THE DARKER SIDE OF INSURANCE

Brian Lawrence*
School of Management, Assumption University of Thailand

Abstract

It seems that insurance and fraud go together, insurance being about money – premiums and claims. Fraudulent claims are made by policyholders, agents, and repairers, sometimes aided by solicitors and doctors. The extent of fraud is vast but cannot be quantified exactly, although estimates can be made from detected fraud. The insurance industries in most nations now spend much money and time on fraud detection and prevention, through a variety of organizations and techniques, usually in alliance with the government and police.

Insurers are said to make some fraudulent claims inevitable, knowing human nature, because of wider cover and breaches of basic insurance principles such as indemnity. The most fundamental principle is 'utmost good faith', which is obviously breached by fraudulent claimants but also by proposers at the underwriting stage. Insures themselves can be part of the darker side, through manipulating the complex insurance accounting calculations, especially the setting up of financial reserves from which to pay future claims. Mis-selling by insurers' agents also happens, plus delay and deception by insurers.

All this sullies and threatens the operation of insurance, which otherwise provides so many essential benefits to individuals, organizations and the economy. Controlling the dark side is a never-ending vigilance. Examples of fraud and control are given from many countries, but particularly from Britain and Singapore.

Introduction

Insurance provides many benefits, so many that modern civilized people and nations would be vastly poorer in the health, wealth, and education. Many research studies have demonstrated the link between insurance and the economy (e.g. Skipper, 1998). Trade would be at a low level as Banks would not lend money, and traders would not risk transporting their goods very

*Brian Lawrence, MSc, BA, FCII, Chartered FCIPD, Chartered Insurer, had an insurance career for over thirty years in Britain, including thirteen years in the City of London. On retirement he was appointed a university insurance lecturer in Singapore for seven years, and then transferred to his present university in Bangkok in 1999.

far. Without the financial security of insurance to cover financial loss through various perils, the wealth now generated through intra-national and international trade would be absent, and with it the money to finance education, healthcare and other basic necessities. At the personal level, individuals and their families would be ruined by illness, death and disaster if there were no insurance available. Yet the image of insurance remains murky, and efforts to inform the public about its widespread benefits seem to fail.

However, there is indeed a darker side to insurance, some of it obvious, some esoteric, and some hidden. The most obvious area of darkness is fraud committed by policyholders when they make a claim. Fraud is defined by the Collins Dictionary as "deliberate deception, trickery, or cheating, intended to gain an advantage". Fraud is a social cost which interferes with the normal cost mechanisms between insurers and customers (Mehr and Cammack, 1980). Fraud is also committed by organisations involved in the consequences of accidents, such as vehicle repairers, salvage agents, builders, and others. Adjuncts to insurance are involved, such as loss adjusters. Insurance employees, such as claims officers and motor engineers, can succumb to temptation of bribes. Less well known are the deceptions and delays practiced by some insurers. Hidden is the deliberate manipulation of insurance accounting, and the fraud committed by those who hack into computer systems and are in collusion with insiders.

Of course, not all those people commit fraud, otherwise insurance would cease to function. But those that do, offer examples to copycats, and also cause honest policyholders to pay more in premiums to cover this financial wastage. Insurance is a peculiar commodity to buy and sell: a promise to pay financial reimbursement if certain perils occur. Probably all other organisations have a fraud element: it is well known that they suffer 'shrinkage' of stock and equipment due to staff or customers. But one of the basic distinguishing principles of insurance is that of trust, 'utmost good faith'. This article will proceed to explain 'utmost good faith'. Examples of various types of fraud will be described, plus some of the actions taken to minimise this dishonesty.

Insurance is Based on Trust and Honesty

An insurance policy is a legal document which specifies the identity of the Insured person or organization, the sum insured, the perils covered, exclusions, warranties, and conditions which must be observed. The document consists of many words and a few numbers. Over centuries the words have undergone many challenges in the courts over interpretation of meaning, which in common law (judge-made law) sets precedents for subsequent cases. Over time, as society changes, precedents can be overturned by new interpretations by courts (or by legislation).

Insurance has some very basic principles which are extremely important foundations, and without which insurance could not operate, and which are so basic and long established that a

court will accept them even though these principles may not explicitly appear in the policy. The most basic are: utmost good faith, the duty of care, and indemnity.

'Utmost Good Faith', which used to be expressed in Latin – *uberrimae fides* – is the principle that there must be total honesty between the insured and insurer. The need for this principle was initially that a proposer for insurance knows the good and bad details of what he wants to insure, while the insurer knows almost nothing unless told by the proposer. The insurer will accept or decline the offered risk (and decide the price and terms if accepting the risk) based on the facts of the risk as declared by the proposer. Obviously the information must be correct, honestly given by the proposer. If relevant information is not disclosed, or is untrue, then the insurer bases its decisions on flawed facts. The disclosure duty is at inception, during the contract, at renewal, and in making a claim (Park, 2004). Taken to its extreme, if too many proposers give dishonest or inadequate information, the insurer will be charging premiums below prices which the true risks warrant. The insurer will then find that its costs outstrip its premium income, resulting in insolvency. Insurance would collapse.

