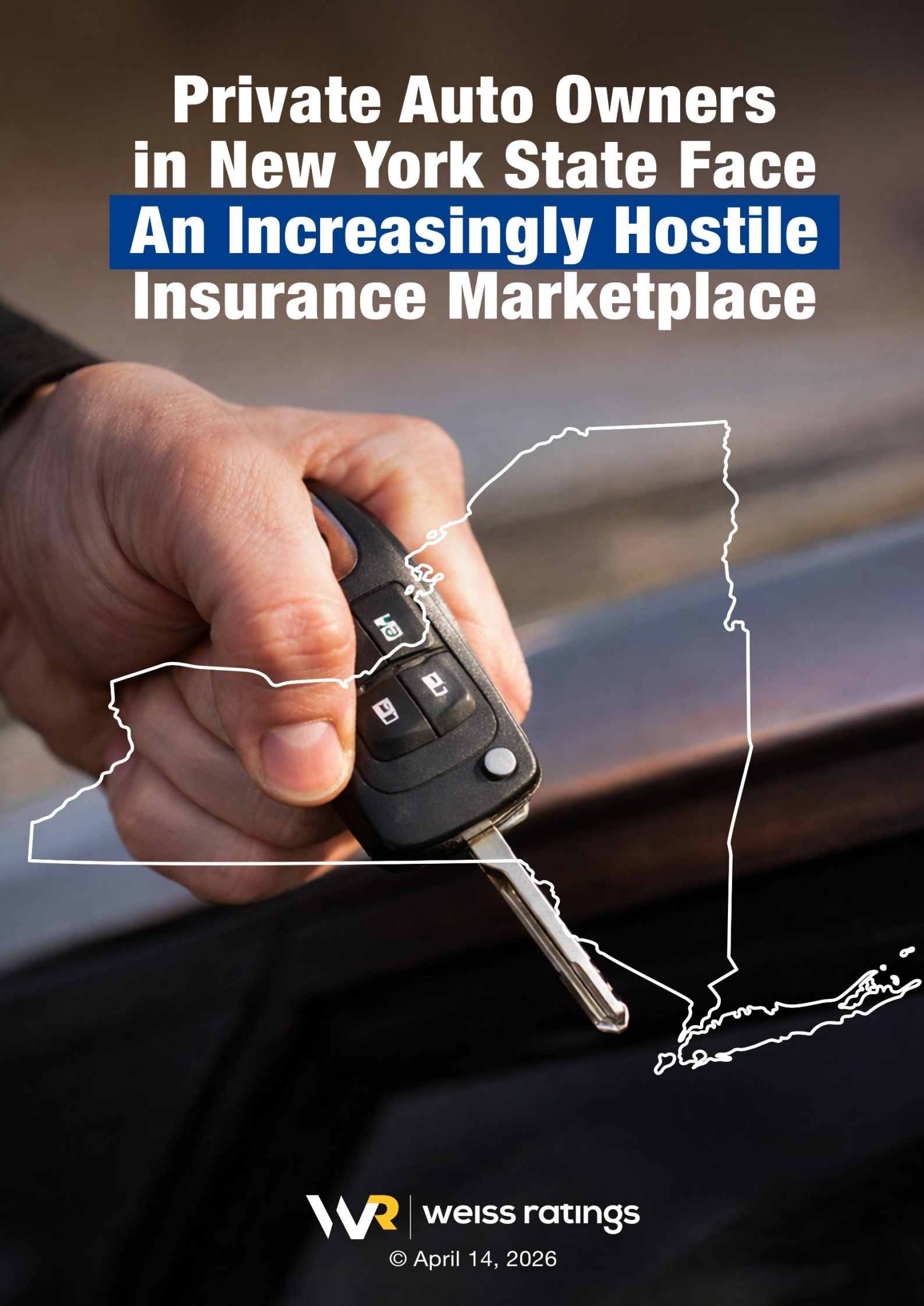
Private Auto Owners in New York State Face An Increasingly Hostile Insurance Marketplace



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Private Auto Owners in New York State Face an Increasingly Hostile Insurance Marketplace

by

Dr. Martin D. Weiss, Founder

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11780 US Highway 1 | Palm Beach Gardens, FL 33408-3080
Contact: Nicole Brown nbrown@weissinc.com +1-561-291-9625

Executive Summary

Private automobile owners in New York State face one of the most challenging insurance environments in the United States, characterized by high premiums, limited transparency, and a rising share of claims closed without payment. This report, based on a 20-year analysis of statutory filings, identifies troubling trends in insurer behavior and structural weaknesses in regulatory oversight that may contribute to these outcomes.

In 2025, insurers operating in New York closed 48.3% of private passenger auto liability claims without payment, representing approximately 1.3 million claims out of 2.7 million filed. In addition, since 2005, the share of claims closed without payment has risen by 44%, increasing from one-third to nearly one-half of all claims. Over the past eleven years, insurers have closed 14.7 million liability claims without payment, underscoring the scale and persistence of this pattern.

