

Sharon Tennyson

Moral, Social, and Economic Dimensions of Insurance Claims Fraud

CONSUMER DISHONESTY STEMS FROM A COMPLEX INTERPLAY OF motivations and circumstances, moderated by morality, opportunity, social norms, and institutional context. The complexity is perhaps nowhere more apparent than in the case of insurance fraud, particularly claims fraud. Claims fraud may arise as a result of deliberate planning or casual opportunity, and in each case it may involve complete fabrication of losses or relatively small exaggerations. It may be motivated by pure profit seeking, a sense of entitlement, desperation, or resentment. It may even arise inadvertently due to differences of opinion regarding contractual terms or an insured event. Insurance claims fraud is thus variously viewed as an economic-contractual problem, a moral-psychological problem, a moral-sociological problem, or a criminal problem.

Because insurance claims fraud involves taking advantage of the insurer's contractual promise to pay (some amount of) losses (in some circumstances), it differs from other common situations of consumer dishonesty such as tax evasion, pilfering from an employer, or shoplifting.¹ This unique contractual relationship has important implications for the character of claims fraud and the ways in which insurers and societies attempt to deal with it. Some have argued that insurance fraud is an example of a "created" crime, because it is determined by the terms of the insurance contract and the strength of their enforce-

ment (Ericson, Barry, and Doyle, 2000). Fraud is detected only through policing, and increased policing will lead to detection of more fraud and therefore to an increased fraud problem. This point of view suggests that the perceived rise in insurance fraud in recent years may result from greater policing rather than from a higher incidence of fraud behaviors, and calls into question the benefits of increased expenditures to detect fraud. However, this ignores the high costs of fraud behaviors to society.²

Once the insurance contract has been defined and agreed upon, its violation through illegitimate claiming will lead to inefficiencies and inequities in insurance markets. Inequities occur because costs are inevitably shifted to others when claims are inflated above those accounted for in the premium charge, or when all consumers' premiums are higher because some consumers inflate their claims. Inefficiencies arise if the possibility of profiting through fraud distorts insurance purchase decisions, loss prevention, or claiming incentives. Additionally, attempts to prevent fraud create contractual restrictions for all consumers that lead to less protection from risks than would occur in a market without fraud. Thus, even in the narrowest economic sense insurance fraud has negative consequences for society.

Nevertheless, the policing of fraud inevitably reduces trust relationships between insurers and consumers and thereby reduces gains from trade in insurance. Reduced trust could increase fraud, since studies show that consumers' with negative perceptions of insurance institutions express more accepting attitudes toward fraud (Tennyson, 1997). This consideration lends a new dimension to the analysis of the benefits of increased policing of fraud. Transactions costs of policing fraud are also high, taking into account both the resource expenditures of insurance companies and the costs of legal enforcement. For these reasons prevention of insurance claims fraud may be a less costly alternative. However, improving prevention efforts requires a better understanding of the different dimensions of fraud, the determinants of consumer behavior, and the relationship between consumer behavior and institutional rules.

THE NATURE OF INSURANCE CLAIMS FRAUD

Taxonomies of insurance claims fraud often start with the distinction of whether or not an insured event occurred (Weisberg and Derrig, 1991). If no event occurred but a claim is filed then the fraud is *planned* or *outright*. Conversely, if a loss occurred but circumstances are falsified or attempts are made to get excessive payments, this is termed *opportunistic* fraud. Planned fraud may be undertaken by an individual on a one-time basis, or may be carried out by professionals in a systematic effort to profit from the insurance system. Opportunistic fraud is undertaken by individuals who experience a loss and attempt to shift the costs to the insurance system. Opportunistic fraud is most often characterized by claims exaggeration (*buildup*), and may be undertaken by the insured alone or with the help of a service provider or legal professional.

Insurance professionals also distinguish between criminal fraud (*hard* fraud) and that which falls into a gray area of abuse or unethical behavior (*soft* fraud). Fraud is viewed as criminal when it displays characteristics sufficient to be prosecuted. This is the case when there is evidence of a clear and willful act of material misrepresentation that violates a law and achieves financial gain for the person taking the action (Derrig, 2006). Planned fraud is much more likely to be criminal fraud, and is therefore a matter of concern for law enforcement. Opportunistic fraud may also be criminal but is more likely to fall within the definition of soft fraud (Viaene and Dedene, 2004). It therefore presents a more delicate management task to insurers, who must be cognizant of both customer relations (Ericson, Barry, and Doyle, 2000) and legal requirements for fair and prompt settlement (Tennyson and Warfel, 2008; Sykes, 1996) when faced with lack of clear proof of fraud.