Insurance policies include a condition that the Insured must exercise reasonable care of what is insured. It means that the Insured must behave responsibly, as though he were not insured. One of the problems of insurance is morale hazard, usually defined as 'carelessness', meaning that the Insured, because of the existence policy, is more careless than he would otherwise be. This was the principle behind marine insurers' refusal to provide any collision cover. They later relented but only to provide 75% of a ship-owner's liability for damage to others (Hazelwood, 2010).

The principle of indemnity is that an Insured should be reimbursed by the Insurer only to the extent of being placed in the same position as he was immediately before the incident (Thomas and Wilson, 2005). If the insured car was a total loss, and was five years' old a new car would not be provided, only a replacement car of similar age and condition, or an equivalent sum of money. If the car could be repaired, and become more valuable because in a newer or better condition, this is called 'betterment' and the principle of indemnity entitles the Insurer to reclaim from the Inured the amount of betterment. This principle protects the Insurer against moral hazard, where an Insured deliberately damages his car to have it 'bettered'.

The disadvantages of insurance include insurance induced losses (which would not have occurred if there were no policy), fictitious losses (which did not occur or not as seriously as claimed), and the deep-pocket syndrome where fraudulent claimants justify their dishonesty by saying that insurers have deep pockets and can afford to pay, and nobody loses. Having described some fundamental principles which allow insurance to operate at all, various types of fraud will now be examined.

Fraud against the Underwriter

Underwriting fraud is where lies are told about the risk, or information deliberately withheld, at inception or renewal, or where there is a significant undisclosed change of risk within the period of insurance. This is a breach of utmost good faith. One third of Britain's largest commercial firms supply false information on proposal forms (Jones, 2007).

There are several types of underwriting fraud (described by Hill, 2010). Premium fraud is where relevant material facts are deliberately withheld or misrepresented so as to reduce the premium. Examples are not disclosing information about past accidents and convictions, telling lies about ages, where the car is kept, or occupation. A major example is 'fronting' where a named young driver on his parent's policy is actually the main driver. Induced Premium fraud is where a customer is actively encouraged in premium fraud by a broker, sales agent or insurance employee so that more policies can be sold. Cover fraud is where the objective is to obtain cover which would have been refused if the full facts were disclosed. Premeditated claims fraud is where a policy is deliberately bought with the specific intention of later submitting a fraudulent claim.

Ghost-broking fraud is where a fraudster deliberately misrepresents himself as a broker to obtain policies through the insurer's on-line sales channels, to commit various frauds, with misrepresentation of details or subsequent cancellation, without the Insured's knowledge. The customer later finds that his insurance is invalid. There is massive ghost-broking by organized fraud gangs in most European countries, with one gang successfully committing more than 10,000 such frauds against one insurer in 18 months. Refund fraud is where the fraudster abuses the insurer payment systems to obtain refunds on policies taken out by using stolen debit and credit cards. Here also, organised gangs can cause extreme losses for targeted insurers, and the gangs sometimes recruit an insurer's own employees as insiders. Certificate fraud is where a fraudster applies for a motor policy and then cancels it (for a refund), continuing to use the certificate as false evidence of insurance when requested by police or others (Hill, 2010).

Another fraud, which involves non-disclosure and deliberate intention to defraud from inception, is where more than one insurance policy is taken out with different insurers. This is known as double insurance (although it may include more than two insurers), and refers to insurance policies which have the same subject matter, same insurable interest, covering the same property liability or person. It is illegal, and obviously is done with intent to make more than one claim for the same incident. Economic recessions, such as the present one in USA and Europe and elsewhere, tempt people to do this (Li, 2010).

One estimate, based on country-wide statistics, is that insurers may be losing at least 10% of their GWP to underwriting fraud. The detection and risk control of underwriting fraud is different from that of claims fraud (Hill, 2010).

Fraud by Claimants, and Collusion by Others

Insurance fraud, by policyholders and third parties, is a constant concern, in most countries. In Britain, it was estimated that in 2009 undetected fraud cost insurers £5.2 million every day (£1.9 billion annually), and this represented an increase of 24% over two years (Pratt, 2009). Fraud which was actually detected and prevented in 2009 saved British insurers £730 million, an increase of 30% over 2007 (Goldman, 2010). The Association of British Insurers (ABI) carried out research into the public's attitudes, and found that 44% of those surveyed thought that increasing the value of a claimed item was acceptable or borderline, and 30% felt the same about overstating the extent of damage. These figures are considered to be unrealistically low when compared to the actual number and cost of detected fraudulent claims. It is difficult to change these attitudes: people think that having paid premiums over a few years they should get their money back, somehow, like a return on investment (Baker, 2003). The ABI reported in 2008 that 1 out of 11 claims had a fraudulent element, with 85% of these involved exaggerating the value of a genuine loss. Half of all detected fraud involved household insurance, yet fraud is also rampant in motor claims. A moneysupermarket.com report in 2010 suggested that 20% of young drivers had 'staged' an accident in order to make a fraudulent claim (Goldman, 2010).