Equally significant is the wide variation among insurers. Allstate Insurance Co. closed more than 55% of liability claims without payment, while others in the same market closed fewer than 30%, suggesting that insurer behavior — not just market conditions — plays a meaningful role in consumer outcomes.

Since 2015, large insurers operating in New York have generated $42.3 billion in investment and other income, exceeding their $27.9 billion in net underwriting gains. This reflects the industry's ability to earn substantial income from policyholders' premium dollars, even in years when underwriting profitability is under pressure. Worse, it creates strong incentives for insurers to maximize their "float" by delaying, cutting, and denying claims.

Until now, New York, along with North Dakota, was the only state that had not disclosed key market conduct data. Although the state has now taken a significant step by joining the National Association of Insurance Commissioners' Market Conduct Annual Statement (MCAS) system for the 2025 data year, the absence of prior-year MCAS data limits the ability of policymakers and the public to assess recent and long-term trends.

New York's auto insurance challenges cannot be explained solely by fraud, litigation, or market conditions. Instead, they reflect a more complex interaction of claims-handling practices, regulatory priorities, and financial incentives. To address these issues, key actions are recommended:

(1) Make MCAS participation meaningful by providing historical context, ensuring timely public access, and integrating the data into regulatory analysis; (2) expand transparency by disclosing company-specific performance data to empower consumers; and (3) pursue balanced reforms that address fraud while also strengthening consumer protections and accountability.

Absent these changes, New York risks continuing on a path where premiums rise while a large share of claims go unpaid, undermining consumer confidence and the long-term stability of the insurance marketplace.

Introduction

If you own a car in New York State, your encounters with insurance difficulties could be more frequent than expected.

You're forced to buy insurance regardless of personal circumstances, and if your coverage lapses for any reason, you risk severe fines, loss of license, and even arrest.

The premiums you must pay are among the highest in the nation. You're often required to pay even more based on your credit score, neighborhood, and other factors that have nothing to do with driving safety records.[1]

If your vehicle is totaled, your insurer often underpays by omitting sales tax and using valuation methods that push your car's value below market.

Adding insult to injury, getting access to the information you'd need to file a complaint with the company — or in court — can be extremely difficult.

In this study, our mission is to tap our 20-year database of proprietary and licensed data on nearly all U.S. insurers in order to answer six fundamental questions:

1. Why was New York one of the least transparent states in the nation with regard to consumer-facing behavior of insurance companies? How can legislators, litigators, consumers, and their advocates penetrate this historic wall of secrecy?

2. How frequently do auto insurers in the state effectively fail to fulfill their implied or explicit promises to policyholders?

3. How has this pattern evolved over the past two decades?

4. Which large insurers are among the most frequent offenders? Which are among the least frequent offenders?

5. To explain rising premiums and defend their market behavior, insurers often point to declining profitability or outright losses. Does the data support this theory?

6. What steps can the New York Legislature take to stabilize the state's auto insurance marketplace?

Part 1. Until this year, New York was the only state (other than North Dakota) that failed to report critical data to the NAIC on the market behavior of insurance companies operating under its jurisdiction.

While New York was sometimes able to rely on alternative reporting mechanisms, certain facts are undeniable: In every year since 2018, the National Association of Insurance Commissioners (NAIC) has published its Market Conduct Annual Statement (MCAS) — the compilation of a detailed annual survey, which tracks (1) claims payments delayed for 60 days or more, (2) claims closed without payment, (3) frequency of

policyholder lawsuits against insurers, and many more factors that can help regulators, legislators, litigators, policyholders, and their advocates better understand the market behavior of insurance companies in each state.

Unfortunately, however, until a very recent change was announced, New York State failed to provide any such data to the NAIC. It did not reveal how often its insurers closed claims without payment, how often they delayed payments, or how often they were sued. With the exception of North Dakota, every other state and jurisdiction in the U.S. has provided these data without fail. New York did not.

In the 1980s and 1990s, New York's insurance commissioners might have defended this lack of transparency by citing the state's tougher rules and stronger enforcement compared to most other states. That was the case then. However, since the creation of the New York State Department of Financial Services (DFS) in 2011, which merged banking and insurance functions, insurance regulators have often shifted much of their focus to fraud control, litigation limits, and other changes that contributed to a decline in the market environment for consumers. Thus, other than an outdated New York tradition of regulatory independence, it is unclear what the justification was for the failure of DFS to participate in MCAS.

In December of 2025, DFS quietly made the decision to participate in the collection of MCAS data for the first time.[2] This is a welcome change. But 2025 data will not be available to the public until the summer of 2026. Moreover, New York's failure to provide the needed information for all years through 2024 makes it difficult for anyone seeking to better understand changes in the state's insurance market. Fortunately, however, with a 20-year history of statutory filings from virtually all insurers in the nation, we can still track broad trends in New York's consumer-facing insurance practices.[3]

In addition, compared to MCAS, our 20-year database of statutory filings offers two advantages: First, it provides a window into the market behavior of each named insurer, while MCAS discloses strictly state-wide averages with no company-specific information. Second, it covers decades of history, compared to no history for New York State and only seven years for nearly all other jurisdictions.[4]

The statutory data is especially valuable with regard to *claims closed without payment*, a metric that few insurers discuss, but that's duly reported in their filings for each major line of business, the focus of Part 2.[5]

Part 2. Auto insurers operating in the state closed nearly half of all liability claims without payment in 2025.

