

FERRETING OUT FRAUD:
THE MANUFACTURE AND CONTROL OF FRAUDULENT INSURANCE CLAIMS

by

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ABSTRACT:

This exploratory inquiry into fraud and its control examines insurance fraud as one type of business-related crime. Insurance fraud is defined as the manipulation of loss circumstances and reports (including to whom, what, where, when and how losses occur) in order to claim insurance benefits that otherwise would not be forthcoming. Since false claiming can be usefully conceptualized as rule breaking committed through or mediated by conventional insurance transactions, the study of such behavior is appropriately focused on the interaction between insurance activities, fraudulent behavior and fraud control. Transactions, rather than individuals or organizations, provide the empirical context for this inquiry.

Data were obtained from a number of sources. In-depth interviews were conducted with insurance claim personnel, claimants, and public and private fraud investigators. Cases were reviewed as part of field site visits with a private investigative agency and a state-run fraud bureau. Secondary sources--e.g. trade journals, claim association proceedings, criminal indictments, newspaper articles and insurance texts--were used as well.

Two questions informed the analysis. First, since insurance fraud offenders use the insurance process to obtain benefits unlawfully, to what extent do insurance organizations and activities influence the construction of false claims. Second, to what extent do processes of image manipulation and the relationship between deceiver and insurance organization influence abilities and incentives to detect and control fraudulent behavior.

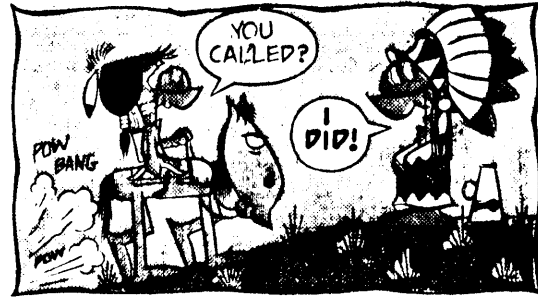
The model of fraud and fraud control developed in this study argues that fraudulent activity persists because of features of insurance process and deceptive behavior which permit offenders to manipulate loss images and reports and discourage potential

social control agents from exerting control. Incentives and opportunities for fraud and its control are analyzed as a consequence of the contradictory character of insurance activities and relationships providing opportunities to deceive, opportunities to conceal the offences, and limits on fraud recognition and control. The uncertainties associated with insurable risk permit fraud offenders to construct deceptive images of loss. Legitimate transactions and organizations cover-up fraudulent intent and shield fraud offenders from their targets. Control, like fraudulent behavior, is mediated through the insurance organization. Other insurance goals and activities often supercede fraud enforcement efforts. Finally, fraud effects are diffused limiting further the incentive to control deception.

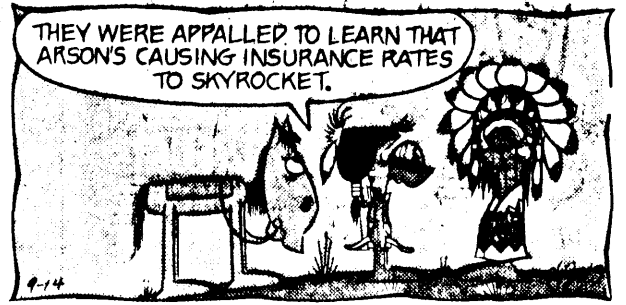
This research highlights an important perspective for analyzing programs and policies. In addition to evaluating whether programs meet their stated objectives, analysts should examine a program's influence on the generation of unintended or deviant outcomes. In this dissertation concepts useful for analyzing the insurance role in the production and control of fraudulent claims are developed.

Thesis Supervisor: Dr. Gary T. Marx
Professor of Sociology

HEROES
by T. KRAN



YOUR FIRE-ARROW SHOOTERS
ARE LOOKING PATHETIC IN
THIS BATTLE!.. YOU'RE THEIR
LEADER! WHY AREN'T THOSE
MEN AFLAME (SIC) WITH ZEAL!



ACKNOWLEDGMENTS

This research would not have been possible without the support, friendship, good-will and patience of many, many people only some of whom I am able to mention here. Gary Marx provided the inspiration to do good work, intellectual encouragement for my own work, insightful criticism, solid advice and support, not only during the course of this research, but throughout my entire graduate program. Deborah Stone and Steven Spitzer continually provided me with thoughtful comments, suggestions and encouragement and I thank them for their time and interest. Susan Bartlett and Cindy Horan, my closest school chums, were constant sources of support, emotionally and intellectually, and helped keep me going when the going seemed to get rough. My fellow "fellows" at the Joint Center for Urban Studies deserve mention for having sat through some crazy lunches and for being around and listening to me trying to make sense out of all of this.

