

A Liability Navigator® thought leadership collection for claims operations leaders

The New Liability Reality

Three perspectives on protecting claims outcomes as complexity rises and capacity shrinks

Verisk

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Experienced adjusters are leaving faster than you can replace them. Social inflation, climbing bodily injury severity, and an industrialized plaintiffs' bar are raising the risk behind every decision those adjusters leave behind. Complexity is rising and capacity is shrinking. And the margin for error has never been thinner.

To help bridge that gap, AI-powered analytical tools, paired with human expertise, are helping liability claims leaders deliver consistent, defensible outcomes even as pressures intensify.

Three perspectives on what that looks like:

1

The New Adjuster Reality

Examines the forces reshaping liability claims—the talent cliff, the loss of tacit expertise, and the role AI now plays in protecting quality at scale.

2

Continuous Innovation

Makes the case that, against a faster, better-resourced opposing bar, the real question isn't whether to adopt AI—it's whether your tools ship new capabilities as fast as the other side's.

3

Winning the Conversation

Shows how documentation discipline, starting at first notice of loss, helps adjusters stay in control of auto property damage arbitration and avoid missing recovery opportunities.

The main takeaway

The claims leaders that come out ahead will be the ones that equip their people to make better decisions every day and stand behind those decisions with consistency, confidence, and defensibility.

1. THE NEW ADJUSTER REALITY

Rising Complexity, Shrinking Capacity, and the Need for AI Assistance

If you lead an auto or general liability claims operation today, you already feel the squeeze. Claim severity is climbing faster than you can hire, and every settlement decision carries more financial weight than it did five years ago. Two forces are converging to create what we call the "new adjuster reality": a demographic talent cliff is thinning the ranks of the experienced professionals who get claims right, while social inflation and litigation pressures are driving up the cost of getting them wrong.

This article unpacks the data behind both pressures and explores how AI-powered analytical tools are helping liability claims leaders close that gap, delivering consistent, high-quality outcomes even as demands continue to rise.



The workforce is shrinking

Just as claims are getting harder to handle, the industry is losing the people best equipped for the job. In 2023, it was projected that nearly 400,000 insurance professionals would retire by the end of 2026.[1] One quarter of the current workforce is already older than 55, and over the next 15 years, an estimated 50% of today's professionals will exit the industry.[2]

	Insurance sector	U.S. general workforce
Median employee age	45	42.2
Unemployment rate	1.5%	3.6%
Roles requiring digital skills	60%	45%

What makes this particularly acute for claims is the nature of the expertise being lost. Experienced adjusters carry decades of tacit, undocumented knowledge: how to read a medical narrative, when a liability argument has subrogation potential, how to calibrate a reserve against a specific jurisdiction's tendencies. The industry faces a potential loss of 20 to 30 million years of combined experience over the next decade, a deficit that training manuals alone cannot address.[3]

The pipeline to replace these veterans is thin. Only 236,000 workers under 25 are positioned to step into the roughly 1.36 million expected openings, and the insurance sector's 1.5% unemployment rate means nearly every qualified candidate is already employed.[2] Replacing an experienced adjuster costs an estimated 50% to 200% of their annual salary. Compounding the problem, 60% of insurance roles now require competency in data analytics, artificial intelligence (AI), or cybersecurity, areas where many retiring veterans were never trained and new hires require significant ramp-up time.[2]

The hidden cost of doing more with less: burnout and leakage

When smaller, less-experienced teams absorb rising complexity without better tools, the consequences show up in two places: people and results.

Fifty-eight percent of frontline claims professionals report spending more than 20% of their time on manual data entry and compliance activities, time pulled directly away from case strategy, claimant communication, and high-value judgment work.[4] Overloaded adjusters make more errors in documentation and reserve setting, which increases compliance risk and exposure to "bad faith" claims. Turnover spikes, remaining staff absorb even heavier caseloads, and the cycle accelerates.[5]

The financial leakage is substantial. An estimated 3% to 5% of all liability payments are inaccurate due to human error or insufficient data at the point of decision.[6] Fifteen percent of claims are closed with missed subrogation opportunities, representing roughly $15 billion in annual industry losses.[7] Research from the CUNY School of Public Health estimates that burnout costs employers between $4,000 and $21,000 per employee per year in lost productivity and turnover.[5] For a carrier with a thousand adjusters, the impact runs well into the millions of dollars.

It becomes clear that doing more with less, without smarter tools, erodes both your people and your outcomes.