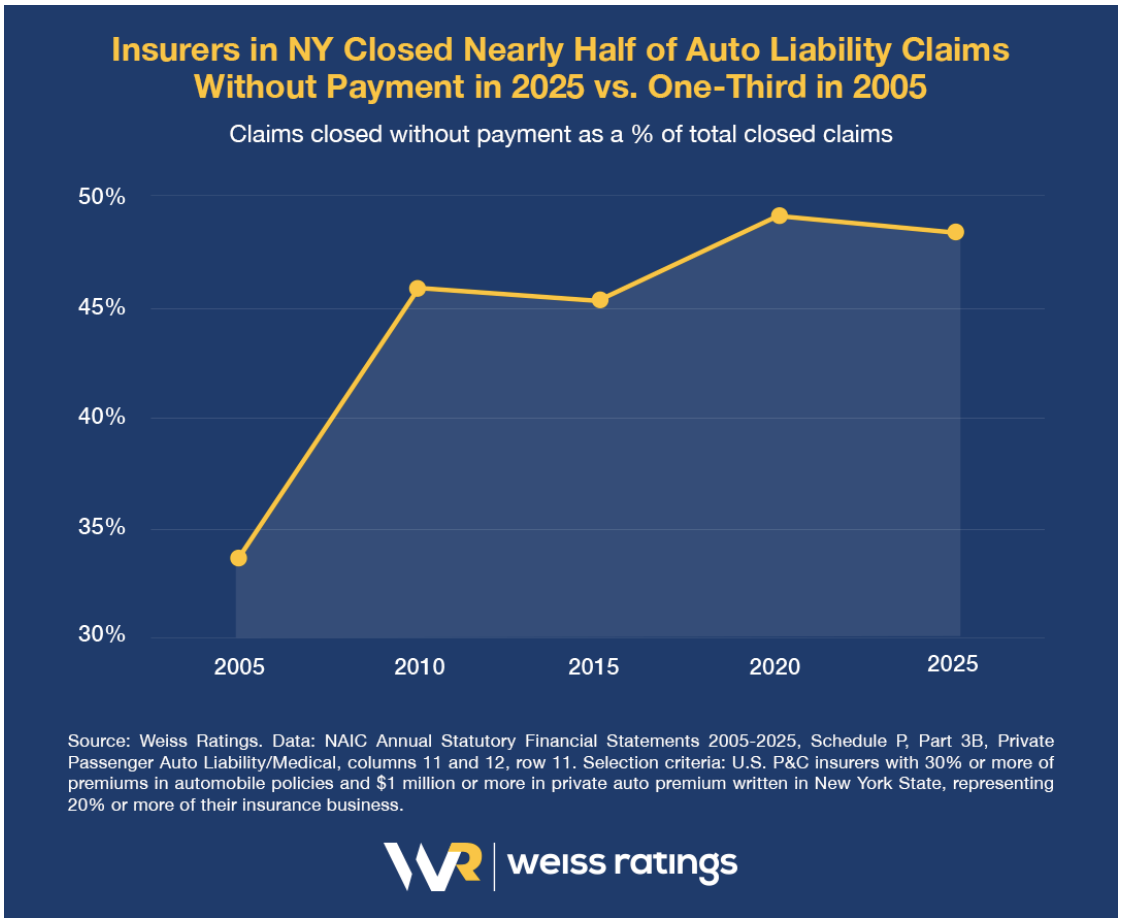
Auto insurers operating in New York State closed 2,675,738 private passenger auto liability claims in 2025. However, among these, only 1,382,405 claims involved some payment to the policyholder. The balance of claims, numbering 1,293,333, or 48.3% of the total, were closed with no payment whatsoever.

To summarize, policyholders filed about 2.7 million liability claims, but roughly 1.3 million, or almost half, were closed without payment. Whether the claims are closed for justifiable reasons or not, we refer to these as “flat-out denials.”

When asked why such denial rates are so high, insurers and their defenders often respond with a vague laundry list of reasons, all without data. However, their response rarely addresses two related issues: A sharp rise in denial rates over time and wide differences in denial rates from insurer to insurer, the subjects of parts 3 and 4.

Part 3. The denial rate of auto liability claims by insurers operating in New York State has risen by 44% since 2005.

Anyone who might argue that the closure of 48.3% of auto liability claims without payment is “normal,” “justifiable,” or “unavoidable” need only look at the history: In 2005, the comparable rate of claims closed without payment was far lower — only 33.6%.



In other words, the “flat-out denial rate” rose from approximately one-third of claims to nearly half of claims — a 44% increase in a key metric that, in a stable market, would not vary significantly from year to year.

