The ROI of Claims Staffing and Education: How Skilled Adjusters Make Carriers More Profitable

A Working White Paper for Property & Casualty Insurer Executives

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Executive Summary

Property and casualty insurers face sustained pressure to improve profitability amid rising severity, legal volatility, and long-tail loss development. In response, many organizations have treated claims staffing and education as discretionary operating expenses—reducing headcount, limiting training budgets, and increasing adjuster workloads to achieve near-term expense relief.

This paper concludes that such actions mischaracterize the role of the claims department, which operates as a distinct enterprise unit whose decisions directly shape indemnity, loss adjustment expenses (LAE), and reserve development.

The insurance policy is a contract to pay covered claims. Premium prices the transfer of risk; the claims department determines whether the contractual promise is fulfilled through policy interpretation. From a capital perspective, claims management ultimately shapes whether underwriting margin materializes or erodes. The claims organization is the carrier's front window: every dollar ultimately paid—or avoided—flows through its reserving, settlement, and litigation management decisions. It is not a back-office cost center; it is a capital-impact function whose structure, supervision, and expertise directly influence indemnity, LAE, and reserve stability.

Because loss payments, reserves, and litigation outcomes develop over multiple accident years, the financial consequences of claims decisions cannot be evaluated on a twelve-month horizon. As Warren Buffett has noted, property and casualty insurers collect premium upfront but discover the true cost of their product much later—sometimes decades after the exposure occurred. Accordingly, decisions regarding claims staffing, supervision, and education are long-horizon capital allocation choices, not short-term labor management adjustments.

The evidence reviewed—including a fully documented public-sector case study, modern carrier disclosures, public-entity risk pool experience, and reinsurer research—shows a consistent pattern. Organizations that invest in manageable workloads, experienced adjusters, and sustained professional development demonstrate:

- More stable reserve development
- Lower severity leakage
- Reduced litigation escalation
- Improved ultimate loss outcomes

Conversely, organizations that constrain staffing and education may temporarily improve expense ratios while increasing indemnity, LAE, and earnings volatility through delayed resolution, reserve stair-stepping, and avoidable litigation in the long term.

Traditional claims key performance indicators (KPIs)—closure speed, inventory counts, and short-term expense metrics—remain useful for operational monitoring but are insufficient indicators of long-term financial performance. Boards that rely exclusively on such measures risk underinvesting in one of the carrier's primary drivers of capital volatility.

<u>Board Takeaway:</u>

Claims governance should be approached with the same discipline applied to pricing, reinsurance, and technology investment. Artificial intelligence and analytics can materially

enhance efficiency, but they function as force multipliers for expertise, not substitutes for it. As automation increases, the marginal financial impact of human judgment rises, making experienced adjusters and effective supervision more—not less—critical.

For governance purposes, claims staffing and education should be overseen alongside pricing, reinsurance, and capital management because they directly influence reserve adequacy and earnings volatility over 3–7 years.

Disclaimer:
Because insurers do not publicly disclose file-level staffing metrics, certain workload illustrations in this paper are directional rather than statistically modeled across carriers. The financial relationships discussed, however, are observable within organizations and consistent with documented reserve development patterns.

The conclusion is not that staffing or education alone eliminate operational pressures within the claims organization. Rather, the evidence supports a financially disciplined conclusion: the structure, supervision, and expertise embedded in claims management materially influence ultimate loss cost and reserve stability and therefore warrant explicit board-level governance as a long-horizon capital investment.

The Current Environment

Across personal and commercial lines, severity has consistently risen faster than rate adequacy. Social inflation, medical inflation, increased attorney representation, and the rise of high-severity jury awards have added significant pressure. Carriers frequently respond by tightening expense budgets, reducing training, or increasing adjuster caseloads.

Most corporate investments are evaluated on timelines that roughly match their payoff. A new system, distribution channel, or pricing model can often be assessed within one to three years.

Short-term financial gains achieved by constraining claims staffing or supervision therefore do not represent true profitability. Instead, they shift cost recognition into future periods through adverse reserve development, higher settlements, increased litigation, and elongated claim duration. From a governance perspective, boards and executive teams must recognize that claims investment decisions cannot be evaluated on a one-year horizon without distorting the underlying economics of the business.

An additional structural pressure affecting claims outcomes is the growing influence of private equity ownership and short-term return expectations. Private equity investment models often emphasize rapid, short-term operating metrics improvement within relatively compressed time horizons.[1] In claims organizations, this pressure frequently manifests as headcount reductions, increased caseloads, or delayed investment in training and supervision—measures that may improve near-term expense ratios but materially increase long-term loss costs.

These responses create systemic downstream costs:

- Poor or inconsistent early investigations
- Delayed or inaccurate first reserves
- Missed recovery opportunities
- Higher litigation referrals
- Greater adverse development

Claims do not behave this way.

For many lines—auto bodily injury, general liability, excess, professional liability, environmental, workers' compensation—the financial impact of today's staffing and training decisions will not fully materialize for years. Early reserving accuracy, litigation posture, investigation quality, and negotiation discipline determine whether losses develop favorably or adversely over time.

This creates a persistent governance problem. Boards and executives review calendar-year loss ratios and expense ratios, yet the claims decisions driving those numbers may have been made by adjusters handling overloaded desks with limited training years earlier. When results disappoint, the instinct is often to focus on adjuster performance rather than system design.

This paper takes the opposite view: claims outcomes cannot be evaluated solely through surface-level KPI performance. Calendar-year metrics may remain favorable even while the underlying

[1] Specifically EBITDA: Earnings Before Interest Taxes Depreciation and Amortization

claims system is financially deteriorating if the measures presented to leadership emphasize speed, inventory, and expense control over reserve adequacy, leakage, and long-term loss development. In such cases, the issue is not frontline effort, but whether the governance framework is capturing the drivers of ultimate cost.

What the Evidence Shows

The multi-source review — including eleven modern carriers/pools and the historical SCRTD/MTA audit — reaches the same conclusion: skilled adjusters reduce ultimate loss costs.

The carriers, pools, and industry sources were reviewed, using publicly available financial filings, annual reports, governance materials, and published research. Where applicable, multiple years were examined to avoid drawing conclusions from a single underwriting or calendar year.

Using one detailed historical case study and eleven modern data sources from stock insurers, public-entity risk pools, and reinsurer research, we show a consistent pattern:

- When adjusters carry excessive workloads with limited training and weak supervision, reserves bloat, backlogs grow, files stair-step toward litigation, and ultimate loss costs rise.
- When organizations invest in more and better claims staff, restructure workloads, and support disciplined claim practices, ultimate loss costs and reserve volatility fall, even in tough legal environments.

The only fully quantified "before/after" example comes from a 1987-1994 audit of the Southern California Rapid Transit District/Metropolitan Transportation Authority (SCRTD/MTA).[2] There, adding staff, cutting caseloads, and reorganizing claims operations reduced case and IBNR reserves from roughly $69 million in September 1989 to $52 million dollars in September 1992 and generated a total of $17 million in savings over a period of 3 years. This is averaged to be $5.67 million in annual savings.

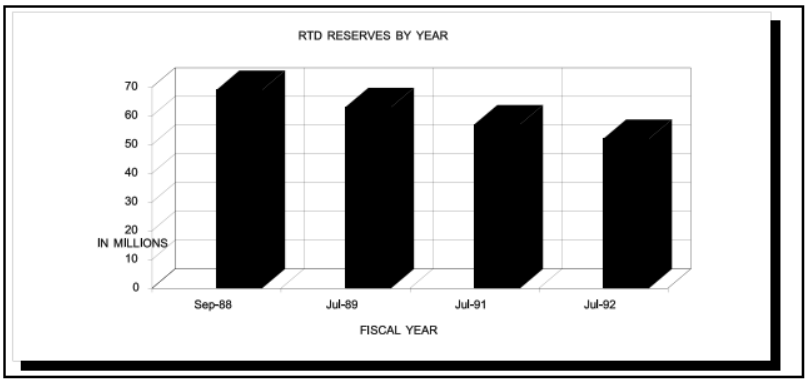

Figure 2

Chart from Frederick J. Fisher's 1991 SCRTD audit illustrating the drop in reserves once the claims department was adequately staffed and trained.

1. Problem Statement: Overhead or Core Product?

[2] Frederick J. Fisher completed a total of five audits. Unfortunately, three have been lost. Source 0 is the remaining two audits.

In many organizations, the claims organization is managed primarily as an expense center, with emphasis placed on headcount controls, vendor contracts, and short-term cost containment.

The data tells a different story.

Across the sources reviewed, three patterns recur:

1. Claim severity, especially in auto and liability, is rising faster than general inflation.
2. Frequency is often flat or down; losses are being driven by size, not count.
3. Reserve development volatility closely tracks how well an organization recognizes and manages severity in real time.

Severity is not an external fate alone. It is shaped by the quality of early investigation, evaluation, negotiation, and litigation management. All of those depend on staffing: how many files each adjuster carries, how cases are triaged, and whether supervisors have the capacity to review and mentor work.