Insurance fraud undertaken or facilitated by service providers—such as body shops in the case of automobile insurance or health care providers in the case of health insurance—is also a distinct category. It may arise in at least two forms. First, it may be an extension of attempts to defraud consumers. Because consumers have difficulty knowing (with certainty) the amount of service that they require, there is

substantial scope for “overselling” by an expert service-provider.³ This may take the form of providing too much service (overprovision) or charging too much for services provided (overcharging).⁴ Such problems of overselling are likely to be greater when services are paid for by insurance because insured customers have less incentive to monitor service quantities or charges. This form of service fraud would clearly be characterized as planned fraud, and would likely be criminal.

Service providers may also engage in the same acts of overprovision or overcharging in order to help consumers evade insurance limits. For example, some auto repair shops may increase charges to insurers in order to waive the deductible for the insured.⁵ In the health insurance context, a number of studies document the willingness of care providers to manipulate insurance restrictions in order to provide higher quality care than is reimbursable under the insurance contract (Freeman et al., 1999; Wynia et al., 2000). Hyman (2001) discusses this problem as a conflict in social norms between physicians and insurers: physicians would view it as necessary to providing quality care, but insurance investigators and government health care programs would view it as criminal fraud. Hyman (2002) concludes that much of fraud in government health care programs falls into this category of aiding consumers in the (opportunistic) buildup of claim amounts rather than planned fraud. However, because physicians have a financial interest in the provision of additional (or excessive) services, we might view with some reservations their arguments that such practices are based on moral necessity.⁶

HOW PREVALENT IS INSURANCE CLAIMS FRAUD?

Conventional wisdom often estimates the prevalence of insurance claims fraud at about 10 percent of claims or 10 percent of claims costs (Tennyson, 1997; Mooney and Salvatore, 1990; Hoyt, 1990), but this statistic appears to be more folk wisdom than fact (Carroll and Abrahamse, 2001; Hyman, 2002; Derrig, 2006).⁷ Because it is believed that much insurance fraud goes undetected and even that which is detected may be dealt with privately (and indirectly), estimating the

prevalence of fraud is difficult and fraught with error. Nonetheless, there have been a number of attempts to estimate excessive claiming or excessive costs. Although the estimates vary widely, the results and methodologies are instructive.

Direct estimates of fraud rates are often obtained from studies that audit insurance claims. This extremely resource-intensive methodology uses insurance claims professionals to review closed claim files in order to gauge the likelihood that each claim is legitimate or fraudulent. Claim reviewers provide a suspicion score for each file and list specific elements of each claim that lead to a higher or lower degree of suspicion. Claim characteristics identified as suspicion indicators may encompass a wide variety of characteristics of the insured, the accident, the injury, or the medical treatments (Weisberg and Derrig, 1991).

Applying this approach in health care, government audit studies estimated that improper payments accounted for 7 percent to 14 percent of total Medicare fee-for-service payments in each of the years 1996 to 2000, with the largest category of overpayments stemming from unsupported services and lack of medical necessity (Hyman, 2002). In private passenger automobile insurance, Weisberg and Derrig (1991, 1995) estimated that upward of one-third of injury claims contained some elements of fraud or abuse in the state of Massachusetts in the 1990s. However, claim reviewers also concluded that less than 3 percent of suspicious claims contained enough evidence of fraud to be denied or prosecuted. Insurance Research Council (IRC) studies of data from nine states in that same time period found similar results (IRC, 1996). A later study by the IRC using national data from 2002 found that about one-quarter of claims (23 to 27 percent) showed some suspicion of fraud or buildup, but the percentage of highly suspicious claims was very small. Only 3 percent of injury claims were found to have a high suspicion of outright fraud and 5 percent were found to have a high suspicion of buildup (Derrig, Johnston, and Sprinkel, 2006).