Most insurance fraud is opportunistic, customers yielding to the temptation of the situation; but there is an increase in organized fraud committed by criminal gangs (Jones, 2008). The rise of criminal gangs particularly affects car insurers in Britain. This fraud is known as car crash fraud. A gang's car will deliberately crash into the back of an insured car. The criminals make their money by making false personal injury claims against the other insurer, the proceeds being used to fund other forms of serious crime. It began in the 1990s and spread from its origin in the North West of England (Jones, 2008). In one case, forty people were brought to court in 2008, after a two-year investigation by the Bedfordshire Police and the Insurance Fraud Bureau, for making false insurance claims totaling £5.2 mn. after staged collisions (The Independent, 17 June 2008, p19).

Life insurance has its own fraud claimants. Faked deaths, to claim the proceeds of a life assurance policy, are well publicized when proved. The intent to defraud may be there at inception (disclosure), during, or at the end of a life policy (claim). Several prominent people in Britain, including a cabinet minister, have 'disappeared' over the years, presumed dead, but later found to be living elsewhere. In another case, a man faked his own death but was later found to be living in a hole under the floorboards, while his family pursued a claim totaling £150,000 sum assured. Another case involved the murder of a business partner so that the policy proceeds would support the struggling business (Purdy, 1995).

There is fraud in commercial insurance, up to one in seven large organisations' claims being exaggerated; and one twelfth of smaller firms openly admitting to exaggerating property or

motor claims (Jones, 2007).

Marine insurance is the oldest type of insurance. It too regularly faces fraud problems, although the extent is difficult measure as the evidence often lies at the bottom of the sea. A new problem emerged with the introduction of electronic bills of lading, huge container ships, and the requirement of Port authorities that emails should be sent to them with details of cargoes to be landed. Hackers into the websites joyfully found the identities of containers containing the most valuable cargo, and conspired with port insiders to make the container and its contents 'disappear'. Another problem is that of 'phantom cargoes', for example, when a container is found to be full of sand. In many fraudulent marine claims there is almost always collusion between thieves, insiders and officials, and sometimes the Insured.

The classic marine case is the 213,000 ton tanker Salem which sank off West Africa in 1980. A massive claim was made of £25 mn for the cargo of oil. Scotland Yard and insurance investigators were called in, and the fraud was revealed. The oil had been surreptitiously landed in South Africa and sold for £20 mn. Seawater had then been secretly pumped into the ship's empty tanks, and the ship was then deliberately scuttled: the businessmen behind the fraud were jailed (Miller, 1995). The International Maritime Bureau is closely involved in fighting marine fraud. It was established in 1981 by the International Chamber of Commerce.

In property claims, for houses and commercial premises, builders and repairers are often in collusion with the Insured. The bill may be inflated by the amount of the insurance deductible, or include items not damaged. It would be too expensive for insurers to investigate every claim. In motor insurance, the insurer's own motor claims engineers, who inspect damaged cars and agree the extent and cost of repairs with the garage, can be in collusion to share the profits from inflated bills.

Loss adjusters, who are independent claims investigators, hired for a fee either by the insurer or claimant, have been known to collude in fraud. Sometimes, claims handlers within an insurance company collude in fraudulent claims, and insures usually have extra-special checks on claims made by staff on their own policies.

Regrettably, "criminal gang fraudsters are aided by apparently respectable businesses such as accident management companies, credit hire companies, storage and removal companies ... [and] even solicitors and doctors" (Jones, 2008, p30).

Breaching the Indemnity Principle is a Cause of Fraud

To increase premium income, the important basic insurance principle of indemnity was breached by insurers in the 1970s in property policies, especially by offering replacement-as-new cover

for home insurance. It was actually advertised as 'new for old'. This created moral hazard, the ever-present fear in insurance; it was an incentive to fraudulent claims. So was the introduction of 'all risks' cover, accidental damage, however caused, rather than the traditional specified perils. The author was an insurance centre manager in England then, and it came to his notice that in one housing estate in a northern city the same burnt carpet was being passed around, and other were deliberately damaged by burning coal 'falling' from the then open fires in every home. Some neighbours talked to claims investigators. Others talked to their neighbours: 'Get a new carpet to replace your old dirty worn carpet, or sofa, or whatever, the stupid insurers will pay'.

