CENTER FOR INSURANCE POLICY AND RESEARCH

NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Journal of Insurance Regulation

Volume 44, Number 6

DOI: http://doi.org/10.52227/27127.2025

# Abstracts of Significant Cases Bearing on the Regulation of Insurance 2025

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**Journal of Insurance Regulation: A Forum for Opinion and Discussion of Major Regulatory and Public Policy Issues in Insurance**

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# Abstracts of Significant Cases Bearing on the Regulation of Insurance 2025

Olivea Myers*

## United States Court of Appeals

### Tenth Circuit

*Renteria v. New Mexico Off. of the Superintendent of Ins. et al.,* No. 23-2123, 2025 WL 635754, at *1 (10th Cir. Feb. 27, 2025).

At issue in this case is a dispute arising from an enforcement action taken by the New Mexico Office of the Superintendent of Insurance ("OSI") against Gospel Light Mennonite Church Medical Aid Plan ("Plaintiff"), which resulted in a final order that required Plaintiff to cease operating as a health care sharing ministry in New Mexico. *Id*. at *1. Plaintiff sought a preliminary injunction to enjoin OSI from enforcing the final order, which the district court denied. *Id*.

Plaintiffs' members make monthly voluntary gifts to assist other members with medical expenses, but members are ultimately responsible for their own medical bills, and members must live by Christian standards and may not request sharing for certain medical expenses, including abortion. *Id*. at *2. OSI received a consumer complaint in which a member asserted that Plaintiff was continuing to charge the complainant without reimbursement. *Id*. After investigating, OSI initiated an administrative enforcement action. It also ordered Plaintiff "'to cease and desist from transacting insurance business in New Mexico,' to provide OSI with data on Gospel Light's plans sold in New Mexico, and to show cause why OSI should not fine Gospel Light for each unauthorized insurance transaction." *Id*. A hearing followed, and the hearing officer found that Plaintiff sold benefit plans or insurance without a certificate of authority. *Id*. OSI issued a final order adopting the hearing officer's recommendation that it should order Plaintiff to cease operations until it complied with the New Mexico insurance code. *Id*.

Plaintiff appealed OSI's final order in New Mexico state court and in the United States District Court, claiming violations of its First and Fourteenth Amendment rights as well as federal preemption and declaratory judgment claims under which Plaintiff argued that OSI's final order conflicted with the McCarran-Ferguson Act, the Affordable Care Act, and the Internal Revenue Code. *Id*. at *3. The court of appeals held that OSI's order did not violate Plaintiff's First and Fourteenth Amendment rights, as Plaintiff did not show that OSI's motivations were based on religious animus rather than enforcement of the New Mexico insurance code. *Id*. at *8. The court held that OSI sought to enforce

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the New Mexico insurance code to protect consumers and that "the 'regulation and licensure of insurance producers' are 'important state interests', and OSI's final order, which enforced the [New Mexico insurance code] against [Plaintiff], is rationally related to the regulation of health insurance," and thus the government action by OSI satisfies rational-basis review, and Plaintiff did not show a substantial likelihood of success on the merits of its First Amendment claims. *Id*. at *9. The court also held that Plaintiff did not carry its burden to prove that OSI's final order was preempted because Plaintiff failed to "show a substantial likelihood to succeed on any of the claims properly." *Id*. at *12. Plaintiff filed a petition for a writ of certiorari in the United States Supreme Court. On October 14, 2025, the Supreme Court invited the Solicitor General to file a brief in this case expressing the views of the United States. The Supreme Court did not establish a deadline for the Solicitor General to file his response.

## State Court

### California

*Lara v. California Ins. Co*., 112 Cal.App.5th 1204, (Cal. Ct. App. 2025).

At issue in this case is a conservatorship that was established when California Insurance Company ("CIC") attempted to merge with a newly formed New Mexico company, CIC II. The application for conservatorship relied upon a California law that requires a court to appoint the commissioner as a conservator of an insurance company if the commissioner shows the company has, without the commissioner's consent, transferred or attempted to transfer substantially its entire business or entered into a transaction to merge. *Id*. at *1218. The commissioner alleged that CIC violated this provision by attempting to merge with CIC II without the commissioner's approval under California law. *Id*.