Consistent with this, one study of workers compensation claims that focused on identifying only criminal fraud suggests that the incidence of fraud is much smaller than the estimates above, ranging from

1 to 2 percent of claims (Derrig and Zicko, 2002). Hyman (2002) also provides evidence from administrative and criminal fraud enforcement data in health care, which suggests a much smaller level of fraud than is suggested by audit studies.

These study results highlight the fact that differing fraud estimates may arise in audit studies based on differences in the fraud suspicion thresholds employed (hard versus soft fraud). Differences may also arise because the exercise is inherently subjective. Proof of fraud is difficult to obtain; the audit approach documents suspicious characteristics of each claim and when enough appear in combination this raises the suspicion of fraud. One study that attempted to validate the approach asked 4 different reviewers to examine the same claim files. While each of the reviewers identified 5 to 10 percent of claims as suspicious, not a single claim was judged to be suspicious by all 4 reviewers (Derrig and Ostaszewski, 1995). This makes the subjective nature of the fraud characterizations readily apparent, and underscores the difficulties of discovering fraud. The study outcome is also consistent with the perspective that insurance claim professionals are trained to be suspicious and are habituated to viewing claims as fraudulent (Hyman, 2001), and suggests that audit studies may be prone to overstating fraud prevalence.

However, other studies quantifying the prevalence of claims fraud by examining patterns in claim costs or claim frequencies have found evidence consistent with high levels of fraud. In one unique study of service fraud in automobile insurance, two damaged cars were presented to each of approximately 100 auto body repair shops in Massachusetts (Tracy and Fox, 1989). The experimental treatment for the two visits was manipulated by characterizing one car as not insured and the other as insured. Repair cost estimates were obtained and compared both across shops and within shops, and the results showed that repair cost estimates were an average of 32.5 percent higher when covered by insurance.

A more aggregated approach to analyzing claiming patterns is presented in Carroll and Abrahamse (2001). These authors use a large data set of automobile insurance claims for bodily injury to compare

the prevalence of soft-injury (sprain or strain) claims to hard-injury claims in different states. This comparison is made because it is often hypothesized that fraud will be mainly observed in soft injuries due to the greater difficulty of injury verification (Dionne and St-Michel, 1991). The research design also makes use of the variation in state laws regarding claim eligibility for general damages (pain-and-suffering awards). General damages provide incentives for fraudulent claiming because the award exceeds the documented medical and wage losses and raises the possibility of financial profit from an injury (Cummins and Tennyson, 1992, 1996). Accordingly, the authors test whether the prevalence of soft-injury claims relative to hard-injury claims is higher in states that do not restrict general damages awards. Their estimates indicate that soft-injury claims are 42 percent more prevalent in the unrestricted states. Since soft-injury claims make up 57 percent of total claims in their data (Abrahamse and Carroll, 1999), this suggests excessive claims in the range of 24 percent. This estimate is fairly consistent with those derived from audit studies.

Of course, state-level differences in claiming may simply reflect unobserved heterogeneity in the determinants of claims. A more convincing research design might examine claim responses to changes in legal rules or contract choice. A small literature in this tradition provides stronger evidence of opportunistic soft fraud.⁸ Dionne and Gagne (2001) show that auto insurance claim amounts are positively related to the policy deductible even after controlling for the determinants of choosing a higher deductible. This finding is consistent with claimants building up of losses to recoup part of the deductible. The authors provide even stronger evidence of buildup by separating the claims into multiple-car accidents and single-car accidents (for which there are less likely to be witnesses). These estimates show that a higher deductible is associated with a 25 percent increase in claim amounts for single-car accidents but no significant increase in claim amounts for multiple-car accidents.

In a similar vein, Dionne and Gagne (2002) demonstrate that drivers who choose replacement cost coverage for automobile theft losses

are significantly more likely to report their car stolen—but only when the policy is near its expiration date. Drivers with replacement cost coverage are not more likely to report a theft at the beginning of the policy or in the middle of the policy period. These empirical studies demonstrate substantial consumer discretion in claims filing in ways that are difficult to interpret as independent of opportunistic claims fraud.