When an insurer treats adjuster staffing and training as a discretionary expense, it increases the risk of exactly the outcomes the board fears most: unstable loss ratios, adverse development, and surprise "runaway verdicts."

2. Source 0: SCRTD/MTA – A Rare Before/After Experiment

The clearest evidence that staffing is an investment comes from a historical audit of SCRTD/MTA's self-insured public liability program.

2.1 Conditions Before the Intervention

Under the prior administrator, LJR Insurance Services, Inc. the claims department showed classic signs of overload and under-management:

- Adjusters carried approximately 600–800 active files each, far above what contemporary practitioners considered sustainable for complex public liability claims or the contractual limit of 450 which was too high in and of itself.
- Open inventory hovered around 8,000 claims.
- Files showed stair-stepped reserves and slow movement toward resolution.
- Case and IBNR reserves totaled about 69 million dollars.

An independent audit by The Fisher Associates concluded that workloads were "far in excess of industry standards" and that poor file handling, not just adverse events, was driving high ultimate costs.

Although no universal benchmark exists, industry commentaries indicate that adjusters handling complex multi-line or liability claims typically manage between 75 and 125 open files. Loads exceeding 150–175 for any line of business are generally viewed as unsustainable for timely resolution and quality investigation.

2.2 The HCM Model and Results

When claims administration transferred to HCM within the SCRTD/MTA structure, the organization pulled several levers at once:

- Increased claims staffing and reduced caseloads to sustainable levels.

- Reorganized claims units with clearer triage and specialization.
- Tightened diary systems and supervisory oversight.
- Introduced consistent investigation and settlement planning.

Within a few years, measurable changes followed:

- Open claim inventory dropped from approximately 8,000 to under 4,000 files.
- Case and IBNR reserves declined from around 69 million dollars to 37.7 million dollars.
- Annual savings were estimated at $8–$12 million per year in reduced ultimate losses and LAE.

Critically, this was not driven by a change in exposure or coverage. It was driven by the level of professional experience embedded in the claims organization, the structure of supervision and workload management, and the timeliness and consistency of resolution.

SCRTD/MTA thus provides a prototype: in a real-world, high-severity liability setting, more and better claims staff produced smaller reserves and lower ultimate costs.

3. Cross-Source Evidence: Modern Echoes of the Same Pattern

The SCRTD/MTA case could be dismissed as a one-off outlier if modern data contradicted it.

The opposite is true.

Insurers do not publish the kind of file-level or staffing data needed for direct ROI computations, but their financial and operational disclosures align with the SCRTD/MTA mechanics. This paper relies on stock carriers, pools, and public entities with available disclosures, but the operational mechanics described—caseload, supervision, education, and their impact on loss cost—apply equally to mutual carriers and other risk-bearing entities.

This framework may be particularly relevant to mutual carriers. Because mutual insurers are organized around policyholder value, long-term stability, and capital preservation rather than quarterly market expectations, the relationship between claims capability and reserve volatility may be even more strategically significant. Multi-year reserve swings, litigation escalation, staffing shortages, and underinvestment in technical training can have amplified implications for mutual carriers that do not access capital markets in the same manner as publicly traded insurers. Accordingly, the thesis of this paper—that claims capability functions as a capital-stability lever—aligns closely with the long-horizon financial philosophy commonly associated with mutual insurers.

3.1 Stock Carriers: Reserving Discipline and Claims Capability

Among large stock carriers, Travelers stands out. Over a ten-year window, Travelers reports that net prior-year reserve development has been favorable, near-neutral, or only modestly unfavorable. Management explicitly attributes this to disciplined reserving and claims practices, supported by investments in training facilities, analytics, and claims technology.

CNA mirrors Travelers and SCRTD/MTA. CNA's longevity and stability in professional and specialty liability lines—where many competitors cycle in and out—suggests that disciplined claims operations contribute to sustainable performance. While CNA does not publish adjuster-

level workload data, its operating posture aligns closely with the SCRTD/MTA lessons: complexity requires expertise and capacity, not compression.

By contrast, Allstate's recent history illustrates what happens when severity and litigation trends outrun operational control. Between 2020 and 2023, Allstate moved from favorable prior-year re-estimates to more than a billion dollars in unfavorable development, driven by higher-than-expected physical damage and injury severity and increased attorney representation. At the same time, the company highlights digital claims tools and specialized resources that have trimmed about 1.2 points from claim expense, a signal that operational changes matter, but cannot fully offset external trends without deeper structural changes.

External severity drivers—social inflation, attorney representation rates, jury behavior, litigation costs driven by third-party litigation funding—are real and material. However, these factors are external. Staffing and supervision determine whether the organization responds to those pressures proactively or defensively. Adequate claims capability does not eliminate external volatility; it governs the insurer's response to it.

Progressive and Hartford, in different ways, tell the same story. Both emphasize segmentation, early settlement, and specialized claim teams. Both explicitly link claim organization activities—closure rates, no-pay closures, case reserves—to reserve adequacy. Neither publishes a clean "claims-per-adjuster" series, but their narratives assume that claim operations are a primary driver of whether rising severity translates into controllable loss ratios or unstable results.

The common message is consistent: even at scale, carriers recognize that underwriting can price for anticipated severity trends, but only claims management can influence how those trends are realized in individual files in real time.

3.2 Public Pools: Intensive Claims and Risk Management in Tough Environments

Public entity risk pools operate in some of the most severe liability environments in the country, often with law enforcement exposures and concentrated political scrutiny. Several of the pools reviewed demonstrate what happens when they lean into claims staffing and risk management.

- Washington Cities Insurance Authority (WCIA) reports heavy lawsuit volume and significant pressure from high-dollar verdicts. Despite this, roughly 52 percent of lawsuits in both 2020 and 2022 closed with no indemnity payment. WCIA attributes performance to pre-defense reviews, risk-management audits, and structured claims work—activities that require skilled people, not just forms.
- Florida Municipal Insurance Trust (FMIT) has built a "world class" catastrophe response system with ride-out teams, critical incident response personnel, and thousands of rapid damage assessments after hurricanes such as Irma and Michael. FMIT reports that this approach has reduced "millions of dollars of out-of-pocket costs" for members and supported 78 million dollars in property dividends over an eleven-year period.
- Minnesota's League of Cities Insurance Trust (LMCIT) and the Texas Municipal League pool both invest heavily in risk and safety consultants, training, and specialist litigation and claims units. Their materials explicitly state that better safety and claims practices reduce losses and make claim trends more manageable over time.

Here again, detailed file-by-file data is not public. However, the strategic behavior is revealing. These entities commit resources to claims and risk staff precisely because they believe doing so keeps contributions from member cities lower than they otherwise would be.

3.3 Reinsurer Research: Macro-Level Validation

Reinsurer research from Swiss Re Sigma and Gen Re provides a macro lens. Their studies quantify multi-year increases in bodily injury and liability severity and connect these trends to legal environment, attorney behavior, funding mechanisms, and changing jury attitudes.

More importantly for this paper, they do not treat severity as immutable. They describe a set of claim-side practices that mitigate severity and reserve volatility:

- Early, skillful contact with claimants.
- Rapid, thorough investigation.
- Specialization in complex liability claims.
- Consistent evaluation frameworks and negotiation strategies.
- Focused litigation management to avoid runaway verdicts where possible.

These recommendations are operationally intensive. They assume trained, adequately staffed claim units with enough time and bandwidth to execute. In other words, at the portfolio level, reinsurers implicitly support the same thesis as the SCRTD/MTA case: better claims staffing and discipline tame at least part of the severity and reserve problem.

4. What the Industry Is Not Measuring

Despite the strong directional support, this paper does not claim to have a single, universal "x more adjusters → y percent reduction in loss and LAE" equation. The limiting factor is not theory; it is data. Accordingly, the analysis identifies directional operational relationships rather than claiming a single-variable causal model across carriers.

Carriers do not publicly disclose file-level staffing metrics such as:

- Adjuster headcount by line and region.
- Average open files per adjuster, stratified by complexity.
- Claim-level operational metrics such as time to first contact, time to first reserve, or number of reserve changes per file.
- Separate Adjusting & Other (A&O) and Defense & Cost Containment (DCC) LAE trends by program, linked to staffing changes.

While this limits cross-carrier statistical modeling, it does not prevent individual organizations from observing directional relationships between workload design, reserve stability, litigation frequency, and ultimate loss cost within their own portfolios.

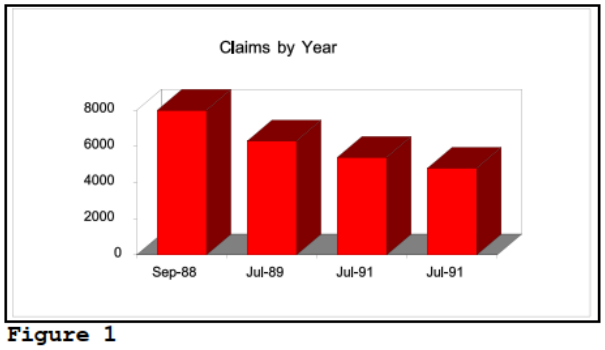

Figure 1

Chart from Frederick J. Fisher's 1991 SCRTD audit illustrating that overall open claim files continued to decrease. This chart specifically shows as of the 1989 audit, open pending was 6,300 claims and in July 1991 the open pending claim was 4,800.