One reason for the change may be that the policy conversation shifted from “keep insurers in line” to a more conflicted triangle of fraud control, affordability, and occasional consumer protection. The net result is that by the 2010s and 2020s, New

York's debate over auto insurance was focused less on disciplining insurers and more on claims abuse, often contributing to an environment in which it's harder for the consumer to file claims and easier for insurers to deny them. That process can make regulators less consumer-friendly even when they may still sometimes intervene on behalf of policyholders. In the process of suppressing fraud, they give insurers a freer hand over claim denials, whether intentionally or not.

An important historical factor to consider is the tightening of New York's no-fault system in 2002 under revised Regulation 68. This revision (1) shortened the deadline for written notice of claim from 90 days to 30 days, (2) shortened the deadline for medical bills from 180 days to 45 days, (3) imposed a 90-day deadline for lost-wage submissions, and (4) changed arbitration and administrative procedures.

These changes were aimed largely at controlling abuse and speeding claim handling, but they also made it easier for claims to be denied or closed. This does not demonstrate deliberate consumer abuse. But the net effect is a hit to consumers, helping to drive up the share of claims closed with no payment after 2005.

Similarly, it might be difficult to demonstrate that New York regulators of 2025 are *uniformly* weaker than they were twenty years ago, and indeed, they have brought meaningful enforcement actions against auto insurers.[6] It is not difficult, however, to show that they have become more *uneven* in their approach, as evidenced in the DFS's own complaint-ranking page, showing auto complaints that commonly involve denials, delays in payment of no-fault claims, and nonrenewal of policies.

Meanwhile, as of 2026, lawmakers are still debating what to do about pricing factors used by insurers that have little to do with a policyholder's driving record, such as credit scores, zip codes, and income. Cutting through these debates, the big picture is undeniable: Between 2015 and yearend 2025, after paying increasingly higher premiums, individual auto owners in New York State have filed a grand total of 14.7 million liability claims that were closed with no payment whatsoever. In total for the 11-year period, the insurers closed 48.6% of all such claims without paying a penny.

Part 4. While several large insurers have closed about half of auto liability claims with no payment, others have done so at significantly lower rates.

Returning to the argument that closing nearly half of claims without payment is somehow "a normal or unavoidable state of affairs," an equally strong rebuttal is the wide range of denial rates among major players in New York's auto insurance market.

Allstate Insurance (domiciled in Illinois) opened and closed 1,243,516 private auto liability claims in New York State in 2025. Among these, it closed 689,832, or 55.5% without payment.

Progressive Max Insurance Co. (OH) and its sister company, Progressive Advanced, each closed 47.4% without payment.

Several others also closed more than 42% without payment.

“This is strictly a reflection of needed efforts to cope with state-wide consumer fraud,” say the companies and their defenders — a common refrain that raises a question, which they may find hard to answer: If consumer fraud is a state-wide problem, how was it possible for other large companies, operating in the same market in the same year, to close the claims they received at significantly lower denial rates?

NY Auto Liability Claims Closed Without Payment in 2025: Ranged From 55.5% to 26.4% of Total Claims Closed

Company	State of Domicile	Total Claims Opened & Closed in 2025	Claims Closed Without Payment	% Closed Without Payment
Allstate Insurance Co.	IL	1,243,516	689,832	**55.5%**
Progressive Max Insurance Co.	OH	91,929	43,551	47.4%
Progressive Advanced Ins Co.	OH	61,286	29,034	47.4%
New South Insurance Co.	NC	11,514	5,316	46.2%
Plymouth Rock Assr Pfd Corp	NY	2,752	1,233	44.8%
Plymouth Rock Assr Corp. of NY	NY	2,407	1,078	44.8%
Progressive Casualty Ins Co.	OH	669,333	292,273	43.7%
Farmers Grp Ppty & Cas Ins Co.	RI	15,652	6,773	43.3%
Esurance Insurance Co.	IL	4,714	2,008	42.6%
21st Century Centennial Ins Co	PA	4,937	2,092	42.4%
Farmers Ppty & Cas Ins Co.	RI	69,562	27,775	39.9%
GEICO Indemnity Co.	NE	131,494	52,005	39.5%
GEICO General Insurance Co.	NE	344,826	133,504	38.7%
Allmerica Finl Alliance Ins Co	NH	4,648	1,793	38.6%
NY Central Mutual Fire Ins Co.	NY	10,055	2,657	26.4%

Source: Weiss Ratings. Data: NAIC Annual Statutory Financial Statement 2025, Schedule P, Part 3B, Private Passenger Auto Liability/Medical, columns 11 and 12, row 11. Selection criteria: U.S. P&C insurers with 30% or more of premiums in automobile policies and $1 million or more in private auto premium written in New York State, representing 20% or more of their insurance business. Table includes only companies with 2,000 or more auto private liability claims closed in 2025.

NY Central Mutual Fire, for example, closed only 26.4% of claims without payment in 2025. Allmerica Financial Alliance closed 38.6% without payment. Even GEICO General and GEICO Indemnity, major players in the state, closed claims without payment at 38.7% and 39.5%, respectively — all denial rates that were far below Allstate’s 55.5%.