THEORETICAL PERSPECTIVES ON CLAIMS FRAUD

Although estimates vary widely, the weight of empirical evidence suggests that fraudulent and exaggerated claims are an important problem in insurance markets. What remains unclear from these studies is the reason for the problem. Studies that attempt to document or measure fraud usually adopt an economic frame of reference. Yet the many avenues through which fraudulent insurance claims may arise are mirrored by the large variety of theoretical perspectives in modeling its causes. Insurance claims fraud has been analyzed by researchers in economics, insurance, business ethics, sociology, law, and psychology, and writers in these different disciplines tend to emphasize different aspects of dishonest behaviors. Nonetheless, most perspectives may be considered modifications to a basic theory rather than substitute theories, contributing to a richer model of the determinants of fraudulent insurance claiming.

The Economic-Contractual View

Because insurance fraud occurs within the context of a contractual relationship between the insurer and the insured, it can be seen as a purely economic response to this contract. This view of fraud builds on economic theories of moral hazard, which recognize that insurance reduces the insureds' incentives to prevent losses, and exaggerated or fictitious claims are characterized as an *ex-post* moral hazard. Under this view consumers decide whether to file an insurance claim, and the amount for which to file, based on the expected gains to filing relative to the costs of filing. If filing a fraudulent claim or exaggerating a legiti-

mate loss has positive expected payoff (net of costs), then the consumer will choose to file. The problem of (ex-post) moral hazard is recognized as an intrinsic business risk for insurers, and the insurance contract, insurance law, insurers' claims handling practices, and even the selection of insureds take it into account (Baker, 1996).

Claims investigations or policing are an important response to fraud. An investigation can benefit the insurer if it results in claim denial or a reduction in claim payment, or if it deters the filing of fraudulent claims.⁹ This latter point is important because the deterrence effects of investigations are often overlooked by insurers and others who evaluate these programs (Tennyson and Salsas-Forn, 2002). Economic theories of the design of insurer claim investigation strategies suggest that the largest savings from investigations will be those derived from deterring fraudulent claiming (Picard, 2000).

In some cases claims investigation is not a solution because its cost is prohibitive or because the truth is very difficult to uncover. In these cases insurers may use claim payment strategies to reduce the payoff from fraud.¹⁰ The direct benefit of this approach is it reduces costs associated with paying the claim. The indirect benefit is that underpaying suspicious claims categories reduces policyholders' incentives to exaggerate the claimed amount. Thus, deterrence effects once again play an important role.

In choosing a claims payment strategy for suspicious claims categories, an insurer must balance the expected reduction in claims fraud with the expected costs of resolving disputed claims. An important consideration in the United States is that many states allow consumers to file tort actions for recovery of damages and the benefit owed under the policy against an insurer who engages in "bad faith" in the settlement of an insurance claim. Allowing insureds to recover damages over and above the insurance benefit owed provides insurers with added incentives to engage in fair and efficient claims settlement (Sykes, 1996). However, if the standards applied in the courts for a finding of insurer bad faith are too lax, and/or if damage awards are too high, this may result in pressure on insurers to pay disputable claims (Abraham,

1986). The costs of fraud will increase as a result, and these costs will be borne by all insurance consumers. Empirical evidence supports the idea that insurance bad faith laws reduce insurer incentives to challenge disputable claims and lead to higher claims costs (Browne, Pryor, and Pueltz, 2004; Tennyson and Warfel, 2008). Thus, efforts by the states to protect consumers in the insurance claiming process may inadvertently contribute to higher costs of fraud.

In the context of insured services discussed previously, insurer network arrangements with service providers may represent a contractual response to fraud. Economic theory suggests that overselling incentives are most easily dealt with in repeat-business settings, where word-of-mouth reputations are important, and where contracts transform the relationship between the service provider and a buyer into a long-term relationship. The logic here is that the threat of losing repeat business, referrals, or a long-term customer relationship will provide the expert with better incentives to provide appropriate service.¹¹ Insurers engaged in repeat business with service providers can develop expertise that leads to a better (or lower cost) ability to monitor for fraud. The threat of losing insurer referrals may also reduce incentives to engage in fraud.

Coverage limits or exclusions of easily falsified losses are other examples of contractual responses to fraud. These may be a double edged sword, however. As discussed by Hyman (2001, 2002) in the health insurance context and by Dionne and Gagne (2001) in automobile insurance, coverage restrictions may increase fraud as consumers or service providers distort claims in attempts to circumvent the restrictions.