The stakes have changed: social inflation and the rise of nuclear verdicts

While your teams are getting leaner, the financial consequences of a single inconsistent settlement are escalating at a pace that manual quality controls can no longer contain. The driver is social inflation: claim costs rising from shifts in societal attitudes, legal system behaviors, and litigation trends rather than traditional economic factors such as medical inflation or wage growth.[8]

Nuclear verdicts, generally defined as jury awards exceeding $10 million, have surged in both frequency and severity. In 2020, roughly 33 such verdicts were recorded.[9] By 2024, that number reached 135, with total award value hitting $31.3 billion, a 116% year-over-year increase. The median nuclear verdict climbed from $25 million to $51 million in the same period.[10]

	2020	2023	2024
Nuclear verdicts (count)	~33	89	135
Total award value ($B)	N/A	$14.5	$31.3
Median award ($M)	$25	$44	$51

Behind these numbers is a generational shift in juror psychology. In 2016, 58% of U.S. consumers believed damage awards were too low. By 2025, that figure had jumped to 76%, and a Swiss Re behavioral science survey that year found that 83% of respondents under age 40 view large awards as fair or insufficient, compared with 41% of respondents over 60.[11] As this cohort increasingly fills jury pools, carriers face a courtroom environment that is structurally more sympathetic to plaintiffs.

Adding fuel, third-party litigation funding has matured into a significant force. Assets under management in commercial litigation finance reached $16.1 billion in 2024, and 82% of U.S. law firm attorneys now report using litigation finance, up from just 9% in 2012.[11] Meanwhile, annual attorney advertising exceeds $2.4 billion, often employing "damage anchors" that set inflated expectations for potential jurors well before they enter a courtroom.[12]

The takeaway
Every undetected liability gap or inconsistent settlement now carries exponentially higher financial risk, even as the workforce equipped to prevent those gaps continues to thin.

Technology solutions as the bridge: how analytical tools close the gap

Analytical and AI-powered claims tools are not designed to replace adjuster judgment. They extend it, giving every team member access to the data-driven insights that used to live only in a veteran's head. The goal is one you already have: consistent, high-quality outcomes at scale, with your adjusters freed to focus on complex decision-making, negotiation, and empathy.



Settlement accuracy and leakage reduction
Data modeling can benchmark incoming claims against thousands of historical outcomes, flagging disparities and guiding both veteran and newer adjusters toward settlements that align with policy guidelines and jurisdictional norms.



Subrogation recovery
Subrogation is a vital revenue stream, but it is often underutilized in casualty claims where fault is treated as binary. Analytical tools that combine accident-specific analytics with state statutes help adjusters identify even marginal percentages of shared fault, turning complex liability scenarios into defensible recovery opportunities that manual review under heavy caseloads routinely misses.



Span of control for managers
Real-time dashboards give claims leaders visibility into bottlenecks, individual adjuster performance, and claims at risk of becoming complex or litigated. Your management role shifts from reactive correction to proactive coaching, allowing you to oversee larger teams without sacrificing quality.[13]



Training and consistency for newer adjusters
Historical case-matching capabilities accelerate ramp-up by anchoring decisions in proven precedent rather than tribal knowledge alone. When a less-experienced adjuster can instantly compare a current claim against similar resolved cases, the quality gap between a ten-year veteran and a first-year hire narrows significantly.

What to look for in a claims analytics solution

Not every claims-handling solution delivers the same return. The solutions producing real, measurable improvements share a few critical characteristics.

Your own data, contextualized
Prioritize bodily injury assessment tools built on your historical claims to capture and scale your team's collective adjuster experience, with industry benchmarks layered in over time to validate performance and broaden context.

Efficient claim analysis
Equip adjusters with tools that support accident reconstruction and consistently apply jurisdictional requirements, reducing friction while preserving judgment and accuracy.

Integrated workflow
Comprehensive claim management platforms that plug directly into your existing claims systems minimize adoption friction, reduce IT lift, and embed insights into daily adjuster workflows.

Explainability
Adjusters and stakeholders need transparency into the specific data points behind every recommendation to support confident negotiation and defensible outcomes.

Measurable outcomes
Prioritize solutions with demonstrated impact on KPIs, including cycle time reduction, settlement consistency, and subrogation recovery.

Sustained innovation
Invest in a platform that continuously evolves, integrating new data sources, analytics, and AI advancements to deliver incremental value over time.