However, it is known that high caseloads force adjusters into triage mode. Under sustained pressure:

- Investigations are abbreviated
  - This is caused by the volume of claims demanding attention.
  - Because the investigation is not thorough, "damage creep" may begin,[3] resulting in carriers resisting the alleged increased damages, which ultimately culminates in litigation and possible large verdicts.
- Early settlement opportunities are missed
- Reserves are set defensively rather than analytically
- Files "stair-step" upward as information is discovered late
- Counsel is engaged earlier and more often than necessary resulting in more expensive and slower fact gathering due to "Legal Discovery" such as motion work, request for productions, admissions, etc.

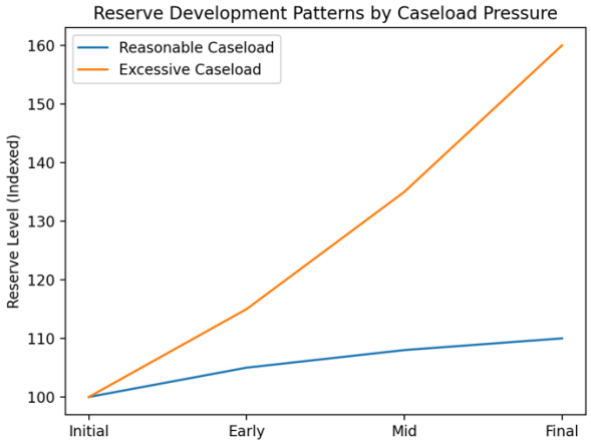

Figure 1 is an illustrative model showing how reserve stair-stepping emerges in high-volume claim environments. When adjusters operate under sustained caseload pressure, loss reserves are often adjusted incrementally over time rather than set accurately early in the claim lifecycle.

[3] "Damage creep" is the author's term for damages that increase because the insured does not begin repairs resulting in additional damages from the initial loss. While the additional damage should not be covered as the policyholder has the obligation to protect the property from ensuing damages, most insureds do not understand their obligations and fear that beginning repairs will cause their claim to be denied. Ultimately, the inability of the adjuster—because they are in triage mode—to explain the insured's duties, also increase LAE.

The understatement of loss reserves (liabilities on the Balance Sheet) could impact the amount of money a carrier invests for sustained profitability or needed elsewhere for expenses.

4.1. Use the Data Already Produced to Obtain Claim Department Staffing and Education ROI
Even a simple comparison—using data the company already gathers—will show whether heavier caseloads correspond to higher indemnity, higher LAE, or wider reserve error. If so, the company is already experiencing the cost of under-staffing.[4]

Executives can request analytics teams to produce a focused set of studies using current KPIs and link adjuster workloads to the ultimate outcome of the claim. It should be understood that this is granular-level data. Management needs to see the results not only on individual claims, but on claims, per line of business, as a whole.

For each claim segment (e.g., personal auto property and liability, homeowners property and liability, commercial property, commercial liability, etc.):

- Group adjusters by average open-caseload band (e.g., 0–75, 76–125, 126–175, 176+).
- For each band, calculate:
  - Indemnity + LAE reserves per closed claim
  - Initial reserve vs. ultimate outcome (reserve accuracy)
  - Proportion of claims litigated
  - Time to final resolution on high-severity files

These outcomes determine capital volatility, earnings stability, and reinsurance efficiency. Claim department staffing decisions that degrade these measures undermine enterprise risk objectives, even if short-term efficiency metrics improve.

Higher caseloads correlate with increased reserve volatility, cycle-time delays, missed recovery opportunities, and higher re-open rates.

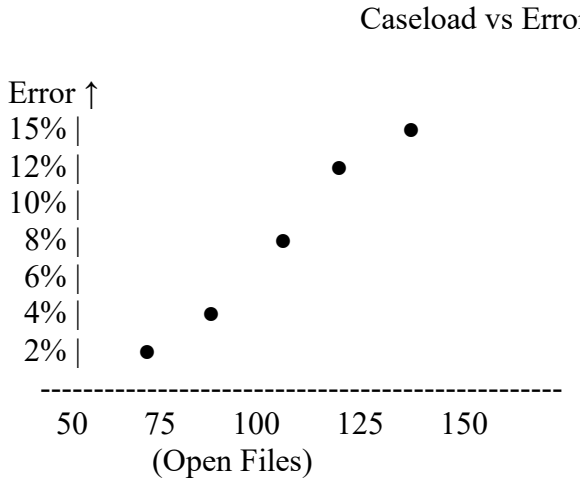

Figure 2 is an illustrative model showing the nonlinear increase in claim-handling errors as adjuster caseloads rise beyond sustainable levels which result in higher ultimate loss costs.

[4] It is critical that boards avoid drawing incorrect conclusions from KPI shortfalls under excessive caseloads. When adjusters are assigned workloads beyond reasonable capacity, KPI performance reflects a structural limitation—not an individual failure. High caseload environments measure the constraints of the system far more than the capability of the people working within it.

Even modest improvements in these areas produce outsized financial impact when applied across large claim volumes. The one high-quality audit (SCRTD/MTA) and eleven modern sources suggest that the same mechanics are still in play.

5. Implications and Next Steps for Insurance Executives and Governing Boards

The strategic question for insurers is no longer whether having adequate adjuster staffing matters. The evidence from SCRTD/MTA, Travelers, CNA, WCIA, FMIT, LMCIT, and reinsurer research indicates that it does. The real questions are:

- How much should be invested, and where?
- How should outcomes be measured?
- How can leadership distinguish between productive claims spending and simple administrative bloat?

Most insurance carriers already track operational metrics:

- claim counts opened and closed by month,
- initial vs. ultimate reserves and paid amounts,
- time to closure,
- call times and touch counts,
- litigation status and outcome.

These metrics reflect activity, not value creation. An adjuster can meet or exceed throughput targets while still producing suboptimal outcomes if caseloads are excessive or decision-making is rushed.

This distinction is particularly important in claims environments that have adopted Lean Six Sigma–style performance frameworks. While throughput, cycle time, touch counts, and closure velocity may be effective measures of process efficiency, they are not necessarily reliable proxies for ultimate claim quality or long-term financial outcome in service-oriented, judgment-intensive operations. In claims, the "defect" often does not emerge at the point of closure, but months or years later through reserve deterioration, litigation escalation, reopen activity, or regulatory findings.

I discuss a Pennsylvania Insurance Department's market conduct exam in the Artificial Intelligence (AI) section of this report. The Department's findings concerning a health insurer identified claim communications that were timely but substantively deficient. This illustrates that process-compliance metrics alone may fail to capture regulatory exposure and ultimate claim quality. And while the example is of a health insurer, property and casualty insurers face the same risks.

The issue is not whether Lean Six Sigma principles improve operational flow; the issue is whether process-efficiency metrics are being supplemented with measures that capture long-tail financial outcome and regulatory risk. What is often missing is not more data, but a different set of questions about that data. Insurance executives need to convert these existing data points into an ROI analysis focused not merely on claim quality, but on overall claim and cost effectiveness.

The most financially meaningful indicators—ultimate indemnity, LAE, reserve development, and litigation rates—often emerge months or years later, well after operational KPIs have been reported.[5] Boards should assume that decisions made today about claims staffing and education will primarily affect earnings volatility three to seven years forward, not next quarter.

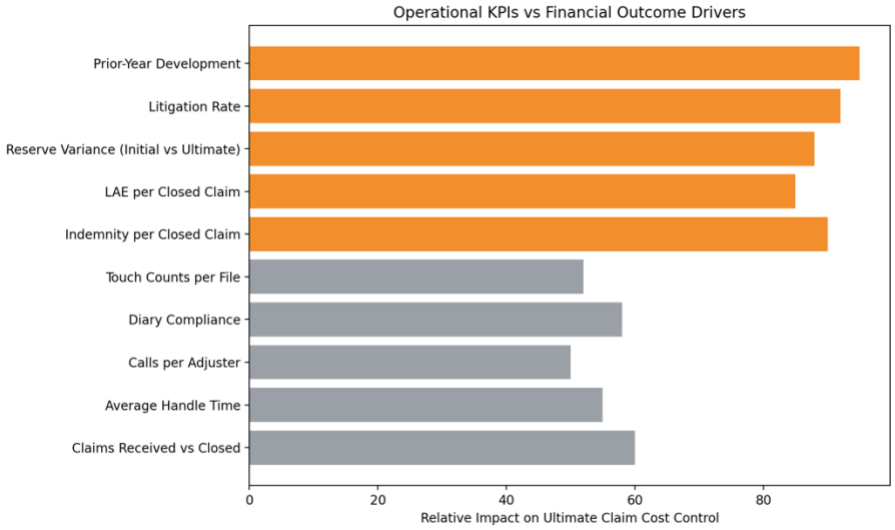

Figure 3 is an illustrative model showing traditional operational adjusting KPIs (gray) which are frequently monitored but weak predictors of ultimate claim cost, while financial outcome drivers (orange) more directly influence indemnity, LAE, litigation, and reserve development.