The Criminal View

When insurance fraud is viewed as criminal, the moral hazard framework must be modified by the potential for criminal penalties, including fines, imprisonment, and loss of reputation. Traditional economic theories of crime suggest that an individual deciding whether to file a fraudulent claim will evaluate the magnitude of the potential gain from a successful filing against the magnitude of penalties from an

unsuccessful filing and the probability of detection (Becker, 1969). If the expected gain from successful fraud outweighs the expected penalties, then the fraudulent claim will be filed. For fixed values of benefits and penalties, the decision trade-off will vary across individuals according to their perceived probability of fraud success, their degree of risk aversion, their discount rate, and their sensitivity to reputation penalties.

Traditional models suggest that even if the probability of detection is small, making penalties large enough can eliminate incentives for crime. If unlimited penalties are not possible then higher detection probabilities are required for deterrence, and deterrence may be imperfect. This idea has particular importance in the claims fraud context because fraud is difficult to prove. As noted earlier, industry estimates of the incidence of suspicious claims are at least 10 times as great as the number of claims that are prosecuted for fraud (Weisberg and Derrig, 1991; McKenzie, 1993; Derrig and Zicko, 2002).

Another problem is that penalties for insurance fraud may be limited by law. Until fairly recently state laws were not particularly clear about its criminal nature. As few as 20 years ago, only 10 states classified insurance fraud as a felony. The decade of the 1990s saw enactment of a variety of antifraud statutes in many states, including felony laws and laws that revoke the licenses of professionals convicted of insurance fraud. Hoyt, Mustard, and Powell (2004) analyzed the effects of these laws on state-level measures of automobile insurance claims most associated with fraud. The study found that laws requiring insurers to establish Special Investigation Units (SIUs) devoted to investigating fraud, laws classifying insurance fraud as a felony, or laws requiring the reporting of convicted professionals to licensing authorities were associated with statistically significant reductions in the level of claims.¹²

Interestingly, state laws mandating insurer SIUs had the strongest effect in reducing claims, indicating that increasing the fraud detection rates provide a stronger deterrent than increasing fraud penalties. Experimental evidence on cheating has also found that higher detection probabilities are more effective in reducing cheating than are higher

penalties (Nagin and Pogarsky, 2003). This lends additional richness to the theoretical framework by suggesting a social dimension associated with embarrassment or reputation concerns.

The Moral-Sociological View

The social dimension of fraud decisions will depend on consumer attitudes toward insurance claims fraud. Holding constant the pecuniary costs and benefits of fraud, consumer attitudes may affect the rate of fraud by creating social stigma or psychic costs of engaging in fraud. Attitudes toward noncompliant behavior will in part reflect perceived social norms. Theories of the development of social norms emphasize peer group or network influences. To the extent that individuals learn their attitudes from others, if insurance fraud is accepted by one's peers then one will be more likely to also find fraud acceptable. Thus, higher public tolerance for fraud or the perception that fraud is commonplace will in turn lead to more accepting attitudes and lower social costs of engaging in fraud.

Additionally, if social attitudes are generally accepting of fraud, the perceived (and actual) likelihood of detection or penalties from fraud may be lower—that is, social norms regarding insurance claims behavior will affect societal responses to fraud as well as individuals' beliefs and actions. Societal responses may in turn reinforce social norms, as has been hypothesized by several authors (Ericson, Barry, and Doyle, 2000; Hyman, 2001; Viaene and Dedene, 2004). They argue that historically—perhaps because insurers were more protected from competition by strict government regulation—insurance fraud was often ignored since costs could be passed on through premiums and paying claims improved customer relations. Such a lack of fraud enforcement could create or reinforce social acceptance of fraud, and may even create misconceptions among consumers about what behaviors constitute fraud.