Verisk's Liability Navigator addresses these requirements. In the face of shrinking experience levels and rising claim severity, it embeds powerful analytics and decision intelligence into every liability decision—helping carriers reinforce adjuster judgment, reduce variability in high-stakes outcomes, and scale expertise without increasing operational burden.

The path forward

The pressures are not easing. The demographic shift in your workforce will deepen over the next several years, the operational strain on your remaining teams will compound, and social inflation (along with an increasingly complex litigation environment) will continue to raise the stakes of every settlement decision. Asking fewer, less-experienced people to handle more complex, higher-stakes claims with the same legacy processes is not a sustainable strategy.

Adopting AI in claims is not a technology project. It is a strategic decision about how you protect both your bottom line and your people. The leaders who act now, equipping their teams with the analytical depth and insight-driven guidance the new reality demands, will set the pace for the next cycle.

Ready to see how Liability Navigator can help your team deliver consistent, data-driven outcomes?

Request a complimentary consultation.



2. CONTINUOUS INNOVATION

Advancing bodily injury claims through continuous innovation

AI-generated demand packages, rising claim severity, and workforce turnover are putting new pressure on bodily injury teams. Static tools and one-time technology investments are no longer enough. Carriers need platforms that continuously evolve, providing better information, greater consistency, and more efficient workflows as litigation environments change.

A demand package that once took days to compile can now arrive in minutes, complete with deadlines designed to pressure a fast settlement. Most claims leaders have already settled the question of whether AI belongs in the claims process. The harder question is whether their technology can keep pace with the demands of the work.

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What's changed on the BI desk

Bodily injury (BI) teams are facing three converging pressures:

- **Plaintiff firms have gotten faster.**
  AI drafting and increasingly sophisticated operations allow them to produce demand packages earlier and apply pressure sooner.
- **Experienced claims professionals are retiring.**
  The people replacing them are learning the job remotely, without a senior adjuster two desks away.
- **Severity continues to rise.**
  Social inflation, medical costs, litigation pressure, and more complex treatment patterns all feed it.

None of that is news to claims leaders. What has changed is the speed at which adjusters must find information, evaluate claims, and apply consistent judgment. The systems supporting them need to keep pace.

Why continuous innovation matters

Most carriers already have AI somewhere in their claims environment. The real differentiator is whether those capabilities continue to evolve as claim complexity, documentation tactics, and settlement pressure change.

Technology designed for yesterday's workflow won't be enough for tomorrow's claims environment. Vendor evaluation is increasingly shifting from feature checklists to innovation velocity: what has been delivered recently, how quickly new capabilities reach customers, and whether innovation is embedded where adjusters already work.

> Vendor evaluation is shifting from feature checklists to roadmap velocity.

How Liability Navigator innovation supports the BI desk

Liability Navigator brings critical BI insights into a connected workflow, reducing time spent searching for information and creating more time for evaluation, negotiation, and policyholder support.

Demand Package Review helps adjusters summarize, de-duplicate, and organize large demand packages in minutes, helping adjusters focus on key medical information, valuation considerations, and injury timelines.

Integrated ClaimSearch® matching surfaces fraud-defense insights directly within the workflow, reducing system-hopping and creating a clearer audit trail before negotiation or settlement.

Provider Scoring highlights billing patterns that may warrant a closer look, giving adjusters another signal for referral, negotiation, or review.

Embedded medical-code intelligence delivers plain-language guidance within the workflow, helping narrow the experience gap between newer and veteran claim handlers.

Evaluation Snapshot consolidates key claim details, damages, recommended ranges, and actionable next steps into a scannable view, while preserving the underlying assessment model.

Five questions to ask a claims platform vendor

Look past the feature list and ask:

1. What did you ship in the last 90 days?
2. How do new capabilities reach existing customers?
3. What data trains your AI, and how do you protect it?
4. How is the technology embedded in the adjuster's workflow?
5. What is not on your roadmap, and why?

The confidence advantage

None of this replaces the adjuster. Bodily injury remains one of the most complex lines to handle, and every claim still depends on human judgment. Better technology provides the information, context, and efficiency needed to make those decisions with greater confidence.

As plaintiff tactics evolve, severity rises, and experienced claims professionals leave the industry, carriers cannot afford to adapt slowly. Liability Navigator helps address those challenges by connecting demand review, fraud insights, provider intelligence, medical bill review, and assessment tools within a continuously evolving workflow.