This wide range of denial rates — from 55.5% to 26.4% — indicates that, in practice, such denials probably involve more than adapting to unfavorable market conditions. They may also reflect corporate strategies to cut loss ratios and maximize underwriting income at the expense of their customers.

Meanwhile, unlike the pattern with liability claims, the “flat-out denial rate” of physical damage claims has been mostly stable since 2005. So, in this line of business, one cannot

make the case that it's gotten worse over time. However, the spread in denial rates between companies is *wider* than with liability claims, ranging from 34.6% to 7%.

NY Auto Demage Claims Closed Without Payment in 2025: Ranged From 34.6% to 7.0% of Total Claims Closed

Company	State of Domicile	Total Claims Opened & Closed in 2025	Claims Closed Without Payment	% Closed Without Payment
New South Insurance Co.	NC	9,741	3,373	**34.6%**
Countryway Insurance Co.	NY	4,835	1,549	32.0%
Progressive Max Insurance Co.	OH	215,825	62,487	29.0%
Progressive Advanced Ins Co.	OH	143,884	41,658	29.0%
Progressive Casu alty Ins Co.	OH	1,541,402	424,383	27.5%
American Family Connect Ins Co	WI	3,130	840	26.8%
Esurance Insurance Co.	IL	12,768	3,398	26.6%
21st Century Centennial Ins Co	PA	3,687	876	23.8%
Allstate Insurance Co.	IL	2,929,992	612,903	20.9%
Farmers Ppty & Cas Ins Co.	RI	235,038	47,411	20.2%
Farmers Grp Ppty & Cas Ins Co.	RI	55,841	10,919	19.6%
GEICO Indemnity Co.	NE	417,301	80,975	19.4%
Plymouth Rock Assr Pfd Corp	NY	6,394	1,190	18.6%
Plymouth Rock Assr Corp. of NY	NY	5,594	1,041	18.6%
GEICO General Insurance Co.	NE	1,392,353	253,274	18.2%
Erie Insurance Co. of New York	NY	2,777	350	12.6%
Allmerica Finl Alliance Ins Co	NH	19,358	2,194	11.3%
NY Central Mutual Fire Ins Co.	NY	43,622	3,055	7.0%
A. Central Insurance Co.	NY	4,847	339	7.0%

Source: Weiss Ratings. Data: NAIC Annual Statutory Financial Statement 2025, Schedule P, Part 3J, Auto Physical Damage, columns 11 and 12, row 11. Selection criteria: Same as prior table.

New South Insurance Co. (NC) closed 34.6% of physical damage claims with no payment in 2025.

Countryway Insurance (NY) closed 32% with no payment.

Progressive Max Insurance and Progressive Advanced Insurance closed 29%.

Plus, another three companies closed one quarter or more with no payment.

In contrast, nine companies closed less than 20% of claims without payment in 2025. That includes:

GEICO General (NE), one of the largest, which closed 18.2% of claims with no payment.

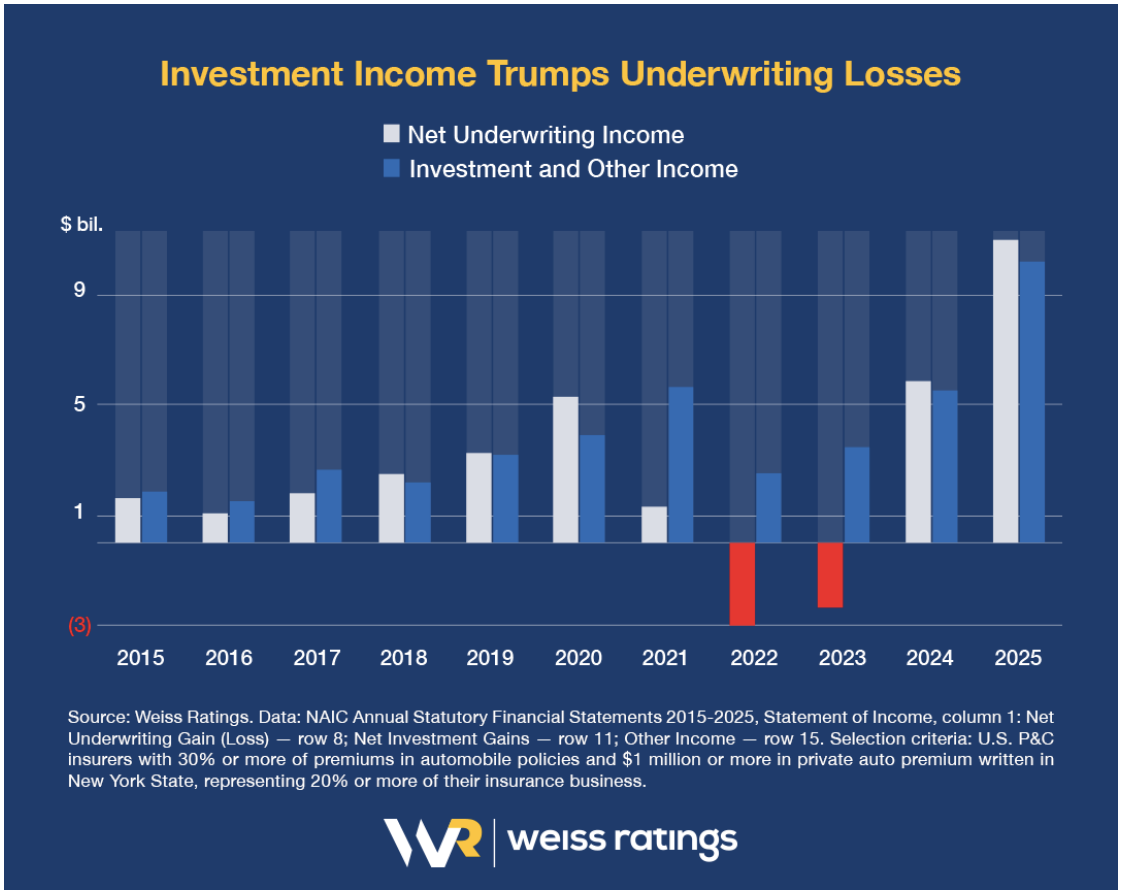
Allmerica Financial Alliance (NH), closing only 11.3% with no payment.

