Actuarial Guidance on Organized Crime Loss Distortion for Captive Insurers

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One of the most exciting parts about working with captive insurance companies and self-insureds is the next phone call, which you never know what may hold. An emerging industry? A new risk exposure? A scary claim? A billionaire tired of paying for insurance? A new captive insurance structure? You never know. And sometimes they catch you completely off guard. For example.…

It started with a simple enough phone call. A client called me last summer and asked if I had heard about recent RICO lawsuits. (He immediately had my undivided attention.) RICO stands for the Racketeer Influenced and Corrupt Organizations Act, a federal law passed in 1970, which was intended and used to prosecute organized crime.

Apparently, the *Insurance Journal* and other publications had just broken a story about a massive insurance fraud ring in New York City.[1] (As an aside, the headline is quite an attention-getter.) The article included allegations of staged workers compensation and auto personal injury protection (PIP) claims that used a network of physicians under their control. There are even allegations of organized crime and other "lenders" financing the fraudulent activities.

According to the allegations in the media articles, the ring was colluding with a group of physicians to create millions of dollars of fraudulent medical treatments, notably workers compensation and commercial automobile claims, particularly no-fault or PIP claims. In the *New York Post* article, the Tradesman Program Managers' contractors insurance program noted that "it forked over $142 million in 2022, three times the $36 million it paid out in 2018. It claims it has been hit with 650 allegedly fraudulent suits over the last four years."[2]

And it wasn't just Tradesman. American Transit Insurance Company (ATIC), a large livery insurer, has filed a $450 million lawsuit against over 180 defendants in the New York and New Jersey area.[3] Other insurance companies have represented to me that they are now finding that the same physicians associated with this fraud ring have been providing treatments to their workers compensation or auto liability PIP claims in recent years. Based on the available information, this fraud ring has had a material impact on commercial auto and workers compensation insurance availability and affordability in New York City for contractors, livery companies, and trucking companies. Sounds like something right out of a John Grisham novel, but where does the actuary come in?

Enter the Actuaries

Some actuaries may think there is precious little specific guidance in actuarial literature to assist an actuary in dealing with fraud orchestrated by organized crime and its impact on an insurance program. But is that true?

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[1] "Racketeering Suit Alleges NY Insurance Fraud Scheme by Lawyers, Medical Providers," *Insurance Journal*, June 19, 2025.

[2] Brad Hamilton and Georgia Worrell, "MS-13, Russian Mobsters Use Migrants in Elaborate Injury Scam—Even Getting Spinal Surgery to Pull It Off: Sources," *New York Post*, June 16, 2024.

[3] "American Transit Insurance Company Files over $450 Million Insurance Fraud Case Against over 180 Defendants," ATIC, December 17, 2024.

Actuaries in the US are governed by Actuarial Standards of Practice (ASOPs) promulgated by the Actuarial Standards Board (ASB). These ASOPs provide broad guidance on what an actuary should consider, document, and disclose when performing an actuarial assignment, dealing with the following broad subjects.

- ASOP No. 23, Data Quality
- ASOP No. 36, Statements of Actuarial Opinion Regarding Property/Casualty Loss, Loss Adjustment, or Other Reserves
- ASOP No. 41, Actuarial Communications
- ASOP No. 43, Property/Casualty Unpaid Claim Estimates
- ASOP No. 53, Estimating Future Costs for Prospective Property/Casualty Risk Transfer and Risk Retention

I have had the pleasure of serving on the Casualty Committee of the ASB and helping to draft numerous ASOPs and revisions to them. While organized crime is not *specifically* mentioned in any of the ASOPs, there is a surprising amount of guidance for actuaries facing similar situations. Let's examine the types of guidance an actuary may rely on in developing a prospective funding study or loss reserve analysis for an insurance program that has potentially hundreds of fraudulent claims in their historical loss runs.

Actuaries deal with many sorts of operational changes within a self-insured business. Examples include changing safety or loss control programs, new hiring protocols (e.g., experience requirements for truck drivers), mergers and acquisitions, technology (e.g., telematics or lane monitoring devices), and changing claims processes or third-party claims administrators. External forces, including economic or social inflation, legislative or judicial changes, re-underwriting of a group captive or group self-insured, global pandemics, tariffs, and many others, also arise. It turns out that the actuarial process for dealing with these forces is quite similar.