This paper does not prescribe a universal staffing or education budget, as appropriate investment levels depend on line of business, claim complexity, jurisdictional mix, current caseload distribution, and the organization's existing supervisory structure. Rather, the objective is to provide a framework through which boards and management can evaluate whether current claims investment levels are financially adequate.

5.1. The Why

A policyholder's experience with the claims organization is a strategic asset because the handling and payment of covered claims fulfill the policy's promise. For the insured, this is the moment the product proves its value.

Even modest improvements in claim settlements can produce outsized returns:

- A 1–2% reduction in indemnity + LAE on high-severity lines
- Fewer litigated claims
- Improved reserve stability

Across thousands of claims, these differences routinely exceed education costs many times over. Education does not need to be perfect to be economically meaningful. Structured education improves decision quality in severity assessment, negotiation, reserve setting, and litigation triage.

[5] Because some books of business, specifically liability books, can and usually do span multiple financial years, insurer governing boards must not assume this is a one year experiment. As the SCRTD/MTA data show, a carrier will not begin to see results for several years.

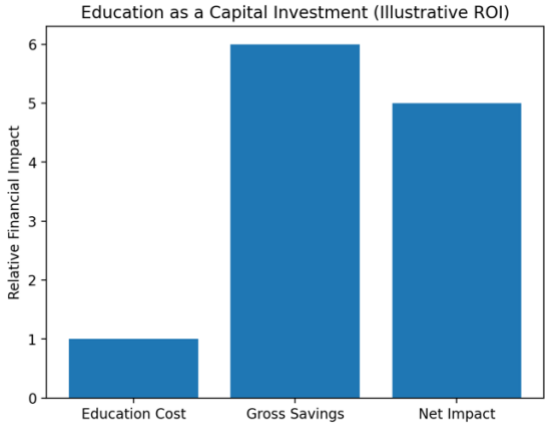

Figure 4 is an illustrative model showing claims education as a capital investment with measurable financial outcomes. Estimates shown use publicly available case studies (SCRTD/MTA, WCIA, FMIT), reinsurer research (Swiss Re, Gen Re), and documented severity/LAE improvements (Travelers, Allstate). Where exact figures are unavailable, values are conservatively extrapolated for comparative illustration only.

This paper does not measure the cost to onboard new employees in great detail, but this fact is discussed in Section 5.3, "The Hidden Cost of Employment". Higher retention reduces onboarding costs, preserves institutional expertise, and materially improves claim outcomes by reducing reserve swings and litigation escalation.

Professional development materially influences employee retention, according to Sabarese's *CLM* article. Retention stability supports claims expertise continuity in high-severity and complex lines. Progressive's 10-Q filings (2011) explicitly link improved bodily injury severity to claim personnel tenure and process improvements.

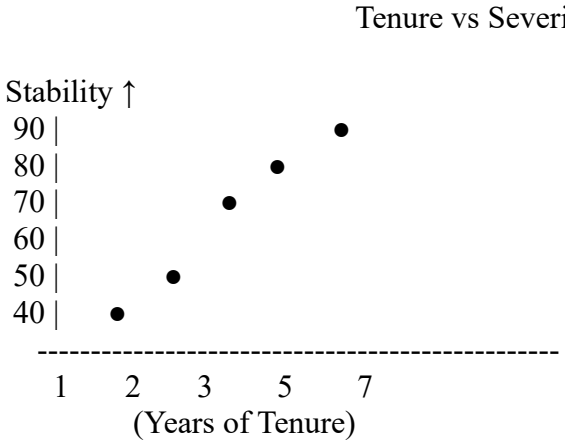

Figure 5 is an illustrative model showing the stabilizing effect of adjuster experience on claim valuation and reserve accuracy. As tenure increases, case reserving becomes more accurate, cycle time compresses, and severity volatility decreases.

Survey data indicate that while governing boards and senior leadership often articulate support for professional development, employees perceive a significant disconnect in its practical execution. In the same survey, 40% of employees reported a perceived misalignment between leadership messaging and actual support for early-career development.

One tangible indicator of this gap is the limited use of paid study time, cited by only 21% of employees as a management-supported tool. Professional development in claims is not self-executing. Without explicit top-down emphasis, structured time allocation, and clear linkage to advancement, early-career professionals will rationally prioritize file volume over long-term skill development.

Carriers have a serious talent flight risk when educational opportunities are not acted upon.

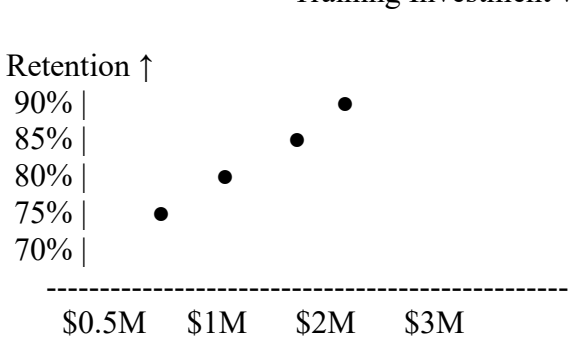

Figure 6 is an illustrative model showing the positive relationship between training investment and employee retention within claims organizations.

Retention functions as a cost control mechanism. Reducing adjuster turnover preserves institutional knowledge, supervisory continuity, and file stability—factors that directly influence ultimate loss cost. Professional development, often categorized as a discretionary "perk," is a measurable retention driver, comparable in impact to compensation. Survey data indicate that 39% of employees report strong support for professional development as a reason to remain with their employer, ranking ahead of commute/location and regular recognition.

5.2. What Insurance Executives Should Measure

If claims capability materially influences ultimate loss cost, reserve stability, and litigation exposure, then governance oversight must extend beyond traditional volume metrics, such as pricing, reinsurance, and growth strategy.

Boards routinely review pricing adequacy, reinsurance structure, and capital allocation using outcome-based financial measures. Claims oversight should be governed with comparable discipline. The objective is not to increase reporting complexity, but to align measurement with long-horizon financial performance rather than short-term activity levels.

Traditional operational metrics—claims closed per month, average cycle time, inventory counts, and labor expense ratios—provide visibility into throughput. However, they do not capture whether claim decisions are improving or degrading long-term financial outcomes. In other words, carriers do not need new KPIs; they need to use the data they already have to answer three questions:

1. Are reserve accuracy and development patterns trending up or down?

Caseloads interact directly with severity. As adjuster workloads increase, time per file decreases. Investigations narrow, early resolution opportunities are missed, and disputes escalate. The result is not simply slower handling; it is higher ultimate cost.

Public-sector claims pools such as SCRTD and MTA illustrate this dynamic clearly. When staffing ratios improve and experienced adjusters are retained, severity moderates and development stabilizes. When caseloads spike or experienced staff leave, losses develop upward even if claim counts remain flat.

Private-sector specialty carriers show similar patterns. CNA, for example, has long emphasized technical claims training, manageable caseloads, and continuity in specialty lines. While no carrier is immune to severity trends, CNA's approach has historically produced more controlled settlement behavior and less volatility than peers that rely heavily on rapid throughput models.

Early improvements from structured staffing and education investments typically appear in reserve stability. Boards should review:

- Initial reserve adequacy relative to ultimate development,
    - Final reserve vs. total paid per closed claim (stair-stepping indicator);
- Frequency and magnitude of reserve strengthening,
    - Indemnity per closed file (normalized by complexity band);
- Patterns of claims escalating to attorney involvement or litigation,
- Average cycle time segmented by severity band.

Improving reserve accuracy reduces volatility, strengthens financial forecasting, and signals disciplined file management.

Litigation frequency and severity often reflect decision quality and supervisory consistency. Relevant indicators include:

- Percentage of claims entering litigation,
    - Indication the claims organization may be understaffed and reacting to losses;
- Time to resolution for litigated files,
- Settlement variance between pre-suit and post-suit resolution,
    - LAE per closed file (A&O and DCC separated where possible);
    - Reserves pre- and post-suit.

Reductions in avoidable litigation typically precede visible decreases in indemnity and LAE.

2. Is the current staffing model creating value or destroying it?

Using existing metrics, carriers can calculate:

- The cost per adjuster (salary + benefits + overhead),
    - This is discussed below;
- The impact of adjuster turnover on cycle time and severity,
    - This is discussed below;
- Whether divisions with lower caseloads produce lower indemnity/LAE,
- Whether experienced adjusters produce more accurate early reserves,
- How much adverse development traces to inexperienced or overloaded staff.

These factors allow boards to convert the claim organizations from a cost center into *the connecting factor between increased costs and decreasing profits to lack of adjuster education and inadequate adjuster staffing*.