As competitive pressures in the industry have increased, pressure to hold down costs led to greater focus on controlling claims costs and claims fraud. The way in which insurers respond to fraud may be impor-

tant, since consumers' attitudes toward claims fraud may be affected by institutional relationships (Tennyson, 1997; Viaene and Didene, 2004). Some theories posit that individuals' (positive or negative) perceptions of an institution will affect their attitudes toward honest dealings with it (Axelrod, 1986). This implies that consumers with negative perceptions of insurance companies and consumers who have had negative interactions with insurance companies will be more accepting of insurance fraud. More detailed models emphasize consumers' perceptions of an institution's *fairness* as important determinants of attitudes toward compliance or cooperation (Cialdini, 1989). This implies that consumers who feel that insurance companies treat customers unfairly (*procedural* unfairness), that insurance companies make too much money, or that premiums are unfairly determined (*distributional* unfairness), will be more accepting of insurance fraud.

This theoretical perspective suggests that efforts to address insurance fraud should include efforts to reduce the perceived prevalence and acceptability of fraud, to improve the image of the insurance industry and to enhance trust relationships between insurance firms and their customers. Research has shown that general insurance education both improves knowledge of insurance and results in more positive attitudes toward insurance institutions (Barrese, Gardner, and Thrower, 1998), and this may be one avenue for changing attitudes toward fraud. Fraud public awareness campaigns such as those sponsored by the insurance industry in recent years may also be effective in this regard.

The Moral-Psychological View

A more psychological (or microsociological) perspective on insurance claims fraud emphasizes that the extent to which social norms are *internalized* and *active* may affect whether consumers' stated attitudes are reflected in their observed behaviors. In this view internal reward mechanisms are important determinants of honest behavior (Mazar and Ariely, 2006). Internal reward mechanisms may fail to deter dishonesty if the social norm of honesty is only weakly internalized, or if the internal reward mechanism is not activated in the relevant decision

context. If the mechanism is inactive an individual will fail to evaluate his or her behavior in relation to accepted norms, leading to a higher rate of dishonest behavior.

Experiments on cheating undertaken by Mazar, Amir, and Ariely (2007) demonstrate several of these points. Their results suggest that participants presented with an opportunity to increase their payoff through cheating will generally do so, and that the magnitude by which they cheat is insensitive to the probability of being detected or the expected penalty for cheating. Nonetheless, the extent of exaggeration was relatively low, with very few participants cheating to the maximal extent possible. The experiments also showed that providing cues to remind participants of their internal standards for honesty (for example, by having them write down as many of the Ten Commandments as they can remember) reduced the extent of cheating. These results are consistent with the ideas that internal reward mechanisms guided subjects' behavior and that subjects had internalized norms of honesty that affected their behavior. In related work, a small-scale survey administered by Brinkmann (2005) found evidence that internal reward mechanisms were among the most important decision-making criteria in hypothetical insurance fraud scenarios. Those considerations were mentioned nearly as often as criteria related to social norms, and more often than criteria related to legal or contractual rules, as being relevant in determining whether claims exaggeration was ethical.

Studies of lying suggest similar conclusions. Subjects in experiments undertaken by Gneezy (2005) were found to be significantly less likely to take actions to skew payments toward themselves when the action involved a lie than when it involved a simple allocation choice. Additionally, the harm caused to another party influenced subjects' willingness to lie. When lying caused larger harm to another, subjects were significantly less likely to lie to increase their own payoffs. In the context of insurance claims fraud this suggests that consumers will be more willing to commit fraud if they perceive the harm to others to be small. This is indeed a common rationalization for insurance fraud acceptance—that it is a “victimless” crime. More generally, the

psychological perspective suggests that rationalizations may increase consumer dishonesty by facilitating self-deception (Mazar, Amir, and Ariely, 2007). Individuals desire to maintain a belief in their own honesty even when engaging in dishonest behavior, and may do so by employing rationalizations or other means to nullify their internal objections to the behavior (Duffield and Grabosky, 2001).