The trial court agreed with the commissioner's petition and granted the conservatorship. The commissioner also filed an application for approval of a rehabilitation plan, which would end the conservatorship. *Id*. The trial court approved the commissioner's rehabilitation plan and ended the conservatorship. *Id*. at *1219. CIC appealed arguing that the conservatorship was unlawfully imposed and that the rehabilitation was an abuse of discretion. *Id*. at *1221. The court of appeals affirmed the trial court's order holding that because CIC attempted an unauthorized merger, even when the insurer involved is solvent, "it is not absurd for the Legislature to intend to prohibit insurers from merging without the commissioner's consent." *Id*. at *1226. The court of appeals also held that the rehabilitation plan was not an abuse of discretion and was reasonably related to the public interest and necessary to address the issues that led to the conservatorship. *Id*. at *1237.

**Connecticut**

*Ins. Comm'r of the State of Connecticut v. PHL Variable Ins. Co. Et al,* No. X06UWY-CV24-6085274S, at *1 (Conn. Super. Ct. July 18, 2025).

This memorandum of decision answers a question of first impression: is a rehabilitation proceeding under the Connecticut Rehabilitation and Insurance Liquidation Act (the "Act") a civil action, such that policyholders have a legal right to intervene in the proceeding pursuant to Connecticut law?

PHL Variable Insurance Company is a Connecticut-domiciled life insurance company with principal offices in Hartford, Connecticut. In 2024, PHL's board of directors passed a resolution consenting to the rehabilitation of the company due to its inability to satisfy certain financial obligations. *Id*. at *2. The commissioner commenced rehabilitation proceedings by filing a petition in superior court. The court entered an order appointing the commissioner as rehabilitator and placing PHL in rehabilitation under the Act.

SWS Holdings moved to intervene in the rehabilitation proceedings to "ensure that their interests are adequately represented and protected in these proceedings, and "'to enable them *to participate fully in an discovery or hearing related to any proposed rehabilitation plan*. . . .' (Emphasis added.)" The commissioner objected to SWS Holding's motion to intervene. and did not dispute that as a policyholder, SWS Holdings has an interest in the rehabilitation proceedings, however, the commissioner argued that a rehabilitation proceeding is not a civil action. *Id*. at *5.

The court agreed with the commissioner, holding that a rehabilitation proceeding under the Act is not a civil action. Connecticut law does not authorize a court to grant general intervenor status to a nonparty who has an interest in a rehabilitation proceeding. *Id*. at *7. The court's decision does not mean that policyholders have no intervention rights under the Act. The court, in its discretion, may grant limited intervenor status to an interested nonparty who seeks to intervene for a specific purpose. *Id*. The court further held that the General Assembly "has charged the commissioner with the responsibility to represent the interests of all policyholders and to make the day-to-day decisions of running an insurance company in rehabilitation status." *Id*. at *10.

**Delaware**

*Hsu v. Navarro*, No. N25C-03-083 PAW, 2025 WL 3013171, at *1 (Del. Super. Ct. Oct. 28, 2025).

Plaintiff experienced water damage to his home and filed a consumer complaint with the Delaware Department of Insurance ("Department") regarding State Farm's handling of his claim. *Id*. State Farm responded to the Department's inquiry regarding Plaintiff's complaint and less than a week later Plaintiff filed insurance coverage litigation against State Farm. *Id*. Plaintiff submitted a Freedom of Information Act ("FOIA") request to the Department and the Department denied the request the following day. Plaintiff submitted a revised FOIA request and the Department subsequently denied

that request. *Id*. Plaintiff appealed the decision of the revised FOIA request to the Delaware Attorney General's office. The attorney general's office issued a decision in favor of the Department holding that the Department did not violate FOIA. The attorney general's office stated that "'[t]he Department is not obligated under FOIA to provide records it does not possess or control.'" *Id*. Plaintiff did not appeal the attorney general's decision but filed this litigation against the insurance commissioner. Plaintiff sought a declaration that the commissioner violated the Delaware Public Records Law. *Id*. at *2. The Department moved for summary judgment on all claims asserted on the grounds of sovereign immunity.

The court held that the claims asserted by Plaintiff are premised on actions or inactions taken by the commissioner in connection with his official duties and not his individual capacity and as such, the commissioner's sovereign immunity is not waived. The court further held that even if Plaintiff had shown that the state waived the defense of sovereign immunity, the action would still be barred by the State Tort Claims Act and granted the Department's motion for summary judgment.