Also there was no previous claims experience data for these new extensions of cover, but the sum insured had to be on a replacement-as-new basis, not indemnity, so premium income was higher, theoretically, but not usually in practice, and therefore 'Average' was applied to under-insurance, which created customer dissatisfaction. However hard insurers try to formulate their policies in simple language, the principles and concepts are poorly known and understood.

Commercial property insurance also breached the indemnity principle by offering replacement-as-new, and the same fraud and Average problems occurred. Arson is always a threat, especially in recessions, when goods or buildings are deliberately burnt to provide insurance payment. On average, the damage done by arson is greater than that of accidental fire (Swiss Re, 1989). Loss of Profits insurance (later named Business Interruption insurance) breaches the principle that losses consequential to physical loss or damage are not insurable, again because of moral hazard.

Insurance Fraud in Singapore

Fraud affects Singapore as it does almost every other country, but Singapore has a longer history than most of taking decisive action. Most claims fraud is committed by personal policy-holders – car and home insurance. Insurance companies used to take the view that to publicise these criminal acts, or to report these incidents to the police, would be counter-productive as it would give other people ideas of how to cheat. This used to be the case in Singapore, until the General Insurance Association and NTUC-Income Insurance decided to involve the police and to publicise criminal convictions from the early 1990s (Lawrence et al, 1998).

Many examples were publicized by the insurers and newspapers. Some claims were exaggerated, the damage to the vehicle being aggravated after the accident by the repairer using a hammer, or replacing parts which were never damaged, or switching good parts with damaged parts from another vehicle. Often, the Insured was not involved in the deception and was surprised when shown the evidence. In other cases, the repair bill was inflated: the repairer

would fix the licence plates onto a similar badly damaged car. Sometimes the Insured was involved, by taking a proportion of the inflated claim payment made to the garage (Straits Times: 4 April 1992, 25 February 1995). Touts used to patrol the highway, listening to radio reports by the police of accidents. They would rush to the scene, offer a full claims administrative service to the Insured, and tow the car to a dishonest repairer (Straits Times, 15 April, 1992). Syndicates of repairers were involved in defrauding insurers. A policy deductible was negotiated with the repairer: the profit from the inflated repair cost being enough to cover the deductible and reward the repairer.

The repairers struck back at attempts to expose them. A senior claims executive was lured out of a Wedding dinner and beaten up. The excuse made to the court by the repairer was the executive was making it difficult to make a living (Straits Times, 18 February 1995). An insurer's motor engineer was attacked by a group of repairers for being too strict in his assessment of repair costs.

Motor claims fraud continues in Singapore, but its extent is controlled by systems introduced by insurers. There must be immediate reporting of accidents (made easy by mobile phones and a 24-hour hotline), taking photographs taken at the crash site, at the repairer's workshop, and on completion of repairs. Insurer's now have a list of authorised repairers, who agree hourly rates for repairs, and other conditions. There are also Vehicle Assessment Centres providing a one-stop centre for motorists after a crash. These centres have the latest sophisticated technology (Straits Times, 6 February 1995). All these measures have the full support of the Automobile Association of Singapore, who also set up a federation of workshops, to raise the integrity of this trade and ensured fair prices and reliable service. Miscreants are expelled. Insurers now use centralized digital databases of current and past claims, and similar central registries have been set up in other countries. The cost is very low, thanks to ICT.

Singapore insurers continue to report fraud cases to the police, and the media highlight those convicted. A recent example is that three people involved in a car-taxi crash in 2008 made fraudulent claims for personal injuries. They were found guilty by a district court, but blamed a tow-truck driver who told his wife and daughters to pretend they had been in the crashed car, and persuaded friends to pretend they had been passengers in the taxi. These phantom passengers claimed for whiplash injuries and other pain. A lawyer instructed by the phantom passengers became suspicious about 20 personal injury claims arising from the car-taxi accident and another crash, and reported this to the government's Commercial Affairs Department (Singh, 2010).

The investigation then conducted by the Commercial Affairs Department widened to include those cheating three other insurers, and five people were jailed. The mastermind had friends at car repair workshops who referred victims to him for help in filing insurance claims. He would induce others to pretend they had been passengers. He also staged his own accidents, also with phantom passengers. The fraud was discovered because of discrepancies in the state-

ments made by the 'victims' (Singh, 2010).

The General Insurance Association of Singapore has now been urged by the Insurance Executive Director of the Monetary Authority of Singapore to set up a central fraud database to enhance fraud detection (Asia Insurance Review, Vol.11, Issue 65: website accessed 4 April 2011).

Insurance Fraud in some other Countries

In Malaysia, there was a warning that insurance fraud could affect economic stability if not controlled, as insurance premiums would have to keep rising (Ong, 2005) At the time it was estimated that 10-15% of claims had fraudulent elements. The central bank, Bank Negara Malaysia, which is also the insurance regulator, set up an anti-fraud unit in 2004 which introduced three insurance fraud monitoring mechanisms: an electronic information database, a verification system for checking submitted claims information, and an application database to detect multiple life policies taken out with various insurers.