Plus, two New York-domiciled insurers — NY Central Mutual Fire and A. Central — which closed a meager 7% of physical damage claims with no payment in 2025.

Despite some differences in risk pools and underwriting mixes, this again raises the question: If large auto insurers operating in the state — like GEICO along with two companies domiciled in the state — can reject policyholder claims at reasonably low rates, why can't others do the same?

Part 5. Since 2015, large insurers in New York have made $42.3 billion in investment and other income — far more than their $27.9 billion in net underwriting income.

Insurers collect insurance premiums in advance. They promptly invest those funds to earn income. But in a world where mutual insurance companies have faded and shareholder-owned companies dominate, they do not directly or indirectly share that income with policyholders. They keep it in their own coffers, compounding over time.[7]



Year after year, this investment income — along with some income from other sources — has been greater than, or similar to, the net income from their core business of underwriting policies.

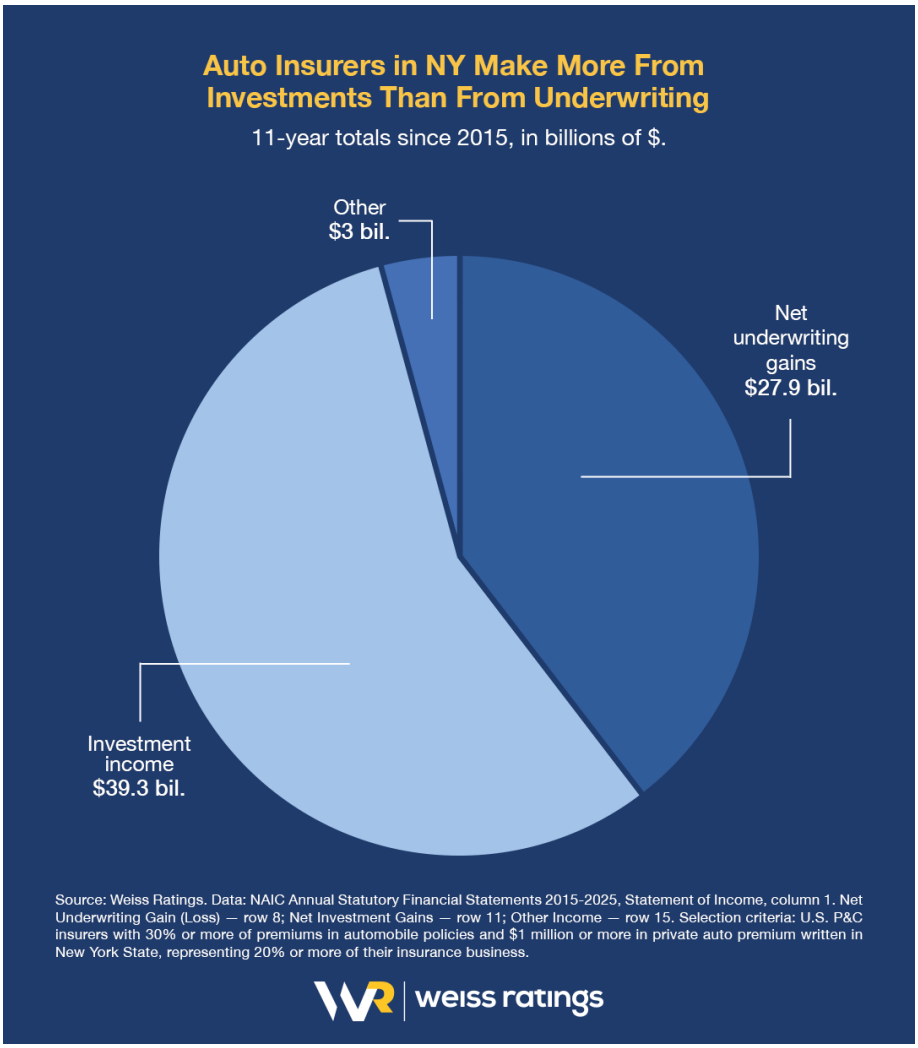
In 2015, 2016, and 2017, investment and other income exceeded net underwriting gains.