**Indiana**

*Larson v. Indiana Dep't of Ins*., No. 24A-MI-2992, 2025 WL 2254293, at *1 (Ind. Ct. App. Aug. 7, 2025).

Appellant Larson obtained his insurance producer license in 2015 and worked as an independent contractor agent for State Farm Mutual Insurance Company in 2016. State Farm conducted an internal audit investigation of Appellant, and he resigned in 2020. The Indiana Insurance Department ("Department") filed a Statement of Charges against Appellant seeking permanent revocation of his license due to his alleged intentional misrepresentation of the terms of an actual or proposed insurance contract or application for insurance in violation of Indiana law and use of fraudulent, coercive, or dishonest practices, or demonstration of incompetence, untrustworthiness, or financial irresponsibility in the conduct of business. *Id*. at *1.

Following a hearing, the Administrative Law Judge ("ALJ") recommending that the Commissioner deny the Department's request to revoke Appellant's license. In response, the Department filed an objection and the Commissioner dissolved the ALJ's recommended order and revoked Appellant's insurance license. Appellant filed a petition for judicial review, and the trial court denied Appellant's petition.

Appellant appealed contending that: multiple exhibits were hearsay and improperly admitted into evidence, a witness was not qualified to provide the proper foundation for admission of the State Farm audit report, and that a portion of an exhibit was improperly admitted into evidence. In an appeal of an administrative agency's decision, the agency's decision is only reversed if it is arbitrary, capricious, or an abuse of discretion. The court affirmed the trial court's decision holding that the court only determines whether the agency's decision is arbitrary or capricious or in excess of statutory authority and the court does not review the trial court's decisions such as

whether or not certain exhibits were admitted properly into evidence. The court further stated that Appellant did not satisfy the burden of demonstrating the invalidity of the agency's decision. *Id*. at 5.

**Michigan**

*Fremont Ins. Co. v. Lighthouse Outpatient Center and Michigan Dep't of Fin. Serv.*, No. 370500, 2025 WL 1095323, at *1 (Mich. Ct. App. Apr. 11, 2025).

An insured of Fremont Insurance Company sustained accidental bodily injuries in a motor vehicle accident, at which time she was insured under a no-fault insurance policy. *Id*. Subsequently, the insured received accident-related healthcare services from Lighthouse and Lighthouse billed Fremont. Fremont issued payment to Lighthouse "'in accordance with the reasonable and customary charge directives of the no-fault act. . . as those provisions existed before. . . the effective date of the no-fault reform amendments'" under Michigan law. *Id*.

Lighthouse filed an Auto Insurance Utilization Review Provider Appeal Request with the Department of Insurance and Financial Services ("DIFS") alleging that it had been underpaid. Lighthouse contended that it was entitled to be paid consistent with the post-amendment fee schedules. *Id*. DIFS ordered that Lighthouse was entitled to additional reimbursement by Fremont for the services provided. *Id*. Fremont appealed the DIFS decision, filing a petition for judicial review in circuit court, seeking a determination that it properly reimbursed Lighthouse as calculated under the pre-amendment payment methodology. *Id*. at *2. Fremont further argued that the DIFS decision was erroneous as a matter of law because the Michigan Supreme Court held in *Andary v. USAA Cas. Ins. Co.*, 1 N.W.3d 186 (Mich. 2023), that "contractual and statutory rights for both the insured and the insurer were vested at the time of the accident, accordingly, with regard to a pre-reform claim, pre-reform reimbursement law, principles, and billing procedures apply." *Id*. Lighthouse responded to Fremont arguing that it relied on a DIFS bulletin which stated that *Andary* expressly limited its holding to two sections of the no-fault act, and that the remainder of the enacted provisions, including the remainder of the fee schedule, are unaffected by *Andary*. *Id*.

The circuit court issued its opinion and order reversing the DIFS decision. The court held that Fremont's substantial rights were prejudiced when DIFS determined that the post-reform reimbursement fee schedule applied with regard to the pre-reform injuries at issue in the case. *Id*. at *3. Lighthouse appealed this decision and the court of appeals affirmed the circuit court's holding that the circuit court properly held that the DIFS order was erroneous. The court of appeals held that the no-fault act that was in effect at the time of the accident is the law that controls her entitlement to her personal injury protection benefits, not the amended provision enacted after the insured's accident. *Id*. at *6.

**Montana**

*Victory Ins. Co. v. Montana*, 423 Mont. 377 (Mont. 2025).