Document, Document, Document

The first step for an actuary in dealing with a change in external conditions is the documentation of facts. What happened? When? How and when was the situation identified? ASOP No. 43 provides the following guidance.

> The actuary should consider whether there have been significant changes in conditions, particularly with regard to claims, losses, or exposures, that are likely to be insufficiently reflected in the experience data or in the assumptions used to estimate the unpaid claims.
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> Source: ASOP No. 43, §3.6.7.

When an actuary first learns about a change in external conditions, the actuary is trying to assess how the external changes could impact factors such as claim frequencies, severities, case reserves, payment or settlement patterns, claims closed without payment, recoveries, and/or shifts between losses (indemnity) and defense costs.

In the case of a client informing us of a potential fraud ring, I immediately had several questions, including the following.

- When did the alleged fraud begin?
- How many claims were involved?
- Is there a way to identify potential fraud claims in the loss data?

- What efforts have been made to stop the fraud (e.g., have insureds or the police been notified)?
- Have claims handling practices been changed? When?
- Have case reserving practices changed? How? When?
- Are claims being closed without payment? When?

Documenting the facts and circumstances well and considering their potential impact on the insurance program (and, therefore, the actuary's data, methods, and assumptions in the analysis) will be invaluable when the actuary is considering those impacts in their data, methods, and assumptions. You need to evaluate the potential impacts before you try to quantify them. Similarly, early documentation expedites writing the actuarial report or other communication.

What Can We Measure?

After establishing a working understanding of the situation, the actuary will move on to trying to quantify the impact of the environmental change(s). Some of the primary guidance for reserving actuaries can be found in ASOP No. 43:

> When determining whether there have been known, significant changes in conditions, the actuary should consider obtaining supporting information from the principal or the principal's duly authorized representative and may rely upon their representations unless, in the actuary's professional judgment, they appear to be unreasonable.
>
> Source: ASOP No. 43, §3.6.7.

Similar guidance for actuaries performing rate-making can be found in section 3.8 of ASOP No. 53:

> The actuary should determine the extent to which historical data (premium, exposure, loss, and loss adjustment) are available and *appropriate* for estimating future costs. [Emphasis added.]
>
> Source: ASOP No. 53, §3.8.

In this example, detailed histories of the potentially fraudulent claims were essential. Once we were able to develop identifiable characteristics for the individual impacted claims, it was possible to then assess the following.

- Paid and incurred loss triangles for fraud-only claims
- Closed and reported claim counts for fraud-only claims
- Defense and cost-containment detail for the claims

In essence, the fraud claims needed to be segregated in a manner similar to how an actuary might separate out catastrophe claims or in more recent vintage COVID-19 cases.

What Adjustments Need to Be Made?

After documenting the nature of the changes in the claims environment and identifying the available data, the actuary will consider modifying the data, methods, and assumptions in the analysis. ASOP No. 23 puts it this way:

> The actuary should make a professional judgment about (whether) … the data require(s) enhancement before the analysis can be performed and/or … judgmental adjustments or assumptions can be applied to the data that allow the actuary to perform the analysis.
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> Source: ASOP No. 23, §3.4.b and §3.4.c.

These professional judgments are an incredibly important part of the role of an actuary dealing with operational changes or environmental issues impacting an insurance program.

For the fraud scenario that we are considering, one approach to adjusting the loss reserve and/or rate-making analyses would be to essentially segregate out or isolate the claims potentially impacted by the fraud activity and evaluate them separately. This could impact current valuations of case reserves, loss development patterns, expected loss ratios, ultimate claims counts, and severities, which is the Bornhuetter-Ferguson method … all leading to revisions to ultimate loss estimates.

ASOP No. 53, Section 3.8.4, provides similar guidance and says:

> The actuary should consider whether additional adjustments to the historical data are needed to reflect the environment expected to exist in the period for which the future costs are being estimated.
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> Source: ASOP No. 53, §3.8.4.