In 2018, 2019, and 2020, it was similar.

In 2021, it was nearly six times larger.

In 2022 and 2023, while auto insurers in the state lost money in their underwriting, they were able to cover virtually all those losses with their investment and other income.

Plus, in the two most recent years — 2024 and 2025 — investment and other income have helped nearly double their gains overall.



All told, in the past 11 years, large auto insurers in New York have made $27.9 billion in net underwriting gains, $39.3 billion in investment income, plus $3 billion from other income sources. This can often create an incentive for certain insurers to maximize the float on funds collected in premiums, while delaying and denying claims payments.

It also raises critical questions: When they push for premium hikes in state legislatures — based largely on temporary pressures in their core business of underwriting policies — do they adequately headline the full scope of their other income sources? Do they provide a balanced review covering both underwriting gains and a business model wherein customer funds generate substantial additional income for the insurer?

Sometimes, the answer is yes. More frequently, however, they leverage their underwriting struggles to support rate hikes, while their investment income — along with undisclosed mechanisms to maximize that income — are often discussed in whispers.

Toward a Fairer Insurance Market for Automobile Owners

The history since 2005 has demonstrated that New York State regulators have had difficulty combating alleged consumer fraud while simultaneously defending consumers from insurer abuse.

Thus, for better disclosure, the state is urged to take at least three critical steps that are both relatively inexpensive for taxpayers and potentially effective for consumers.

Step 1. Make MCAS participation meaningful by ensuring transparency, comparability, and usability.

New York residents know less about insurance company practices that are relevant to their choice of policies than they know about virtually any other financial product sold in the state. However, those who blame the consumer for "ignorance" may themselves be ignoring the true causes.

First, existing financial disclosures by insurers and their regulators are hard to find, harder to understand and, above all, virtually impossible to compare without spending hundreds of thousands of dollars per year for the purchase of the relevant databases. This is not only an impediment to transparency for average consumers, but can also create barriers for analysts, regulators, legislators, and insurance companies themselves. Most do not have access.

Second, existing market performance information — critical to help consumers make rational choices of insurers and policies — is not effectively accessible.

As we cited earlier, for its MCAS reporting, the NAIC conducts yearly surveys to determine each insurance company's market behavior, including (a) the percentage of claims closed without payment, (b) claims delayed 60 days or more, (c) non-renewals, (d) policyholder lawsuits and other key data — both for auto and home property insurance. However, New York did not join this process until 2025, years after all other states except North Dakota had already participated. To correct this deficiency, it should:

Provide transitional historical context. Without historical context, a single year of MCAS data risks obscuring long-term patterns rather than revealing them. While full retroactive MCAS reporting may not be feasible, the Department of Financial Services (DFS) can publish historical data to match or approximate key MCAS metrics for prior years, including not only complaint ratios, but also data on claims denials, delays, and more. This would enable meaningful trend analysis without imposing unrealistic burdens on insurers.

Ensure timely and public accessibility. MCAS results for New York should be made available promptly and in a user-friendly format, with clear explanations of each metric and its significance.

Integrate MCAS into policy and regulatory analysis: MCAS data should not be treated as a passive reporting exercise, but as a core tool for evaluating market conduct, consumer outcomes, proposed legislation, and the effectiveness of regulatory policy.

Step 2. Be the first state to disclose company-specific MCAS data or equivalent.

In addition to its own participation in MCAS, to remain faithful to its tradition as a tough regulator, DFS should be among the first state regulators to press for even greater disclosure.

Currently, the fact that the NAIC discloses strictly state-by-state averages — without disclosure of company-specific information — makes it impossible for consumers to know which insurers to favor and which to avoid.

Among the many critical metrics tracked by the NAIC, the only one for which relevant data are publicly available is the percentage of claims closed without payment. But the data are buried in official filings of thousands of insurers, which few consumers have access to and fewer still might understand. Moreover, insurers themselves disclaim these data, blaming high rates of claims denials on illegitimate or fraudulent damage claims. How often is that truly the case? Not even the regulators can say because insurers do not disclose data on why claims are denied.

Full disclosure of these facts is necessary to empower consumers to make rational decisions, vote with their dollars, and help stabilize insurance markets. Consumers considering the purchase or renewal of policies should be given easy access to an online look-up tool that instantly provides financial and performance data on each company in every U.S. jurisdiction. These should answer questions such as:

How often has this insurer failed to renew its automobile policies?

How often does it close liability claims without payment? How often on physical damage claims?

On average, how much does the insurer cut claims payment estimates?

How often does it delay claims payments by 60 days or more? What is the average delay time?

How often is the insurer sued by its policyholders?