Victory Insurance Company ("Victory") is a Montana property and casualty insurer. In 2019, Victory issued workers' compensation insurance policies to several Montana businesses. *Id*. at 381. In 2019, Victory entered into an agreement with Clear Spring Property and Casualty Company ("Clear Spring"), where Clear Spring would reinsure all of the policies at issue in this case. *Id*. In late 2019, Victory and Clear Spring agreed that Victory would sell its book of business to Clear Spring, including the workers' compensation policies. *Id*. Victory sent an email to the insured companies stating that their Victory policy was "upgraded" to a Clear Spring policy. *Id*. The Commissioner of Securities & Insurance, Office of the Montana State Auditor ("CSI") filed a notice of proposed agency action alleging that Victory illegally cancelled its policies and asserted that it could impose up to a $2.7 million fine. *Id*.

Victory requested a hearing, and CSI moved for summary judgment on the question of whether Victory committed a violation. *Id*. Victory filed a motion for summary judgment as well. *Id*. The hearing examiner issued its order finding that Victory committed 165 violations of Montana law and that CSI could impose a fine of up to $4,125,000. *Id*. at 382. The CSI issued a final decision in which it adopted the hearing examiner's order and imposed a fine of $250,000, with $150,000 suspended, coming due only if Victory "'commit[ted] further violations of the Insurance Code within one year.'" *Id*. Victory petitioned the district court for review of CSI's final decision pursuant to the Montana Administrative Procedure Act. The district court affirmed CSI's final decision. Victory appealed arguing that the hearing examiner improperly granted summary judgment in favor of CSI on the question of whether Victory violated Montana's insurance law, that CSI violated Victory's due process rights when it imposed the fine, and that Victory was entitled to a jury trial.

The Montana Supreme Court held that the assignment of policies from Victory to Clear Spring constituted a cancellation of the policies and the hearing examiner did not err when he granted summary judgment on the issue of whether Victory violated Montana insurance law. *Id*. at 385. The court held that the policy of the Montana insurance code, as administered by CSI, is to "'ensure that the interests of insurance consumers are protected.'" *Id*. at 388. The rationale behind imposing a fine is to deter future violations of the insurance code by imposing a sufficient penalty. *Id*. The court held that the fine was appropriate under the law. *Id*. The court held that summary judgment was proper because there were no material disputes of fact left in the case and "regardless of whether Victory might have been otherwise entitled to a jury trial, it was not deprived of that right when the [h]earing [e]xaminer properly used summary judgment to resolve the case." *Id*. at 390.

**Nevada**

*Protective Ins. Co. v. Nevada Ins. Comm'r*, 562 P.3d 215 (Nev. 2025).

Zeljkovich's vehicle collided with Matthews' vehicle. As a result, Matthews filed a negligence lawsuit in Virginia. Before the finalization of the settlement, Zeljkovich's insurer, Spirit Commercial Auto Risk Retention Group became insolvent, and was placed into receivership and liquidation. In response, Matthews sought uninsured motorist benefits from his insurer, Protective Insurance Company, which eventually settled the claim and acquired subrogation rights against Spirit's estate. In Nevada, claimants to an insolvent insurer's estate are subject to a process of claim prioritization against the insurer's remaining assets in accordance with NRS 696B.420(1). Protective filed a claim with Spirit's Special Deputy Receiver, who notified Protective that the claim would fall within a residual prioritization category, NRS 696B.420(1)(g), and that due to insufficient funds, the settlement amount could go unpaid. Protective objected, claiming that it should fall under 696B.420(1)(b), which covers injury liabilities.

The Nevada Supreme Court held that the claim properly falls under NRS 696.420(1)(g). Subsection (b) states that when the underlying claimant, the subrogor, is provided indemnification by other benefits, recovered or recoverable by the claimant, the claim falls outside of subsection (b). Because Protective paid Matthews, he had "recovered" under the plain meaning of the statute. *Id*. at 218. While statutory guarantee associations are given the subsection (b) priority, a private insurer like Protective is excluded, as it is not a statutory guaranty association. Additionally, NRS 687A.095 "flat-out bars insurers from suing to recover from any insured whose insurance companies have become insolvent." *Id*. at 221.

**New Jersey**

*Genworth Life Ins. Co. v. Zimmerman,* No. A-1231-23, 2025 WL 1601261, at *1, (N.J. Super. Ct. App. Div. June 6, 2025).