3. Is the carrier investing enough in skilled adjusters, or only in the bare minimum?

Claims staffing decisions are often framed narrowly: how many claims an adjuster can close per month, how long files remain open, and how labor costs compare to budget. While these measures provide visibility into activity levels, they fail to capture what matters most financially: whether coverage determinations are accurate, reserves are set appropriately, and settlement strategies prevent avoidable escalation—decisions that ultimately drive indemnity, LAE, and earnings volatility.

For example, Travelers CEO, Alan Schnitzer, states in Sclafane's January 23, 2026 *Claims Journal* article that the carrier met their 2025 goal of closing 90% of catastrophe claims within 30 days. It is not known how many claims were reopened due to disputed coverage determinations, inaccurate reserves, reinspections, and litigation. Indemnity and LAE grow silently because these latter metrics are not linked to a well-educated and skilled adjuster force.

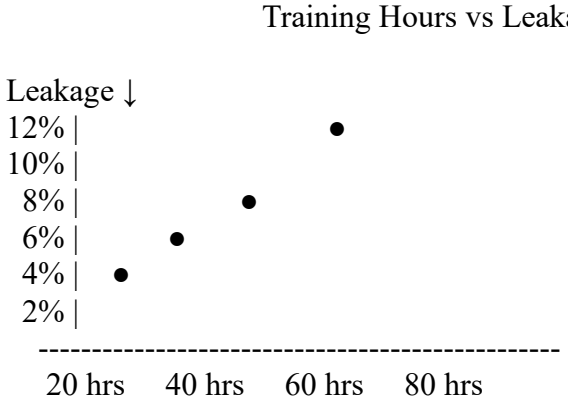

Figure 7 is an illustrative model showing the expected decline in claims leakage as adjusters receive additional structured training hours. Each incremental 20 hours of targeted technical training yields measurable improvements in file handling quality.

Claims outcomes are not random. They respond to expertise, experience, and timely intervention. Claims organizations' training investments in many carriers remain materially underfunded relative to their impact on indemnity, LAE, and reserve stability. As a result:

- Adjuster knowledge may plateau or regress with the continued retirement of senior adjusters,
- Reserve accuracy erodes,
- Litigation referrals rise.

While many carriers invest meaningfully in trainee onboarding, sustained technical development and supervisory mentorship beyond the initial training period often receive comparatively less financial emphasis. As mentioned later in the paper, if artificial intelligence (AI) increasingly handles the routine and small claims, this does not create a pipeline of well-educated and seasoned adjusters to handle the more complex losses with the retirement of senior adjusters.

Executives routinely approve capital investments—technology platforms, product expansions, distribution initiatives—based on expected returns. Claims education can and should be evaluated using the same financial discipline. Improvements come from better scoping, more consistent coverage interpretation, earlier liability recognition, and stronger documentation.

In order to have an effective claims operation, expertise in the active supervisory review and oversight must be applied to the claim file early enough to matter. Claim supervisors, by virtue of their experience handling similar losses, are uniquely positioned to identify files that are trending toward escalation—whether through excessive reserve growth, coverage disputes, communication breakdowns, or early litigation signals—and to intervene through guidance and mentorship before those outcomes harden.

In practice, however, many organizations treat claim supervisors as additional adjusters and assign them their own caseloads. This structure introduces material risk. A supervisor, overseeing five adjusters, each carrying 200 active claims, is indirectly responsible for the trajectory of approximately 1,000 files. Even if supervisory review occurs selectively—based on complexity, tenure of the adjuster, or claim maturity—the cognitive and time demands of that oversight are substantial.

When supervisors are also responsible for managing their own files, meaningful review inevitably becomes reactive rather than preventive. Oversight occurs only after a claim has closed, escalated, or entered litigation. At that point, opportunities to influence outcome, control severity, or redirect claim strategy have largely passed. This mirrors the same triage dynamic observed when individual adjusters carry excessive workloads: attention shifts from proactive decision-making to damage control.

Accordingly, when evaluating what constitutes an adequately staffed claims organization, governing boards should distinguish clearly between the role of the adjuster and the role of the supervisor. Assigning supervisors independent caseloads undermines their primary function. A more effective structure reallocates claim volume away from supervisors by adding front-line adjuster capacity, enabling supervisors to focus on oversight, mentoring, and early intervention—where their expertise has the greatest financial impact.

The breakeven threshold is modest from a financial perspective as seen in Appendix A. If enhanced supervisory oversight prevents one major reserve misstep, one unnecessary bad-faith exposure, or one preventable excess verdict annually, the avoided volatility may exceed the cost of the supervisory role. Evaluating supervision strictly through headcount efficiency obscures this asymmetry.

Lower caseloads per adjuster and dedicated supervisory oversight are strongly associated with reduced error rates, greater file-level attention, and improved consistency of claim resolution. These conditions translate not only to lower leakage but also to improved policyholder experience.

This is not simply a stylistic management choice; it is an organizational design decision with measurable consequences for claim severity, litigation frequency, reserve development, and long-term loss performance.

5.3 The Hidden Cost of Employment

There is a cost to hiring and retaining employees, and thus far this paper has focused on the detriments of operating without an adequately staffed and properly educated claims organization. That cost, however, extends beyond payroll and immediate staffing shortages.

Another significant cost arises from turnover and onboarding. The Society for Human Resource Management (SHRM) found the average cost to hire a new employee in 2025 is approximately $4,700. Deloitte has estimated that employee turnover can carry replacement costs equal to roughly 1.5 to 2 times annual salary, reflecting not only direct recruiting and onboarding expenses, but also the indirect productivity losses associated with vacancies, training time, and delayed proficiency.

Using Kansas compensation figures, replacing a claims adjuster may cost an insurer approximately $119,910 to $159,880 when salary-based replacement assumptions are applied. [6] Yet the true financial impact is often deeper and less visible in standard expense reporting.

Research published by Kellogg Insight suggests that otherwise healthy companies may experience profitability declines of approximately 3% when they are not properly staffed. In claims operations, unfilled roles do not simply reduce capacity; they increase file inventories for remaining staff, delay file movement, and place additional strain on experienced adjusters and supervisors. Over time, this can contribute to burnout, increased attrition, and cascading vacancy costs that materially exceed the apparent savings associated with delayed hiring.

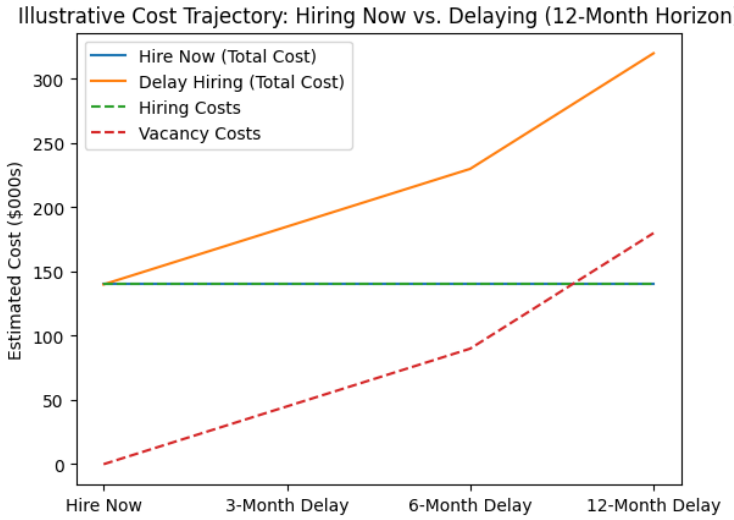

Figure 8 is an illustrative model demonstrating how vacancy costs compound over time and can materially exceed the known cost of hiring, even when recruiting costs are readily quantifiable.

State departments of insurance increasingly examine operational adequacy when elevated complaint levels, delayed communications, or claim-handling inconsistencies emerge. Market conduct examinations assess timeliness, documentation, and continuity through structured, fact-based review processes. These examinations serve as a formal mechanism for evaluating operational discipline and consumer impact. Staffing adequacy is, therefore, not solely an

[6] Kansas average adjuster salary $79,940 x 1.5 = $119,910; $79,940 x 2 = $159,880

internal efficiency consideration; it also carries regulatory and reputational implications that may influence capital planning and surplus strength.

In California, the Department of Insurance identified "troubling patterns… including the frequent reassignment of multiple adjusters with little continuity in communication, inconsistent management of similar claims, and inadequate record-keeping or information-sharing among claims teams," noting that such practices prolonged recovery and eroded consumer trust.

Louisiana has codified concerns regarding claim continuity during catastrophe events. Under La. R.S. 22:1264, when an insurer changes the adjuster primarily responsible for a claim three or more times within a six-month period, the insurer must provide a written status update, assign a primary contact, and furnish multiple direct communication channels. While enacted in the catastrophe context, the statute illustrates a broader operational principle: repeated reassignment often reflects staffing strain, surge-capacity limitations, or turnover, all of which can increase delay, consumer dissatisfaction, and downstream claim costs.

Colorado has similarly codified continuity concerns. Under C.R.S. § 10-4-110.8(III), insurers must provide a written status report when a policyholder is assigned a third or subsequent adjuster within a six-month period. Like Louisiana's statute, this requirement reflects a broader regulatory recognition that repeated adjuster reassignment is not merely an administrative inconvenience, but an operational control issue with implications for delay, consumer trust, and downstream claim cost.