INSURANCE FRAUD AND THE HONEST CONSUMER

Most analysts believe that the costs and prevalence of opportunistic soft fraud—particularly buildup—vastly outweigh those of the more systematic, planned, or criminal claims fraud. This suggests that consumer ethics, attitudes, and psychology are an important element in the insurance fraud equation. Empirical studies support the idea that accepting attitudes toward fraud contribute to excessive claiming in insurance markets. In an analysis of bodily injury liability claims rates in private passenger automobile insurance, Cummins and Tennyson (1996) found that the percentage of consumers in a state who found claims fraud to be acceptable was positively and significantly related to the statewide claims rate. In a similar study of life insurance claims, Colquitt and Hoyt (1997) found that the extent of fraudulent claiming in a state was significantly and positively related to the percentage of the state's consumers who found claims fraud to be acceptable.¹³

Indicative of the scope of the problem, surveys show a high level of acceptance of claims fraud among consumers. In periodic surveys over the past 20 years, the IRC has found that a relatively large minority of consumers find some forms of insurance claims fraud to be acceptable. For example, in a 1989 survey, 25 to 31 percent of consumers viewed exaggerating a claim to be acceptable in some circumstances and in 2000 these percentages remained nearly the same—between 24 and 35 percent. These percentages have declined somewhat in recent years but remain high: in 2003 (the latest year data is available) between 20 and 29 percent of surveyed consumers found claims exaggeration acceptable.

The averages mask great variation in attitudes. Cummins and Tennyson (1996) find substantial regional variation in fraud accep-

tance in IRC survey data, and IRC analysis of the data shows differences between large and small cities and rural areas. Analysis of individual survey responses reveals attitudes vary by demographic characteristics. Tennyson (1997) finds that women, the highly educated, and the elderly are less accepting of claims fraud, and Dean (2004) provides evidence of lower tolerance of fraud among women. Tennyson (1997) also finds a role for personal ethics, finding that consumers' acceptance of insurance fraud and tax fraud are significantly and positively related. Tennyson (2002) finds that consumers' with more insurance experience (more policies and more claims) are less accepting of insurance fraud.

Evidence from a more detailed survey by the Coalition Against Insurance Fraud (CAIF) provides a richer view of social and personal determinants of attitudes toward fraud. This study categorized consumers according to their survey responses regarding attitudes toward insurance fraud and beliefs about appropriate penalties (CAIF, 1997). Consumer beliefs varied from complete rejection of fraud and the view that it should be harshly punished, to tolerance of fraud under certain circumstances, to acceptance of fraud and the view that it should be only lightly punished. Using cluster analysis the study found four distinct groups of consumers. *Moralists* were those who were least accepting of insurance fraud and favored strong punishments for fraud; *realists* generally thought insurance fraud was unethical but acknowledged that it happens and were willing to justify it in some cases; *conformists* were fairly accepting of insurance fraud because they thought it was common; *critics* had the highest acceptance of fraud, along with negative views of the insurance industry. These clusters are supportive of broad sociological influences on consumers' fraud attitudes.

Moral-psychological factors also appear to be important. For example, consumers are more accepting of fraud when it is rationalized as reimbursement for previous expenses (premiums or deductible) than when it is not (IRC, various years). Differences in consumer fraud acceptance rates using different survey instruments are also suggestive. For example, both the IRC surveys and the CAIF survey asked respondents about their views

of the acceptability of various forms of insurance claims fraud. However, in the CAIF survey these questions were preceded by a series of questions regarding ethical behaviors, reasons for thinking that certain behaviors are ethical or unethical, perceived degree of concern about insurance fraud, and the effects of fraud on insurance premiums. Perhaps not surprisingly, fraud acceptance among the CAIF survey respondents was far lower than the levels found in IRC surveys. Only 2 to 5 percent of respondents found fraud behaviors acceptable in the CAIF survey, compared with 25 to 39 percent (over various years) in the IRC surveys. Similar results were found by Brinkmann and Lentz (2006) with Norwegian and German subjects: using the CAIF survey instrument they found fraud acceptance rates ranging from 3 to 4 percent. These results may be explained by the preliminary questions activating respondents' internal honesty standards as discussed in Mazar, Amir, and Ariely (2007).

FOCUSING ON SOCIAL AND PSYCHOLOGICAL DIMENSIONS

Over the past 20 years, insurance claims fraud has received increasing attention in the insurance industry, in academic studies, and in public policy spheres. Empirical studies of fraud have proliferated and the findings have stimulated innovation in methods of classifying claims and detecting fraud. On the public policy front, antifraud watchdog and advocacy groups have appeared on the scene along with insurance fraud awareness campaigns and stronger laws against fraud. The resources devoted to researching and policing insurance fraud have increased substantially.