Genworth Life Insurance Company ("Genworth") appealed a final agency decision by New Jersey Department of Banking and Insurance ("Department") denying a rate increase for its long term care ("LTC") insurance policies. Under the Department's rules, insurers are allowed to request rate increase to realign premiums with expected claims. *Id*. at *2. Genworth issued approximately 13,300 "guaranteed renewable long term care policies in New Jersey. *Id*. Genworth came to the realization that it underpriced its LTC policies by miscalculating the number of policyholders who would cancel their coverage or allow it to lapse. *Id*. As a result, Genworth adopted a nationwide multi-year action plan to achieve rate increases so that it could continue to pay claims. *Id.* New Jersey enacted legislation and the Department adopted rules governing the issuance of LTC policies. Genworth requested rate increases in 2016 and 2017. The Department denied those requests, but the Department did approve a lower rate increase that would be phased out over multiple years in each instance.

In 2020, Genworth requested rate increases on its LTC insurance policies. The 2020 requested increases included the balances of the 2016 and 2017 requested rate increases denied by the Department. *Id*. at *3. On January 8, 2021, the Department issued the first of a series of disapproval letters citing deficiencies in the applications and requesting additional information. *Id*. The Department determined Genworth's filings did not satisfy the requirements for a rate increase. *Id*. at *4.

Genworth then requested an administrative hearing, and the Department granted the request. The administrative law judge found that Genworth argued that the Commissioner must approve its requested rate increases as their request satisfied the formulas outline in the rate-increase regulations. Genworth further argued that the Department's disapproval was beyond its regulations. The administrative law judge further held that the Department did not act outside its regulatory authority and that its "determination was consistent with past positions of negotiation with insurance providers to arrive at rate increases that balance the insurers' interest against policyholders' interest." *Id.* at *7. The acting commissioner issued a final decision and order adopting the administrative law judge's initial decision disapproving Genworth's requested rate increases for its LTC policies.

Genworth appealed the Department's disapproval of its applications for a rate increase and argued that the decision was arbitrary and capricious, as well as contrary to law. *Id*. at *9. The court of appeals affirmed the Department's decision as judicial review of an agency's determination is limited. *Id*. The court held that the Department's decision was supported by sufficient credible evidence and was not arbitrary or capricious. *Id*. at *11.

**Washington**

*Jolley, DMD, PLLC v. Washington State Off. of Ins. Comm'r*, No. 59466-8-II, 34 Wash. App.2d 1057, at *1 (Wash. Ct. App. May 28, 2025).

Dr. Craig Jolley is a dentist and business owner who offered a membership club, allowing uninsured patients to pay a monthly fee in exchange for certain services such as dental cleanings and exams. *Id*. The insurance commissioner determined that Jolley's membership club met the definition of insurance and issued a cease and desist order for the unauthorized provision of insurance. *Id*. Jolley sought administrative review of the cease and desist order. Jolley argued that his membership club was a direct practice and that it could not be considered insurance. *Id*. The administrative law judge ordered that the challenge could be raised directly in a trial court without the need to exhaust administrative remedies. *Id*. While the administrative adjudication was pending, Jolley filed a petition in the trial court seeking review of an alleged rule that excluded dentists from the direct practice program. *Id*. The commissioner moved to dismiss Jolley's petition because Jolly failed to exhaust his administrative remedies before filing. *Id*.

The trial court granted the commissioner's motion and dismissed the petition after concluding that the Washington Administrative Procedure Act's exhaustion requirement applied to all of Jolley's claims. *Id*. Jolley appealed, arguing that exhaustion was not required for his rule challenge. *Id.* The court of appeals reversed the trial court's decision, holding that Jolley sought only to halt the enforcement of the alleged rule and the alleged enforcement of the cease-and-desist order and did not seek to have the cease and desist order declared invalid in his trial court petition. *Id*. at *12. The court further held that the trial court improperly dismissed his rule challenge claim because he failed to exhaust administrative remedies, and exhaustion is not required for the trial court to adjudicate his claim on the merits. *Id*. The court of appeals remanded the case and ordered the trial court to conduct a review of the alleged rule where "the first step is to determine whether the agency statements that Jolley takes issue with were in fact a rule within the meaning of the A[dministrative] P[rocedures] A[ct]." *Id*. at *13.