Bodily injury claims will always require human judgement, but the pace and complexity of the work will continue to evolve. Our focus is on continually improving our solutions to provide adjusters with better information, greater consistency, and more time to apply their expertise where it matters most.

The baseline has changed. Claims organizations need technology that evolves alongside the work, not technology designed to solve yesterday's challenges.

See what continuous innovation looks like inside Liability Navigator

Want to see how it handles a real demand package? Contact your Verisk representative or request a demo.

3. WINNING THE CONVERSATION

Tools that help adjusters stay in control of APD arbitration

When liability is identified early, carriers are better positioned to recover later.

APD arbitration depends on more than the final contention. It depends on whether the initial fault determination was supported by the right evidence, accurate comparative-fault analysis, applicable statutes, and clear documentation showing their rationale from the start. Verisk's Liability Navigator helps carriers move from fragmented, manual reviews to a guided accident liability workflow that supports stronger decisions from FNOL through carrier-to-carrier negotiation and arbitration.

Most auto property damage disputes aren't decided in arbitration. They're decided weeks earlier by an adjuster making a call with whatever evidence they happened to gather. Too often, that call is 100/0.

When an adjuster is buried in caseload, the path of least resistance is to assign the loss entirely to their own insured. The file closes as a paid claim with no recovery pursued, never reaching subrogation or the carrier-to-carrier negotiation that could lead to arbitration.

Winning liability arbitration is a documentation discipline that starts at first notice of loss (FNOL).

Three forces are squeezing the adjuster's desk

1 **An institutional knowledge gap**
The industry faces roughly 400,000 retirements by the end of 2026[14], with about a quarter of the adjuster workforce retiring within five years. Gen Z isn't filling the pipeline at replacement rate, and veteran intuition about comparative negligence is walking out the door.

2 **Caseload volume**
Arbitration Forums member carriers filed roughly 2.4 million subrogation demands and 1.2 million arbitration disputes last year, with more than $26 billion contested. Industry estimates put manual review at roughly 80 minutes per file.

3 **Rising APD severity**
Higher vehicle repair costs, total-loss values, and rental expenses are raising the stakes on every liability decision. The average cost per auto liability claims climbed 67.5 percentage points cumulatively between 2019 and 2025[15], pushing the gap between settling a physical damage claim and settling a liability claim to a ten-year high.

The cost of bypassing a comparative-fault assessment is materially higher than it used to be.



The three failure modes that decide APD arbitrations

Defaulting to 100/0 when the facts support a split
The costliest mistake is never identifying comparative fault in the first place. When shared liability goes unrecognized early, carriers can miss recovery opportunities before the file ever reaches negotiation or arbitration.

> Adjusters who don't think in percentages don't recover anything.

Consider a multi-lane left turn: Your insured crosses three lanes safely and gets struck in the fourth. The other driver had a clear view of the turning vehicle and sufficient time to react. That's a 70/30 or 60/40 call, not a clean 100/0. Adjusters who don't think in percentages don't recover anything.

Summarizing the statement instead of memorializing it
Ask a long-tenured claims professional where carriers lose cases they should have won, and the answer comes fast: "It's documentation—having the facts memorialized."

The failure plays out predictably:

- The adjuster takes a recorded statement, types a summary into the file notes, and moves on.
- The audio sits in a separate system.
- The admissions, the sequence, and the moments the other driver's account contradicts itself never make it into a structured, citable record.

At arbitration, the contention becomes the adjuster's word about what the statement said.

The evidence inventory that should be in every contention package hasn't changed in 15 years: recorded statements from both parties and any witnesses, the police report, scene photos and a diagram with points of impact, vehicle photos, and repair estimates. What has changed is how reliably that package gets assembled by an adjuster working their 40th file of the week.

Citing the wrong statute, or no statute at all
For most adjusters, finding the right state vehicle code section means a web search or a hunt through an internal intranet. A 20-year industry veteran recently called this workflow "scary."

Multi-state books make it worse. An adjuster evaluating a rear-end accident in California one hour and a disputed-lane-change loss in Virginia the next must navigate entirely different negligence standards. Pure comparative, modified comparative with a 51% bar, contributory—they all start to look the same after dozens of claims. Or an adjuster may handle a claim in California one hour—where a driver who is 70% at fault can still recover damages—and a claim in Virginia the next, where 1% fault can eliminate recovery altogether. Keeping those rules straight across a multi-state book isn't easy.

The result is a contention opposing carriers and arbitrators can pick apart, and a settlement posture that gives up ground before the negotiation starts.