Fraud is a serious issue in USA. The Coalition Against Insurance Fraud (CAIF) estimated in 2007 that fraud cost insurers at least US$80 billion every year. Health care insurance fraud is serious: the National Health Care Anti-Fraud Association (NHCAA) estimated that over US$50 billion annually is lost to outright fraud: other estimates put it as high as US$200 billion. USA also has crash-for-cash criminal gangs (KPMG, 2007b).

India has insurance fraud problems. Jayaprakash (2004) proposed detailed action to collate and analyse data to establish the size of the problem. Korean insurers experience fraud (Kim and Kim, 2010). In Thailand, one example is marine fraud connected with the theft from barges going down the Chao Phraya river to transfer their cargoes to ocean ships. Criminal gangs steal 30-40 1,000kg sacks of rice and sugar from each boat that passes. There is collusion involving barge supervisors, surveyors, and ocean ships (Keeratipipatpong, 2011).

In Hong Kong, there is a rising trend of insurance fraud, both opportune and organized. If it is not forcefully controlled it will undermine the proper functioning of the insurance market and the cost would eventually have to be shared by all customers. This financial leakage has to be plugged, and a Task Force has been set up to help insurers report suspicious claims to the authority and take proactive prevention. As an example, in 2009 the Task Force helped insurers handle two cases with claim amounts exceeding HK$3 million each (Choi, 2010).

Deception and Delay by Insurers

From over thirty years of practical insurance experience, the author has accumulated knowl-

edge of the operations of many insurance companies, especially in England, but knows that insurers' dark practices extend to many countries. There is the initial routine rejection of claims, especially liability and travel claims. Protracted arguments are used over cover, exclusions, and amounts. Third party claimants are treated worse. The purpose is to delay or avoid eventual payment., thus improving cash-flow, increasing investment income, and sometimes enabling reserves to be under-estimated.

There is also inertia selling. This is where the insurer offers wider cover at renewal, for additional premium, through 'negative option'. This means that the Insured has to deliberately state that he does not want what is offered; otherwise the cover and additional premium is automatic.

A recent example of insurers acting against the interests of customers is where motor insurers in Britain have been accessing competitors' planned price changes. Car insurance in Britain is fiercely competitive, mainly through TV advertising and on-line quotation comparisons. In many countries, motor insurance accounts for the largest share of general premium income. The attraction of this business for insurers is the premium volume, the steady monthly cash-flow income (almost non-seasonal) and the investment income that this can generate, with the long-tail effect of liability claims meaning that payments are postponed, often for years.

In this specific case, British insurers had been accessing data of competitor's detailed pricing structures and plans through shared software provided by a credit firm, Experian. One big motor insurer, RSA (Royal Sun Alliance) reported this practice to the Office of Fair Trading (OFT) for a possible infringement of competition law. The OFT investigated and in 2011 seven insurers (including RSA) agreed to limit the data accessed. Now, the data will be anonymous and will represent the average of five insurers, and will not include planned price changes (Yahoo UK & Ireland, Finance; yahoo.co.uk, accessed 26 March 2011).

Insurers consistently have a bad image, however hard they try to inform the public of what insurance is and how it if so beneficial. To the layman, insurance is an esoteric necessity which he would rather not spend money on, and finds his claim is rejected or reduced because of some policy words. The millions of satisfied customers receive no publicity from a media interested only in negatives.

The image issue, which contributes to people feeling justified in making fraudulent claims, gets a ritual hearing at annual conferences, such as the UK Insurance and Financial Services Conference in September 2002. The industry berated itself, rightly, for its publicized failures, such as the massive mis-selling of endowment pension policies in the 1990s, the failure of the Equitable Life company, and the hidden undisclosed commissions paid to advisers and agents. The Consumer Association was reported as stating that 'if this industry can rip off the consumer, it will'. The best attended meeting at the conference was on the topic of 'An Issue of Trust'. One

CEO asked whether the industry was now operating under the practice of 'utmost bad faith'. Unfair treatment, fraudulent activities and mis-selling, can happen even in a financially sound and transparent insurer (Miani and Dreassi, 2008).

Causes

Crime and greed are a permanent part of human life. We are flawed individuals living in flawed societies. A sense of honour and honesty is developed through many sources, especially parents, religion, education, and prevailing culture and its role models. Legal penalties, including fines and imprisonment, are a deterrent for many.