The recurrence of substantially similar statutory requirements across multiple jurisdictions strongly suggests that continuity breakdown has become a recognized systemic claims-handling risk rather than a jurisdiction-specific concern.

Separate from continuity concerns, the California Department of Insurance's targeted market conduct examination involving Allstate's post-wildfire operations resulted in approximately $7.46 million in additional claim payments and interest to policyholders. Importantly, this corrective action appears to have arisen substantially from valuation, disclosure, and underwriting-control deficiencies—including replacement-cost estimate communication and dwelling characteristic discrepancies—rather than from claims staffing alone.

That distinction strengthens rather than weakens the broader thesis of this paper: operational control failures, whether in staffing, supervision, documentation, or valuation processes, ultimately emerge as downstream financial costs. In this instance, a single regulatory corrective action represented nearly 90 times the annual base salary of a Kansas-based claims supervisor. Claims departments frequently absorb the financial consequences of control failures originating elsewhere in the insurance value chain.

The question for executive leadership is not merely whether staffing costs should be managed, but whether apparent expense savings today create deferred cost recognition tomorrow through turnover, operational disruption, regulatory exposure, or corrective payments.

5.4 Artificial Intelligence, Workflow Compression, and the Human Judgment Gap

Artificial intelligence (AI) is increasingly shaping claims operations, primarily by improving efficiency in administrative and analytical tasks. Current applications include organizing claim notes and documents, summarizing files and recorded calls, and supporting pattern recognition across large claim portfolios. Bain & Company estimates that effective deployment of AI tools could result in a 20–25% reduction in loss adjustment expenses and a 30–50% reduction in leakage, producing "more than $100 billion in benefits for insurers and customers" (Donnelly et al.). As a result, carriers are being encouraged to scale investment in these technologies.

Chubb's CEO Evan Greenberg stated that the automation or digitization of approximately 70% of claims and underwriting processes reflects a broader industry movement toward workflow compression, administrative automation, and straight-through processing. While these developments may materially reduce time spent on repetitive tasks, they do not proportionately reduce the need for licensed, professional judgment.

This distinction is critical. The percentage of workflow steps that can be automated is not equivalent to the percentage of professional judgment that can be removed from the claim process. Administrative activities such as first notice of loss intake, document ingestion, estimate summarization, diary management, and payment workflow routing may be materially accelerated through AI-enabled systems. However, the remaining work frequently consists of the most legally consequential and judgment-intensive aspects of claims handling, including coverage analysis, causation determinations, denial decisions, settlement negotiation, and litigation-sensitive communications.

From a financial perspective, any apparent savings from staffing reductions must be evaluated in the context of cost migration. The cost does not disappear; it simply moves from one envelope to another—whether from payroll and training expense to indemnity leakage, litigation cost, supervisory remediation, and regulatory exposure.

5.4.a AI Workflow Compression

Artificial intelligence is best understood as a force multiplier, not a substitute, in claims operations.

AI tools increase efficiency by accelerating information processing, standardizing routine tasks, and highlighting patterns across large portfolios. These capabilities reduce administrative friction and support consistency, but they do not reduce the underlying need for professional judgment. In practice, AI shifts the nature of claims work toward higher-value decision-making rather than eliminating it.

As automation handles more transactional activity, the marginal impact of human decisions increases. Errors in judgment, evaluation, or escalation carry greater financial consequence when they are amplified across automated systems. In this environment, fewer—but less-experienced—adjusters do not reduce risk; they concentrate it.

For boards and senior leadership, the implication is straightforward:

> AI investment strengthens the return on experienced, well-trained adjusters and supervisors. It does not replace them. Organizations that pair advanced tools with

under-resourced or over-extended claims staff risk accelerating poor outcomes rather than preventing them.

Executives may view claim correspondence as an administrative task suitable for automation; however, even routine status letters are often subject to specific regulatory content requirements that depend on claim-specific judgment. Pennsylvania regulations, for example, require insurers that need additional time to investigate a first-party claim to provide the insured with a letter explaining why additional time is needed and when a decision may be expected.

These communications are not merely clerical. They require the adjuster to assess the status of the investigation, identify what remains outstanding, and communicate a reasonable anticipated timeline. The failure to adequately inform the insured has itself been cited as a market conduct issue. Accordingly, automating claim correspondence without meaningful claim-specific human judgment risks accelerating regulatory noncompliance rather than operational efficiency.

Accordingly, claims technology and claims staffing should be evaluated together as a single capital strategy. Efficiency gains from AI are realized only when qualified professionals are available to interpret outputs, intervene early, and apply judgment where automated systems cannot.

AI may assist with workflow routing, document organization, claim note synthesis, and identification of communication deadlines; however, substantive claim communications that require claim-specific reasoning, regulatory compliance, or licensed judgment should remain the responsibility of the adjuster.

5.4.b. AI Human Judgment Gap

In practical terms, AI may reduce administrative task time while simultaneously increasing cognitive load per adjuster by concentrating complex claim decisions among fewer professionals within the same claim unit. One adjuster may be required to handle the volume of work historically distributed across multiple adjusters in that same unit, even if the routine administrative touches on each file have been reduced.

It is important, however, to recognize that insurers have been using forms of artificial intelligence in claims for decades. Tools such as Xactimate and Colossus represent early examples. Xactimate enables adjusters and contractors to generate structured estimates for property damage, while Colossus produces bodily injury settlement recommendations based on inputs provided by adjusters regarding injury characteristics, treatment, and other claim factors.

These tools illustrate an essential distinction: AI functions as a decision-support mechanism, not as a decision-maker. Like a calculator, AI can accelerate processing, improve consistency, and surface insights, but it does not replace professional judgment. The outputs of systems such as Colossus depend entirely on the quality, completeness, and judgment applied to the underlying inputs.

That distinction has legal and operational significance. In the early 2000s, carriers' use of Colossus became the subject of class action litigation alleging biased claim outcomes. While the technology itself was central to the allegations, the litigation underscored a broader point: responsibility for claim decisions rests with the insurer, not the software. Delegating evaluative

judgment to automated systems without sufficient human oversight introduces both financial and governance risk.

Human sign-off is not equivalent to meaningful human review if workload compression makes independent analysis impracticable. In such environments, adjusters may increasingly rely on system-generated recommendations, top-sheeting the file by reviewing summary notes, draft coverage positions, or recommended payment amounts without fully independently validating policy language, causation evidence, scope reasonableness, or jurisdictional legal considerations.

The presence of a human signature on a coverage letter or payment authorization does not, by itself, establish that meaningful human judgment occurred. AI may summarize an estimate, identify potential variances, and prepare a draft payment recommendation, but the licensed adjuster must still independently verify whether the estimate is reasonable, whether the claimed damage is causally related to the covered event, whether depreciation or matching issues are implicated, and whether the proposed payment aligns with the policy's insuring agreement and applicable endorsements.

Regulators have increasingly recognized the need for governance controls surrounding AI use in insurance. The NAIC Model Bulletin on the Use of Artificial Intelligence Systems by Insurers and related state-level guidance emphasize that accountability remains with the insurer and its licensed professionals, even where AI systems assist with claim administration and decision support. This reinforces that AI may support workflow execution, but it does not displace professional responsibility for claim outcomes.

Emerging research on AI-assisted cognition further suggests that time savings in routine tasks do not necessarily translate into increased capacity for more complex analytical work. In claims operations, efficiency gains on routine files do not automatically create proportional capacity for complex property, liability, or catastrophe matters. Indeed, the automation of routine claims may create a long-term workforce development concern by reducing the volume of simpler files through which adjusters historically develop the judgment required for more complex claims.

Accordingly, while AI can and should be leveraged to enhance efficiency and reduce administrative burden, it does not eliminate the need for experienced adjusters and supervisors. On the contrary, the more claims organizations rely on advanced tools, the greater the need for skilled professionals capable of interpreting outputs, exercising judgment, and intervening when claim trajectories require human expertise.

The Practical Roadmap

In order to produce real and lasting change, insurance executives would include adjuster education as an investment measurement, treat reserve variability as a system diagnostic, and annually review the ROI on adequate adjuster education and staffing.

1. Measure Education as Any Other Capital Project

Executives routinely approve capital projects—new systems, new distribution channels, operational redesign—based on projected return on investment. Adjuster education warrants evaluation under the same financial discipline.

If claims outcomes materially influence the company's financial performance, then claims expertise functions as a strategic asset rather than a back-office support activity. Governance structures and reporting visibility should align with that reality.