Separately, insurance agents should be required to provide this same data to all existing or prospective customers on each company that's considered for the purchase or renewal of policies.

In sum, addressing consumer-unfriendly practices, such as those made evident in this report, is an immediate priority. However, without full disclosure of performance data, consumers are likely to remain vulnerable to abusive practices.

Step 3. Reforms For (not Against) Insurance Consumers

The average observer might expect that, in an insurance market where consumers face rising premiums, longer payment delays, reduced claims payments, and high rates of claims closed without payment, proposed reforms would focus primarily on increasing transparency, strengthening accountability, and improving outcomes for policyholders. However, recent legislative proposals suggest a very different emphasis.

In New York, Governor Kathy Hochul has advanced a package of auto insurance reforms aimed at reducing premiums by addressing fraud, limiting abusive litigation, and tightening eligibility for certain types of claims and recoveries. Key elements under discussion include narrowing legal thresholds for recovery, restricting damages under specific circumstances, and modifying aspects of the state's liability framework.[8]

Supporters argue that these measures are necessary to combat fraud, reduce systemic costs, and ultimately make insurance more affordable for consumers. They contend that staged accidents, inflated medical claims, and litigation incentives have contributed significantly to rising premiums and market instability.

However, critics argue that these reforms may disproportionately affect legitimate claimants. They warn that tightening legal standards and limiting recoveries could reduce access to compensation for injured policyholders, particularly in borderline or disputed cases. Some have also expressed concern that projected savings are unlikely to be passed on to consumers in the form of lower premiums.

At the same time, very little is proposed to improve transparency in insurer behavior — particularly with regard to claims handling practices such as payment delays, reductions in claim estimates, and the high percentage of claims closed without payment, as documented in this report.[9]

This imbalance is counterproductive and high-risk. As shown in Parts 2 through 4, insurers operating in New York State already close a substantial share of claims without payment, with wide variation among companies. As shown in Part 5, insurers also generate significant income not only from underwriting but from the investment of funds from premiums, creating additional financial incentives that are not typically visible in public policy debates.[10]

Against this backdrop, reforms that primarily focus on restricting claims or limiting legal recourse — without corresponding measures to improve transparency and accountability — are likely to reinforce existing imbalances in the marketplace and hardships for consumers.

The data and trends presented here strongly suggest that without greater transparency and accountability, rising premiums may continue alongside high rates of unpaid claims — an outcome that undermines both consumer trust and market stability.

A far more effective approach will be to better balance efforts to combat fraud with meaningful steps to ensure that consumers have access to clear, comparable information about insurer performance along with meaningful avenues to enforce their contractual rights.

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[1]Consumer Federation of America. *Credit Scores and Auto Insurance: What's Fair?* Research finds that the relationship between credit-based insurance scores and actual driving risk is indirect and raises concerns about fairness and disparate impact.

[2] NAIC, *New for 2025 Data Year*.

[3] The Weiss Ratings database covers more than 4,500 insurance companies, filing statutory reports four times yearly, each with thousands of data points. In addition, for each insurer and each reporting period, the data includes hundreds of calculated formulas, indexes and ratings.

[4] The history of statutory filings best supports the study of national trends without breaking out certain market behaviors by state or jurisdiction. For example, it provides breakdowns of each company's premiums earned by line of business and by state, but only nationwide metrics on key performance metrics, such as claims denials.

[5] In order to track historical trends for claims closed without payment in New York State, three company selection criteria are applied: (a) U.S. P&C insurers with 30% or more of premiums in automobile policies, (b) $1 million or more in private auto premium written in the state, (c) representing 20% or more of their insurance business.

[6] For example, in 2020, New York State fined Allstate, State Farm, AIG, and Tri-State, requiring over $10.6 million in restitution for systemic no-fault claims-handling failures, including late payments, missed deadlines, and incorrect benefit calculations.

[7] Pricing models incorporate expected investment income. Whether they do so adequately, however, is debatable.

[8] Recent trends in the Florida home insurance market provide a stark warning. Tort reform legislation passed in 2023 made it more difficult for homeowners to sue their insurer for abuses such as delayed, reduced, or denied claims. But the data indicate that Florida tort reform backfired: In 2022, before tort reform, home insurers operating in Florida closed 40% of all claims with no payment. In 2024, apparently empowered by tort reform, they closed denied claims more aggressively, closing 46.7% with no payment. Most surprisingly, policyholders sued more often as a percentage of claims closed.

[9] National Association of Insurance Commissioners (NAIC). *Consumer Insurance Search / Complaint Index Reports*. Claims handling issues — including delays, denials, and settlement disputes — consistently rank among the most common sources of consumer complaints in property and casualty insurance. See also U.S. Government Accountability Office (GAO). *Insurance Regulation: Key Issues and Ongoing Challenges*. GAO highlights limitations in publicly available data on insurer market conduct and the difficulty consumers face in comparing insurer performance.

[10] Warren Buffett, Berkshire Hathaway Annual Letters. Buffett describes insurance "float" — premiums held before claims are paid — as a major source of insurer profitability and investment income.