What an integrated liability workflow changes

The shift is from paper manuals, browser tabs, hand-typed summaries, and standalone scoring software to a single guided workflow that consolidates evidence, statutes, and assessment into one record. Verisk's Liability Navigator is built around that shift. For APD, four connected capabilities make up the accident liability workflow, each one feeding the next from FNOL through the carrier-to-carrier call.

An API-driven recorded statements workflow
The adjuster uploads the statement. The platform transcribes it, populates the structured investigation questions, and feeds those answers into the liability assessment. The statement becomes data the assessment runs on.

Points-of-impact and interactive accident scene diagrams
Visual evidence reconstructs the physics of the loss. The multi-lane left turn becomes a 70/30 conversation backed by a diagram instead of a 100/0 default backed by a comment.

A curated statutory library, governed and current
The relevant vehicle code section surfaces next to the investigation question for that state. An Insurance Laws and Minimum Limits view shows the negligence rule for every state on one screen.

A suggested liability range with pros-and-cons negotiation points
The adjuster enters the carrier-to-carrier call already knowing the strong and weak parts of their case and what the opposing carrier will push on.

Most APD disputes resolve at that carrier-to-carrier call, before arbitration.

Video capture of the loss event is the next leap. When the footage shows the sequence, the liability split becomes self-evident, and some disputes never need to reach subrogation at all. The carriers with an integrated workflow today will absorb that shift faster than the carriers still piecing files together across systems.

For carriers weighing whether to build this in-house: Timelines stretch, model maintenance compounds, compliance validation gaps don't close, and the interface degrades the moment IT priorities shift.

What it means for claims management

Settlement accuracy and consistency
Structured workflows force comparative fault to be evaluated rather than skipped. One sample client study revealed a 28-percentage point increase (from 4% to 32%) in applied liability when using Liability Navigator.

Subrogation recovery
More files get evaluated, so more files become recoverable. Subrogation is the only place claims operations make money; everywhere else is loss.

Span of control and on-the-job upskilling
Structured prompts act as a coaching layer. A two-year adjuster works through the same investigation questions a 20-year veteran would, and variance across the team narrows.

Audit and litigation defensibility
Each determination comes with documented rationale, statutory citations, and the underlying evidence—ready for QA review, regulatory examination, or a bad-faith allegation.

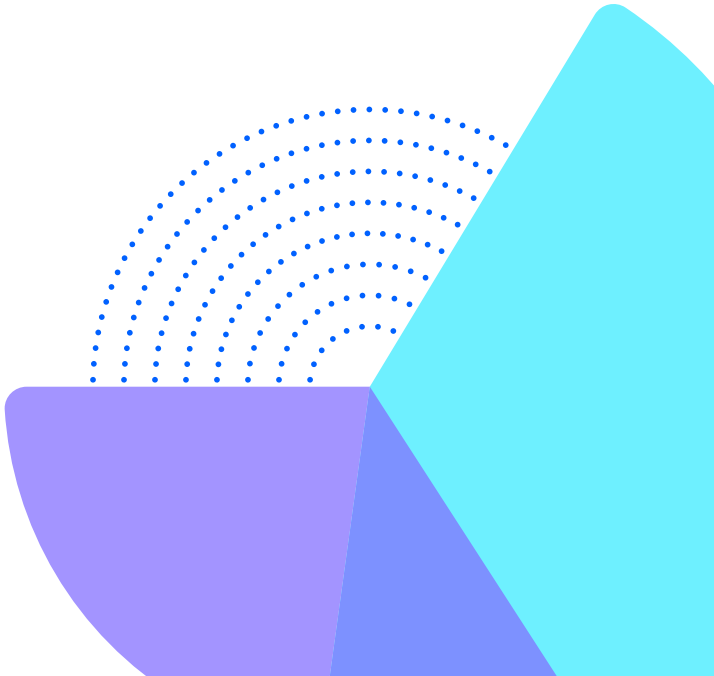
> Subrogation is the only place claims operations make money; everywhere else is loss.

What the carriers at the forefront are doing differently

The carriers staying ahead give their adjusters a workflow that produces the same complete, statute-backed, evidence-supported contention package every time. The payoff happens weeks before any arbitration filing: In the 100/0 call your adjuster doesn't default to, and in the file that gets referred for recovery instead of simply getting closed and paid.

Stay in control of liability decisions from FNOL through arbitration.

Request a Liability Navigator demo.



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