The objective is not to treat education as symbolic or discretionary. It is to apply the same financial discipline used everywhere else in the enterprise. Senior claims leadership incentives are often tied to expense ratios and closure velocity. These should be balanced with:

- Reserve discipline
- Reduction in loss leakage
- Development of adjuster expertise
- Stability of long-tail outcomes

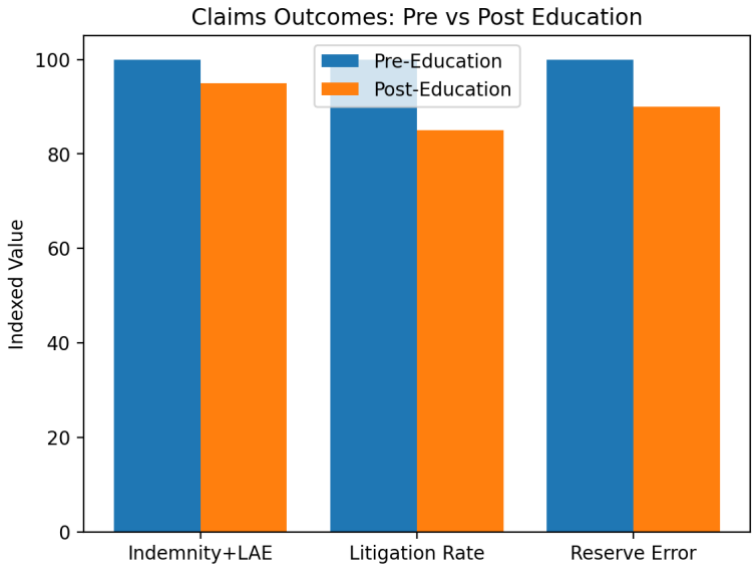

Figure 9 is an illustrative model comparing claim outcomes for a defined group of adjusters before and after structured education, against a matched comparison group.

The objective is not to attribute all improvement to training, but to isolate directional changes in indemnity, LAE, reserve variance, and litigation incidence relative to peers. Such alignment shifts emphasis toward decision quality rather than volume metrics and reduces the incentive to prioritize short-term expense compression at the expense of long-term stability.

When the governing board recognizes that claims expertise—through education and appropriate staffing—is a core determinant of long-term financial strength rather than an operational detail, measurable effects typically include reductions in both hard expenses, such as LAE, and soft costs, such as employee turnover and onboarding.

Claims education should be budgeted and governed like infrastructure:

- Dedicated annual education budgets
    - A fixed allocation of $1 million, for example, could send adjusters, physically, to:
        - national claims seminars,
        - property/auto/GL specialty schools,
        - fraud/SIU certifications,
        - Xactimate/estimating courses,

        - and adjuster designations (CPCU, AIC, CLMP, SCLA).
- Annual reporting on:
    - Staffing levels and caseload distribution
    - Education participation and credential completion
    - Impact of staffing and training on loss outcomes
- Broad educational participation across experience levels
- Protected study time as a formal policy, not a perk

Education programs that reach many adjusters at moderate cost often outperform small elite programs with limited reach.

They should also dedicate one hour per adjuster per week—off the phones, guaranteed—for structured, employer-supported professional education. This is the only way to turn education from a "nice-to-have" into a quantifiable operational improvement.

2. Treat Reserve Variability as a System Diagnostic — Not an Adjuster Diagnostic
Reserve accuracy and development trends must be analyzed at the system level, not interpreted as evidence of individual adjuster performance. Tracking reserves not only from initial to ultimate reserve, but also from ultimate reserve to ultimate settlement amount will:

- Identify units or regions with consistently lower reserve error and fewer late, large reserve increases on the same line of business.
- Examine whether those units have:
    - Lower caseloads,
    - More experienced adjusters,
    - More structured supervision, or
    - Higher rates of completed training and designations.

When caseloads exceed sustainable thresholds or when adjusters lack adequate training, support, or supervisory bandwidth, KPI performance will deteriorate regardless of individual capability.

In these instances, reserve volatility signals a structural failure of load, resources, process design, and a failure to be properly staffed.

3. Evaluate the Claim Department Staffing and Educational ROI Annually
Just as capital projects are reviewed annually, claims education and staffing investments should be reassessed each year using outcome-based financial metrics. Programs demonstrating measurable improvement warrant expansion; those that fall short warrant refinement rather than abandoned reflexively.

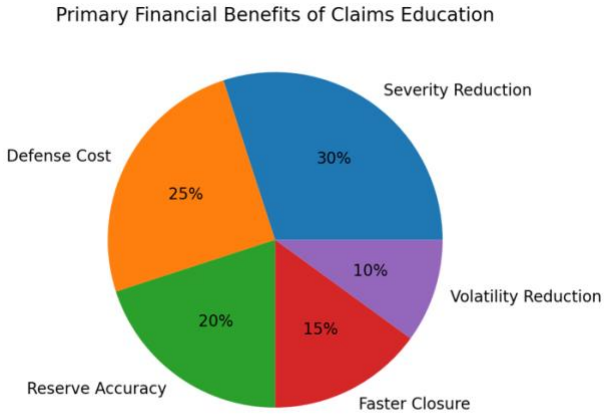

Figure 10 is an illustrative model demonstrating how financial benefits from claims expertise are distributed across multiple outcome drivers.

Improvements often emerge first in reserve accuracy and litigation avoidance, followed by reductions in LAE and indemnity as files mature. Given the multi-year nature of claim development, these shifts may not be fully visible within a single fiscal year.

A sustainable claims strategy also requires explicit attention to the talent pipeline. Claims capability is not static; it depends on the ongoing development, supervision, and retention of experienced professionals. As senior adjusters retire or transition roles, unstructured replacement increases file-level variance, supervisory strain, and reserve instability.

The claims profession faces a structural pipeline imbalance. Entry-level talent is frequently directed toward distribution and underwriting roles, while claims positions are often overlooked. External occupational classifications may describe claims adjuster roles as requiring only a high school diploma or equivalent. Whether or not that baseline fully reflects the complexity of modern claims handling, it signals that the potential labor pool is broader than many carriers' current recruitment filters suggest.

Organizations that require four-year degrees as a default screening mechanism may unintentionally constrain their pipeline. An alternative approach is to recruit capable candidates from a wider educational base and pair that recruitment with structured education, certification pathways, and tuition support aligned with claims-specific competencies.

Boards should consider proactive alignment between recruitment strategy, community college partnerships, and structured professional certification pathways to ensure a sustainable inflow of claims talent equipped for long-horizon financial responsibility. Structured tuition support tied to relevant risk management or insurance curricula can increase entry-level capability density while reducing onboarding time and supervisory burden.

4. The Claims Department's Interactions with Other Departments

The claims department is often the first enterprise function to know that the insured risk no longer matches the risk originally priced. Claims frequently absorb the downstream financial consequences of underwriting, mis-valuation, and distribution errors because it is the first department to encounter the actual loss facts. Through inspection reports, estimates, photographs, statements, and causation analysis, the claims department often becomes the earliest point at

which material discrepancies in risk profile, insured values, or exposure assumptions are identified.

Artificial intelligence may be particularly effective in identifying and routing risk-profile discrepancies discovered during the claims investigation process to underwriting and distribution teams for prospective policy corrections, valuation updates, and premium adequacy review.

5. Board Action Checklist: Questions for Management
For practical governance application, boards and executive leadership should use the questions in Appendix B as a concise management oversight checklist. These questions are derived from the measurement framework and financial indicators discussed in Section 5.2, "What Executives Should Measure," and are intended to facilitate rapid review of whether claims capability, staffing, supervision, and technology investments are aligned with long-term capital stability. It is not intended to be exhaustive; rather, it is designed as a high-level governance tool to prompt management discussion and identify areas requiring deeper operational review.

Conclusion
Claims staffing and education should be understood as long-horizon capital decisions whose financial effects emerge over accident years, not fiscal quarters. Treating them as discretionary expenses to be optimized annually misaligns governance with the economic reality of the insurance product.

Boards and executive teams that expect immediate earnings improvement from claims cost reductions risk mistaking timing shifts for true profitability. Short-term expense relief achieved through higher workloads or reduced training often defers cost recognition into future periods through adverse reserve development, higher settlements, and increased litigation intensity.

The evidence assembled in this paper—most notably the SCRTD/MTA case, supported by modern carrier experience, public-entity risk pools, and reinsurer research—is consistent with the idea that claims outcomes are not random. They are shaped by workload design, experience, supervision, and the consistent application of professional judgment. When claims organizations are adequately staffed and supported, ultimate loss costs and reserve volatility decline. When they are not, capital risk increases.

Any examples involving specific carriers are based solely on public disclosures, regulatory findings, and publicly reported operational metrics; no internal staffing, file-level, or proprietary claims data was available for review.

This paper does not contend that staffing or education alone directly cause all claims outcomes. Claims severity, litigation environment, catastrophe frequency, jurisdictional differences, and underwriting practices all materially influence ultimate loss cost. Rather, the evidence supports a directional relationship consistent with the SCRTD/MTA mechanics: claims staffing, supervision, workload, and professional development are among the operational variables that materially influence reserve stability, leakage, and long-term financial volatility. Boards should treat claims capability as one of the controllable levers within a broader performance system.

Accordingly, the analysis should be read not as a claim of single-variable causation, but as an evidence-based examination of how claims operating structures correlate with measurable financial outcomes over multiple accident years.