A rare philosophical statement by a senior insurance manager examined developments in society and individual ethics at the end of the last century in Britain, which particularly affected personal policyholders. As society became richer "the materialistic outlook bred contempt for basic and traditional values such as honesty. ... Keeping up meant possessions at any price by borrowing thieving or putting in bogus and exaggerated claims" (Garwood, 1994: p5). At the same time, insurers offered wider cover for home insurance, including replacement-as-new and accidental cover (such as a paint pot accidentally spilt on the carpet). It seems that insurers abandoned sound underwriting principles in the race for growth and market share, compounded by aggressive advertising and marketing.

Other writers have blamed the huge increase in lawyers who specialize in personal injury claims and advertise heavily their no-win no-fee service. These lawyers promote minor or non-existent injury claims, in a blame-and-claim society. In research, an insurer found that 57% of solicitors surveyed reported a rise in fraudulent personal injury claims over the previous ten years, for invented or exaggerated injuries, especially after car accidents. Also involved, indirectly, are the many TV price comparison sites for motor insurance, where it is easy to enter false data onto a computer screen to find the cheapest price (Goldman, 2010).

Fraud Control Measures in Britain

The Association of British Insurers (ABI) has long been very active in combating fraud, through its Fraud Prevention Bureau (Litton, 1998). Its Motor Insurance Anti-Fraud & Theft Register (MIAFTR) has been operating since 1987. There is also the Electronic Life Industry Exchange Intermediary Register, the Credit Anti-Fraud Register, the Equipment Register, and the Art Loss Register. The ABI set up the Claims & Underwriting Exchange (CUE) in 1994, which is a database register of current claims and for the past three years, which makes it easy to identify regular claimants who might switch insurers. There are also links with other IT databases such as credit-worthiness agencies covering individuals and companies, and others

which perform financial stress tests on companies, looking at solvency and liquidity. The head of one of these insurance databases said in 1995 that 50% of all fire claims were due to arson (Shillito, 1995). There is also an online vehicle identification system, providing registration and other details.

Other agencies involved are the Financial Services Authority (FSA), the Insurance Fraud Bureau (IFB), the National Fraud Authority (NFA), The Fraud Prevention Service (FPS), and the CIFAS, the UK's overall fraud prevention service. The IFB, set up in 2006, is funded by the insurance industry, and focuses on detecting and preventing organized and cross-industry insurance fraud. IFB insurers (who have more than 95% of the UK's personal insurance claims) share their claims data through the CUE. IFB works with many UK and international police forces, and operates a free telephone 'cheatline' for anonymous information (Goldman, 2010). In its first twelve months, it saved the industry £8 million, after initiating 20 police operations leading to 74 arrests (Jones, 2008). The IFB says that crash-for- cash gang fraud reduced by 11% in its first two years because of its intervention, and also reported that these reduction are seen when it works jointly with 13 police forces, but in areas with non-involved police forces, crash-for cash fraud is increasing (Pratt, 2009).

The NFA is an agency of the office of the government's Attorney-General, and works with a variety of organizations including government, law enforcement, and voluntary bodies to focus and co-ordinate fraud generally across the UK. The FPS covers organizations involved in banking, credit cards, asset finance, retail credit, mail order, insurance, investment management, telecommunications, factoring and share dealing. Members share information on fraud, and its CIFAS was the first data sharing scheme of its kind in the world (Goldman, 2010).

In addition to databases and matching-software, insurers have also moved into the behavioural sciences to detect claim fraud. They use psychological profiling and cognitive interviewing. Voice Recognition Analysis (VRA) has been used since 2002: it works like a lie detector identifying stress, and is mostly used for telephone conversations with claimants. Claimants dare not refuse permission for this device to be used (Jones, 2008). Obviously the front-line control is exercised by claims handlers and assessors, who now receive regular training in fraud detection. Private investigators are also used, and they are also specially trained (Jones, 2007).

Some fraudsters whose claims are rejected by the insurer even take their case to the Insurance Ombudsman, well known for forcing recalcitrant insurers to make personal insurance payments but who will reject claims where there is evidence of fraud (Jones, 2008).

Most fraud control is directed at individuals, personal policyholders, because of their number, but commercial fraud also has its techniques, many of which are common to those used for individuals. There is a role for forensic investigation of business claims, by identifying fraud

markers, and the use of experienced forensic teams and forensic accountants. The key to successfully identifying a claim as fraudulent is motive. This is usually financial, hence the need for forensic accountants (Parton, 2006).

Manipulation of Insurance Accounting

Insurance accounting is very different from accounting for others. Although non-life policies are usually issued for one year (with renewal options), that premium income can be spread over two calendar years, and claims payments can be spread over ten or more years (Abbott, 1990). Yet annual insurance accounts are understandably required, by the shareholders, tax authorities, and insurance Regulators. The major problem is that a financial reserve has to be created, set aside, from which to pay all outstanding claims. Claims reserving is where 'creative accounting' can be found, and can make it appear in the annual company statement that the insurer has made a profit whereas the reverse may be true. It is complicated by such arcane issues as IBNR (claims incurred but not reported) and a variety of actuarial methods.