Much of the focus has been directed toward detecting and criminalizing fraud. Fraud awareness campaigns often emphasize the criminal nature of fraud and the likelihood of being caught and penalized, and success in fighting fraud is often measured by number of cases brought or convictions obtained.¹⁴ Derrig (2006) notes an increased willingness on the part of insurers to litigate fraud and to refer cases to law enforcement agencies. Yet opportunistic soft fraud is widely believed to be much more prevalent than criminal fraud. Care must be taken in

applying these approaches to address this broader problem. Improving fraud detection and advertising this fact may provide an effective deterrent to some opportunistic fraud. A criminal focus may also help to instill consumer beliefs that insurance fraud is not commonplace and not acceptable. However, research suggests that many consumers do not view some forms of claims exaggeration as fraudulent. They may not relate messages about "insurance fraud" to these behaviors. For the majority of the consuming population, education and awareness efforts might be better directed to different messages. A criminal focus applied to these cases may reinforce negative perceptions of insurance institutions and their fairness to consumers. Negative perceptions may encourage more fraud and may lead to other consequences such as stronger regulation or stricter bad faith claims settlement laws.

Experimental research suggests that consumers are less likely to take advantage of opportunities to cheat if internal honesty monitors are activated in the moment of decision. Consistent with this, evidence from consumer surveys suggests that when internal monitors are primed, most consumers state that insurance fraud (even minor claims exaggeration) is unacceptable. The evidence also shows that consumers with more insurance experience and those with recent claims experience are less likely to believe that claims exaggeration is acceptable. These patterns imply that preventing opportunities to cheat, improving consumer knowledge, and providing moral cues in claiming situations may be more effective policies in reducing opportunistic soft fraud. More generally, greater focus on the social and psychological dimensions of insurance claims fraud may increase the success of soft fraud prevention and decrease the likelihood that the focus on fraud will impair insurance relationships.

NOTES

1. These characteristics imply that insurance claims fraud is a form of (ex-post) moral hazard in the insurance contract; that is, the insurance contract will by its very existence produce the incentives for consumers to claim more than is owed from the insurer.

2. It also misses the fact that policing for fraud may have deterrent effects.
3. Empirical studies confirm that problems of this form occur in some markets for auto repairs; see Hubbard (2002) and Schneider (2007).
4. Darby and Karni (1973) provide the first treatment of this problem. Dulleck and Kerschbamer (2006) provide an integrated treatment of the theoretical literature that has developed.
5. The Coalition Against Insurance Fraud discusses this type of fraud on its website <http://www.insurancefraud.org/auto_repair_fraud.htm>.
6. Hyman (2001) is careful to acknowledge this point.
7. An exception is the work of Caron and Dionne (1997), who estimate that fraud accounts for about 10 percent of total claims costs in Quebec automobile insurance.
8. Dionne and St-Michel (1991) find that changes in workers' compensation coinsurance rates affect the duration of work absence for sprain injuries but not for injuries that are easier to diagnose. Meyer, Viscusi, and Durbin (1995) find that changes in state rules that increased workers' compensation benefit amounts for some workers but not for others led to longer injury durations for workers affected by the increase but not for the others. These patterns are consistent with fraud but may also reflect underreporting prior to the changes.
9. In fact, theory shows that if insurers could precommit to the optimal auditing strategy (forever) then all claims fraud would be eliminated and audits would serve only as a deterrent. More realistically, when precommitment is not possible, auditing serves to both detect and deter fraud (Khalil, 1997).
10. For theoretical development of these ideas see Sykes (1996); Crocker and Tennyson (2002); Loughran (2005). Empirical studies suggest that insurers at least implicitly employ such strategies (Crocker and Tennyson, 2002; Loughran, 2005).
11. For the earliest work on this idea see Klein and Leffler (1981).
12. Laws requiring insurers to print a warning on application and claim submission forms stating that insurance fraud is a crime, and laws

requiring the state to form an insurance fraud bureau, had no significant effect on claims levels.

13. Both of these studies used data on fraud attitudes from the IRC's *Public Attitude Monitor* series.
14. The CAIF provides examples of campaigns; see <http://www.insurancefraud.org/public_outreach/index.htm>.

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