Artificial intelligence and advanced analytics strengthen this conclusion rather than undermine it. While these tools improve efficiency and consistency, they do not replace judgment. Instead, they increase the scale and speed at which human decisions affect financial outcomes. Boards should assume that AI magnifies the financial impact of human judgment, good or bad. Under-resourced or inexperienced claims teams using powerful tools can accelerate poor outcomes at scale.

For governing boards, the strategic choice is not between controlling claims expense and protecting profitability. It is between managing claims capability as a core financial asset or allowing long-tail risk to accumulate outside the visibility of short-term metrics.

Organizations that recognize claims staffing and education as investments—measured, governed, and reviewed alongside other capital deployments—are better positioned to manage severity trends, stabilize earnings, and protect surplus in an increasingly volatile legal and social environment. Those that do not may find that apparent savings today are offset by materially higher costs tomorrow, when the true economics of their claims decisions finally emerge.

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- CNA Financial
  - Years reviewed: approximately 2015–2024
- Florida Municipal Insurance Trust (FMIT)
  - Years reviewed: approximately 2011–2024
- Gen Re Research Briefings
  - Years reviewed: multiple briefings 2019–2024
- Minnesota League of Cities Insurance Trust (LMCIT)
  - Years reviewed: approximately 2019–2023
- Progressive Corporation
  - Years reviewed: approximately 2018–2024
- SCRTD / MTA (Southern California Rapid Transit District / Los Angeles County MTA)
  - Years reviewed: approximately 1987–1994
  - Information from Frederick J. Fisher, JD, CCP
- Swiss Re (Sigma Reports)
  - Years reviewed: multiple studies published 2018–2024
- Texas Municipal League Intergovernmental Risk Pool (TMLIRP)
  - Years reviewed: approximately 2018–2023
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About the Author

Chantal M. Roberts, CPCU, AIC, RPA, ITP is a claims consultant, educator, and author with more than two decades of experience in property and casualty claims handling and management. Her professional background spans front-line adjusting, team leadership, and claims management roles across a broad range of lines, including commercial auto, personal auto, commercial property, homeowners, catastrophe claims, inland marine, and general liability.

Ms. Roberts' perspective is informed by direct, hands-on experience managing claim inventories, supervising adjusters, and making real-time coverage, reserving, and settlement decisions under operational constraints. In addition to her industry roles, she has served as an expert witness, where her work frequently involves reconstructing claim file histories to identify when and why outcomes deteriorated. In that context, she has consistently observed that adverse claim outcomes often trace back to a specific operational inflection point: excessive caseloads that force adjusters into triage rather than thoughtful claim evaluation.

This paper reflects Ms. Roberts' synthesis of that professional experience with publicly available carrier information, industry research, and historical claims studies. While much of the publicly accessible data does not isolate claims staffing variables with precision, the underlying patterns are consistent with what claims professionals observe in practice: staffing levels, training, and experience materially influence indemnity, allocated loss adjustment expense, reserve development, and litigation outcomes.

The foundational empirical support for this analysis includes legacy claims work conducted by Frederick J. Fisher, JD, CCP, whose research provides rare longitudinal insight into how claims staffing and handling practices affect ultimate loss costs. Ms. Roberts' role in this paper is to interpret and contextualize those findings within modern claims operations, financial reporting realities, and board-level decision-making frameworks.

Ms. Roberts is an independent consultant and researcher. Ms. Roberts also serves as an instructor in Risk Management and Insurance at the community college level. She has no financial interest in staffing vendors, training providers, or claims technology platforms. The views expressed are intended to support informed governance and long-term financial stewardship of insurance operations, rather than to advocate for any specific commercial solution.

About the Collaborator

Frederick J. Fisher, JD, CCP, is the President of Fisher Consulting Group, Inc., and a nationally recognized authority on insurance claims operations, professional liability, and claims cost analysis. His career spans more than four decades and includes senior roles across claims adjusting, claims auditing, third-party administration, underwriting, and specialty insurance distribution.

Mr. Fisher began his career as an independent E&O claims adjuster and later acquired and expanded a claims firm that provided qualitative claim audits, risk management, loss control services, and TPA functions. His claims auditing methodologies and attorney management standards produced substantial cost savings for large public-sector and private-sector clients, including the Southern California Rapid Transit District (now the Los Angeles County Metropolitan Transportation Authority). Many of the performance benchmarks and attorney

management frameworks he developed were subsequently adopted by insurers and remain in use today.

In addition to his consulting work, Mr. Fisher founded and led a wholesale brokerage and MGA specializing in professional liability and specialty lines. He has lectured extensively since the late 1970s, giving more than 180 presentations, authored more than eighty articles in industry publications, and serves in faculty and leadership roles for the Claims College and the Claims & Litigation Management Alliance. He is a Founding Member of the Professional Liability Underwriting Society (PLUS), a Past President (1998), and was awarded the PLUS Founders Award in 2019. He is also a frequent expert witness in matters involving professional liability, coverage interpretation, and claims-made policy issues.

Mr. Fisher's research and professional work emphasize the long-term financial consequences of claims staffing levels, claim handling practices, and organizational design—particularly in long-tail lines where claim outcomes may not fully emerge for decades. In this paper, his work provides the empirical foundation for evaluating claims staffing and expertise as strategic capital decisions rather than short-term operating expenses. Responsibility for synthesis, interpretation, and application to current carrier operations rests with the author.

Disclaimer

Except for materials, charts, and analysis provided directly by Frederick Fisher, research on individual insurers, industry benchmarks, and professional development outcomes was conducted with the assistance of an AI research tool. That tool was used to locate, compile, and synthesize publicly available information. Any errors in factual research are attributable to that process.

All analysis, interpretation, conclusions, and opinions expressed in this paper are solely those of the author.

Charts included in this paper are illustrative in nature. They are not based on proprietary carrier data and are intended to demonstrate analytical frameworks that executive teams may apply using their own internal information.

Appendix A: Illustrative Supervisory Staffing Example

Kansas compensation figures are used solely as an illustrative midpoint to avoid distortion from higher-cost coastal labor markets and to provide a conservative baseline for the supervisory staffing example. The employment search engine, Indeed, states the average base salary of an adjuster in Kansas is $79,940 and the average base salary of a claim supervisor in Kansas is $91,661.

Scenario 1—Team Leader Dual Role (supervisor with pending)

If a team leader carries 50 files and operates as a supervisor to four other adjusters, a carrier can "save" $79,940 in salary. This section does not yet count the "cost of employment" which is mentioned in section 5.3 below.

- Adjuster base salary: **$79,940 x 4 adjusters = $319,760**
- Supervisor base salary: **$91,661**
- Total team base payroll:

$$\$319{,}760 + \$91{,}661 = \$411{,}421$$

Scenario 2—Dedicated Team Leader

However, if the team leader was dedicated solely to a supervisory position, one other adjuster would be needed.

- Adjuster base salary: **$79,940 x 5 adjusters = $399,700**
- Supervisor base salary: **$91,661**
- Total team base payroll:

$$\$399{,}700 + \$91{,}661 = \$491{,}361$$

Considering a simplified illustration, if a single adjuster handled 1,000 files annually and average paid severity exceeded underwriting expectations by $1,500 per file due to incremental settlement drift, documentation gaps, or delayed corrective oversight, the aggregate variance would total $1.5 million. Across a five-person team, the variance would reach $7.5 million.

Even if supervisory review mitigates a portion of that variance, the illustration demonstrates the asymmetry of scale: relatively small per-file deviations compound materially across high-volume portfolios.

The Break-Even Point

- 5 adjusters × 1,000 claims each = 5,000 claims/year
- Leakage reduction needed to justify the dedicated team leader:

$$\$79{,}940(adjuster\ salary) \div 5{,}000\ (claims) = \$15.99$$

The dedicated team leader needs to reduce leakage approximately **$16 per claim** (across the team) to break even.

Or, using the $7.5M leakage figure:

$$\$79{,}940 \div \$7{,}500{,}000 = \mathbf{1.07}\%$$

A dedicated team leader needs approximately 1.07% reduction in leakage in the illustrative $7.5M team estimate to justify their salary.

Appendix B: Board Action Checklist

To translate the findings of this paper into actionable governance oversight, boards and executive committees should require clear management reporting on the following questions. This checklist is not intended to be exhaustive; rather, it is designed as a high-level governance tool to prompt management discussion and identify areas requiring deeper operational review.

1. What is our average open caseload by line of business, claim complexity, and adjuster tenure band?
2. How do reserve accuracy and prior-year reserve development vary by caseload intensity and supervisory span?
3. What is our annual per-adjuster investment in technical education, CE, supervisory coaching, and post-trainee development?
4. What percentage of claims are reopened, escalated to litigation, or require supplemental payments after initial closure?
5. How do claim quality outcomes vary across adjuster experience levels and training cohorts?
6. Which current KPIs measure long-term financial outcome (indemnity, LAE, reserve development) rather than only short-term throughput?
7. How are AI and workflow automation initiatives being evaluated alongside staffing adequacy, supervisory capacity, and claim quality controls?