"Consider" is a really interesting word in ASOPs and comes with a certain level of nuance. Consider does not mean "must modify," nor does it mean "must give full credence or credibility." Purely hypothetically, a managing general agent might tell an actuary how their long-haul trucking program for owner-operators is so much better than the industry that they believe the rates per powered unit should be half of those charged by the rest of the industry. After discussions and review of the program, the actuary finds the following.

- No documentation of stricter underwriting criteria
- Safety and loss-control protocols consistent with industry standards
- The program has only been in operation for 6 months
- Very little credible claims experience
- No vehicle type, load type, or geographical characteristics that would indicate lower loss costs

In this case, documenting the information that the actuary considered while making no modifications to the analysis is likely appropriate.

One common challenge for actuaries dealing with internal operational changes is appropriately reflecting the impact of changes. An important truth that I have learned in my years of practice is that operational improvements are rarely instantaneous or perfectly effective. As a result, an actuary who gives "full credit" for operational changes is likely overcompensating. In the fraud case that we've been examining, an assumption that all potentially fraudulent open claims, including defense costs, will be closed without payment is likely to be optimistic. Similarly, the potential for subrogation or other recoveries in this matter is a complicated, drawn-out matter at best. By the same token, operational changes entirely are not permitted at all and must be considered in some way.

Document Again

Once the revisions (if any) have been made to the analysis, it is time to produce the actuarial report.

A number of the actuarial standards have relevant guidance on disclosures in the report.

Obviously, this situation presents a significant data issue, so it makes sense that one of the key applicable ASOPs would be ASOP No. 23, Data Quality. Section 3.1 states:

> If significant data limitations are known to the actuary, the actuary should disclose those limitations and their implications.
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> Source: ASOP No. 23, §3.1, Data Quality.

In the fraud case, this might be an issue if the fraud claims were difficult to identify or isolate. Even if you can identify and isolate the potential fraud claims, there may well still be a material data limitation.

Another cornerstone standard is ASOP No. 41, which deals with actuarial communications, such as reports. Relevant to dealing with material amounts of fraud in an insurance program, it provides guidance such as the following.

> The actuary should consider what cautions regarding possible uncertainty or risk in any results should be included in the actuarial report.
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> Source: ASOP No. 41, §3.4.1.

ASOPs No. 36 and 43 provide similar guidance focused on loss reserves. This documentation of sources of uncertainty is an important element of most loss reserve reports.

In addition, if the fraud was discovered subsequent to an actuarial analysis, section 3.4.6 of ASOP 43 suggests that the actuary should disclose the event if it becomes known after the last information date and before the report is issued and it has a material effect on the findings. ASOP No. 41 also provides extensive guidance on the types of disclosures required in the report.

If the limitations in the available data create a material constraint to the actuary's analysis, ASOP No. 43, section 3.2, states:

> Where, in the actuary's professional judgment, the actuary believes that such constraints create a significant risk that a more in-depth analysis would produce a materially different result, the actuary should notify the principal of that risk and communicate the constraints on the analysis to the principal.
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> Source: ASOP No. 43, §3.2.

This is an important disclosure for any actuary in a situation where they are materially constrained by imperfect data. ASOP No. 43 goes on to give guidance for the even more difficult situation in which the data constraints are so pronounced that the actuary simply cannot form an opinion. ASOP No. 43, section 3.8.5, states:

> If the actuary cannot reach a conclusion due to deficiencies or limitations in the data, analyses, assumptions, or related information, then the actuary should either state that no opinion could be rendered or choose not to render an opinion.
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> Source: ASOP No. 43, §3.8.5.

In both of these situations, it is essential that the intended user and other readers of the report understand the circumstances under which the actuary was operating in producing the actuarial report.

The Next Phone Call

Mercifully, not every email or phone call I receive is like this one. That should be a relief for those of you considering a career as a consulting actuary. However, when I do get the next phone call, it will be with my tremendous appreciation for the ASB and ASOP. Their guidance truly does try to give the practitioner guidance and guardrails, even in the most unusual circumstances.

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