: "A person suffering accidental property damage shall claim property protection insurance benefits from insurers in the following order of priority: insurers of owners or registrants of vehicles involved in the accident; and insurers of operators of vehicles involved in the accident." The Court analyzed when a vehicle is "involved in the accident" under the no-fault act, examining a line of Michigan Supreme Court decisions beginning with *Miller v Auto-Owners Ins Co*, which held that "[i]njuries involving parked vehicles typically involve the vehicle in much the same way as any other stationary object (such as a tree, sign post or boulder) would be involved."

The Court relied heavily on *Heard v State Farm Mut Auto Ins Co*, which held that "[w]hen a vehicle is parked, it is deemed not to be in use as a motor vehicle, and, for purposes of the act, it is like a gasoline pump, the wall of a service station, or a tree." *Heard* also stated that "language throughout the no-fault act" indicates "a parked vehicle is not involved in an accident with a moving vehicle." In *Turner v Auto Club Ins Ass'n*, the Supreme Court held that for a vehicle to be "involved in the accident" requires that "the vehicle be used as a motor vehicle at the time of the accident" and "must actively, as opposed to passively, contribute to the accident."

Applying this authority, the Court held that the Escape was not "involved in the accident." The Escape was parked and unoccupied when struck, was not being used as a motor vehicle, and played no active role—it was simply struck and propelled forward. The Court rejected plaintiffs' attempts to distinguish the case based on "spontaneous combustion cases" where parked vehicles caught fire due to mechanical failures, noting those cases involved damage caused by mechanical features distinguishing vehicles from ordinary stationary objects, whereas here the Escape "happened to be in the wrong place at the wrong time" and remained a passive object.

Takeaway: While the previous case shows that determining whether a vehicle is "parked" can be tricky, this case illustrates what happens when a vehicle is undisputedly parked—it's not "involved in the accident" at all. Under *Miller*, *Heard*, and *Turner*, a properly parked, unoccupied vehicle that is struck by a moving vehicle and propelled into property is not 'involved in the accident' for purposes of PPI benefits under MCL 500.3125. A parked vehicle is treated as a stationary object—no different than a tree or building—unless it is undergoing maintenance, suffers a mechanical failure causing damage, or one of the parked vehicle exceptions in MCL 500.3106(1) applies. The vehicle must "actively, as opposed to passively, contribute to the accident" to be considered involved.

Policy exclusions conflicting with statutory priority invalid; rescission as to innocent third party requires weighing all equities

Muzafer Isovska v Leana Fitzpatrick, USA Underwriters, Progressive Marathon Insurance Company, and Michigan Automobile Insurance Placement Facility
Docket No. 368902

Plaintiff was driving a Ford Focus when she was struck by another driver. The Focus was registered to both plaintiff and her daughter, with both having the same address. Plaintiff was the named insured under a USAU policy covering a Toyota Yaris (not involved in the accident), and the daughter was an excluded driver under that policy. The daughter had a separate Progressive policy listing herself as named insured and the Focus as the insured vehicle. When the daughter procured the Progressive policy, she failed to identify plaintiff as a resident relative. Progressive later rescinded the policy *ab initio* based on this material misrepresentation, refunding all premiums. USAU denied plaintiff's PIP claim because the Focus was not listed on its policy. The MAIPF also denied benefits. Suit was filed and summary disposition motions followed.

Regarding USAU's motion, the Court held that USAU's Exclusion D, which barred PIP coverage when an insured was injured while occupying a vehicle owned or registered by the insured but not listed on the policy, was invalid. The Court relied on *Lee v Detroit Auto Inter-Ins Exch*, which held that under the no-fault act, "persons, not motor vehicles, are insured against loss." The Court emphasized that MCL 500.3114(1) clearly states a PIP policy applies "to accidental bodily injury to the person named in the policy" with no statutory language linking the right to recovery with whether the vehicle involved was registered, insured, or covered under the policy.

The Court concluded that "it is the public policy of the no-fault act, as manifested in the plain language of MCL 500.3114(1), that an insured meeting the statutory criteria first turn to their no-fault insurer for the recovery of PIP benefits,

regardless of whether the vehicle listed under the policy was involved in the accident." USAU's Exclusion D directly contravened this statutory mandate and was therefore invalid. However, the Court recognized that USAU's Exclusion E, which barred coverage for owners or registrants of vehicles without required security, mirrored MCL 500.3113(b). The applicability of Exclusion E depended on whether Progressive's policy was rescinded as to plaintiff.

Turning to Progressive's motion, the Court vacated the trial court's order granting summary disposition on rescission grounds. The Court held that a genuine issue of material fact existed regarding whether plaintiff was a party to the daughter's misrepresentation. The trial court had concluded that plaintiff was not an innocent third party because she was a co-registrant of the Focus and the daughter's resident relative, making her "a party to the misrepresentation." The Court found this conclusion unsupported by the record, noting that plaintiff's deposition testimony established the daughter handled insurance matters and plaintiff was not even clear whether the Focus was registered in her name.

The Court explained that under *Bazzi v Sentinel Ins Co* and *Pioneer State Mut Ins Co v Wright*, when rescinding a policy as to an innocent third party, trial courts must balance five nonexclusive factors: (1) the extent to which the insurer could have uncovered the fraud before the injury; (2) the relationship between the fraudulent insured and innocent third party to determine if the third party had knowledge of fraud; (3) the nature of the innocent third party's conduct in the injury-causing event; (4) availability of alternate avenues for recovery; and (5) whether policy enforcement only relieves the fraudulent insured of personal liability. The Court held that on remand, if plaintiff is determined to be an innocent third party, the trial court must weigh all relevant equities before deciding whether rescission as to her is appropriate.

Finally, the Court affirmed the MAIPF's summary disposition because both potential outcomes on remand would preclude MAIPF liability. If the Progressive policy is not rescinded as to plaintiff, she could recover from USAU under *Lee*, eliminating MAIPF responsibility under MCL 500.3172(1)(b). If the policy is rescinded as to plaintiff, the Focus would be uninsured, triggering the statutory bar in MCL 500.3113(b) that would also preclude MAIPF benefits.

Takeaway: Policy exclusions that bar PIP benefits to a named insured based solely on which vehicle was involved in the accident violate MCL 500.3114(1)'s mandate that coverage follows the person, not the vehicle. When an insurer seeks to rescind a policy as to an alleged innocent third party based on another insured's fraud in procurement, courts must determine whether the third party had knowledge of or participated in the fraud and, if not, must balance all relevant equities before allowing rescission. The familial or ownership relationship between the fraudulent insured and alleged innocent third party does not alone establish knowledge of fraud sufficient to support summary disposition. Insurers take note: policy language that conflicts with state law accomplishes nothing.

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