Inadequate reserves puts an insurer in a dangerous position as its solvency margin is incorrectly calculated and it may be unable to meet its obligations (Tang, 2003). If an insurer is in a period of increasing premium income, it is easier to show a fake profit. A declining account is when the truth rapidly emerges. Sophisticated data software, if correctly programmed, can be made to show whatever the insurer's top managers want. Claims reserves must include future expected payments and expenses, so that the insurer is "able at all times to meet its commitments to policyholders and beneficiaries" (Cholvijarn, 2003).

Reserves have to be adjusted as the facts become increasingly known, especially for liability claims which have a long-tail stretching to ten years or more, and insurers tend to underreserve when premium rates can be high in hard markets (Swiss Re, 2006). Regulators are paying more attention to the quantification of uncertainty (KPMG, 2007a).

Insurance law regulation varies across countries, although there are moves for international standardisation). Regulators usually require monthly/quarterly and annual statistical statements, and can make random inspections to an insurance company, but this depends on the regulator having enough skilled staff (Tang, 2003), and whether it is in a country which truly operates the rule of law rather than the rule of cronies and 'persons of influence'. In Britain, the Financial Services Authority (FSA) banned 13 people with fines of over £400,000 (Goldman, 2010). In Singapore, the insurance regulator, within the Monetary Authority of Singapore, has the authority to suddenly turn up on an insurer's doorstep and demand to see all the records, documents and computer data. It actually does that, and publishes its findings in its annual report, which refers from time to time to underestimation of claims reserves.

In Thailand there is not the same level of skilled independence and authority, although improvements are being made. Insurance, because of its cash-flow funds, is an attractive industry to be in for those with evil intent, and it also has money-laundering possibilities. An actuary involved in insurance in Thailand commented that there is no problem in Thai insurers meeting the new risk-based solvency capital rules which will be implemented in September 2011. Rather, he sees the key threat to insolvency is fraud, pointing out that five insurers became insolvent in the past ten years, not because of lack of capital but because of internal fraud (Chye, 2011).

Some insurers have foreign domicile, usually in a tax haven, where company details can not be forcibly disclosed to an enquirer; in some it is impossible to discover the owner of the insurer or any financial details. Some domiciles are even fictitious. Assets are fake, including Hitler bonds, coal deposits, penny shares, real estate miles from any road, and cross-holdings in equally dubious sister companies (Jones, 1995). There are failures every year by some insurance companies when their insolvency is discovered. In Britain it tended to be rapidly expanded car insurers whose owner manipulated the reserve system – until eventually exposed by falling sales or discovered by the Regulator.

Conclusion

It is depressing to report such widespread dishonesty in what is such a beneficial industry. But hiding it, pretending it does not exist, which used to be the case so as not to encourage copycats and not further damage the reputation of insurance, is fortunately long gone because of fraud's increasing extent in societies which seem to have weakened their traditional values. Publicising convictions, and the fact that insurers now use very sophisticated detection devices and other controls, reminds the public that there is the risk of being caught. The presence of fraud in a claim voids the cover, meaning no payment at all and probably a police report. Insurance Regulators, Ombudsmen and consumer associations, are a check on the less-than-honest behaviour of some insurers. Limiting dishonesty in insurance is an essential but never-ending process.

References

Abbott, Bill (1990), Profit and solvency in general insurance. In Diacon, Stephen, A *guide to insurance management*, Basingstoke, Palgrave Macmillan.

Baker, Martin (2003), Unfair game, *The Journal*, Chartered Insurance Institute, May.

Choi, Agnes (2010), Hong Kong, Country Report, *East Asia Insurance Congress*, Bali, October.

Chye, Pang-Hsiang (2011), Thailand: fraud is bigger threat to solvency than capital require-

ments, *Asia Insurance Review, eWeekly*, II (69), April.
Cholvijarn, Piyabutr (2003), Keynote opening address at the *7th Annual Asia-Pacific Risk & Insurance Association Conference* July, Bangkok.
D'Arcy, Stephen P. (1994), The Dark Side of Insurance, Chapter 8 in Gustavson and Harrington, 1994, qv.
Garwood, Keith (1994), The fight against fraud. The CII Journal, March.
Goldman, Nicholas (2010), It's a steal, *The Journal*, Chartered Insurance Institute, December, p30-33.
Gustavson, S.G., and Harrington, S.E. (1994), *Insurance Risk Management and Public Policy*, Boston, Kluwer Academic Publishers.
Hazelwood, Steven (2010), *P&I clubs, law and practice*, 4th ed., Lloyds Shipping Law Library, London, Informa Law.
Hill, Chris (2010), The hidden menace, *The Journal*, Chartered Insurance Institute, October/November, p38-39.
Jayaprakash, J. (2004), A study of the need for fraud analysis in insurance in India, *Asia-Pacific Risk & Insurance Association, 8th Annual Conference*, July, Seoul, Korea.
Jones, Harvey (2007), Fraud Busters, *The Journal*, Chartered Insurance Institute, June, p37-40.
Jones, Harvey (2008), The struggle to make honesty the best policy, *The Journal*, Chartered Insurance Institute, February, p28-31.
Jones, Trevor (1995), A once and future problem, *The CII Journal*, March, p5.
Keeratipipatpong, Walailak (2011), Seal hunt, *Bangkok Post*, 24 January, pB1.
Kim, Hunsoon; and Kim, Jaeltyun (2010), A study of soft fraud in automobile insurance claims in Korea, *World Risk & Insurance Economics Conference*, Singapore, August.
KPMG (2007a), Quantifying uncertainty in technical reserves, *Insurance Insights*, May, p50-055,KPMG International.
KPMG (2007b), Beating insurance fraud, Frontiers in Finance, September, p23-24, KPMG International.
Lawrence, B.C. (1996), Motor insurance in Singapore. In C.K.Low (Ed), *Actuarial and Insurance Practices in Singapore* (pp191-216), Singapore: Addison-Wesley.
Lawrence, Brian; Leong, Angeline; Lum, Hong Ching; Ong, Chun Kiam (1998), Controlling motor claims fraud, *Actuarial & Insurance Review*, 1, 164-180. Singapore, Nanyang Business School.
Li, Chenglin (2010), Double insurance and fraud, *The Journal of Risk Management and Insurance*, 14: 1-16.
Litton, Roger (1998), Crime prevention and the insurance industry, *Journal of the Society of Fellows*, 13(1), p26-44.
Mehr, Robert I. and Cammack, Emmerson, (1980), *Principles of Insurance*, 7th Edition, Homewood Ill., Richard D. Irwin.
Miller, John (1995). Diving below the surface, *The CII Journal*, March, p31-33.
Ong, James (2005), Insurance fraud in Malaysia: a growing menace, *Malaysia Commercial*

Fraud and Financial Crimes Conference, Kuala Lumpur, July.
Park, Semin (2004), The post-contractual duty of utmost good faith in insurance contract law, *The Journal of Risk Management & Insurance*, 9, p51-67.
Parton, Tony (2006), Role of forensics in fraud scene investigations, *EAIC Conference, Special Issue of Asia Insurance Review*, August, p47.
Pratt, Kevin (2009), Focus on fraud, *The Journal*, Chartered Insurance Institute.
Purdy, Eric (1995), A matter of life and death, *The CII Journal*, March, p28-29.
Shillito, Douglas (1995), IT – the fraud detector, *The CII Journal*, March.
Singh, Kushwant (2010), Trio in insurance scam may get probation, *The Straits Times*, 21 and 23 December 2010.
Skipper, Harold D. Jr. (1998), The role of insurance in development: an economic perspective, *Singapore International & Actuarial Journal*, Vol.1.
Swiss Re (1989), *Arson*, Zurich, Swiss Reinsurance Company.
Swiss Re (2006), Measuring underwriting profitability of the non-life insurance industry, *Sigma No3*/2006, Swiss Reinsurance Company.
Tang, Benjamin (2003), Major threats to insurance solvency, *7th Asia-Pacific Risk & Insurance Association Conference*, July, Bangkok.
Thomas, Jeffrey; and Wilson, Brad Michael (2005), The indemnity principle, *The Journal of Risk Management & Insurance*, 10, p30-46.

Assumption University

Au is considered the leading private university in Thailand in the fields of Business, Management and Information Technology as demonstrated by the placement of many of its graduates in key management and technological positions in industry, government, banking, insurance and multi-national conglomerates worldwide.

The University's curriculum is patterned after the American semester hour credit system and most textbooks are similar to those used in international universities. Graduates receive an education that is both globally marketable and flexible, leading to highly productive careers within the various sectors of society from which the students come and to which they aspire.

CALL FOR PAPERS. We welcome papers, in English, on risk and insurance topics. Initially, please email your Abstract and personal details to: bLawrence@au.edu. If accepted, papers should range from 3,000 to 6,000 words in length, Times New Roman font size 12, single spacing, using APA Style referencing.

ASSUMPTION UNIVERSITY OF THAILAND

Hua Mak Campus
592/3 Ram Khamhaeng 24 Rd., Hua Mak, Bang Kapi, Bangkok 10240, Thailand
Tel. +66 (0) 2300-4543-62, Fax. +66 (0) 2300-4563
Suvarnabhumi Campus
88 Moo 8 Bang Na-Trad Highway, Km. 26, Bang Sao Tong, Samut Prakan 10540, Thailand
Tel. +66 (0) 2723-2222, Fax +66 (0) 2707-0395

www.au.edu, abac@au.edu