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My closest friend and strongest supporter, my husband Charlie Gwirtsman, deserves at least half of my PhD degree. He got me through it. Charlie, I have just one question—"Do I have a dissertation?"

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INTRODUCTION

Over the past decade insurance scams have become nationally recognized phenomena. Arsons-for-profit, medicaid fraud, welfare fraud—terms once familiar only to program administrators—are commonly known today. Arson-for-profit is perhaps the most visible of all types of insurance fraud. The burning of America's cities has been well addressed in national and local media. The United States Senate as well as other state and local legislative bodies have established special commissions to study the problem. Community groups have organized around the arson issue. Enforcement task forces have been established in several jurisdictions.

Ronald Reagan's 1980 presidential campaign rallied around the issue of "fraud, waste and abuse" in government services. Campaign rhetoric identified categories of welfare, medicaid and food stamp "cheats." In arguing for separating the "truly needy"—those deserving benefits—from those receiving them,

Reagan suggested implicitly, if not explicitly, that United States citizens were stealing from their social insurance system.

Doctors, lawyers and auto body shop owners who set up phoney automobile accidents and then submit phoney claims to insurance companies have been exposed by national and local media. In 1980 reporters from the Chicago Sun Times and TV station WLS went "undercover" to expose an organized insurance fraud ring involved in setting up fake automobile accidents and submitting phoney insurance claims to several insurers. Reporters uncovered instances of unnecessary treatments, even surgery, simply for the insurance payoff. Also in 1980 Massachusetts' Governor Edward King created a task force to examine auto theft and auto theft fraud. The task force reported that an estimated twenty-five percent of all reported auto thefts were actually fraudulent.

In addition to the highly publicized arsons-for-profit, medicaid mills and fraudulent auto thefts, insurance schemes include: persons who murder their spouses for life insurance benefits; men who deliberately shoot off their arms and legs for disability benefits; and families who act out burglaries in their own homes. The thread which ties arson fires, welfare cheating, phoney accidents, intentional injuries and fabricated auto thefts together is the potential for filing fraudulent insurance claims—theft by deception.

All insurance programs, public and private are susceptible to fraud. Fraud means simply willful deception. Offenders deceive, trick, or, in some way, pervert or manipulate truth in order to induce others to part with their property or to surrender legal rights (e.g. insurance benefits). Insurance fraud offenders manipulate facts so that it appears as if they are eligible for insurance compensation when they are not. A successful insurance fraud projects a credible account of loss when no such insurable loss conditions, in fact, exist. Offenders use the system, deceptively, to convince those allocating benefits that they are deserving of insurance compensation.

1.0 CONCEPTUALIZING BUSINESS--RELATED THEFTS

Insurance fraud can be categorized as one of a number of business-related thefts. Embezzlement, employee thefts, check forgeries are others. The literature on business-related crimes has produced a number of different ways to conceptualize them. Business-related crimes have been conceptualized as crimes committed by persons in the course of their white-collar occupations, crimes committed by individuals in organizations, crimes committed by organizations, or crimes committed against organizations. These conceptualizations focus on the victim (is it an organization and if so, what kind?) on the offenders (an organization or an individual?) or on the social control agents (inside or outside regulators?).

The analytic split between victims, offenders and social control agents common to conventional views of business-related crimes obscures one of the most important features of business-related thefts. Offenders utilize conventional business transactions and actors to commit their crimes. Offenders are part of the system and use the system to beat it. Distinctions between rule breaking and conventional activities and actors are often blurred.

Since the interaction between conventional transactions and rule breaking is an important feature of business-related crimes, they can be usefully conceptualized as crime committed through or mediated by conventional organizational transactions. Unlike other forms of theft, offenders do not have to "break into" the system. Once inside, offenders need not take extraordinary measures to achieve their ends. Consider, for example, fraudulent insurance claims. Insurance fraud offenders are insurance policyholders and, thus, have purchased the right to be claimants. Conventional claim processing transactions provide the vehicles through which these insurance "thefts" occur.

Offenders often commit business-related theft through organizations or economic systems which have existing social control mechanisms. Financial organizations have audit systems. Insurance claim departments employ adjusters or investigators whose jobs are to verify claims. Thus, fraud offenders commit their crimes through organizational systems which make some

attempt to control their rule breaking behavior.

2.0 QUESTIONS RAISED BY CRIMES MEDIATED THROUGH ORGANIZATIONS

This conceptualization of crimes committed through or mediated by organizational or economic transactions raises two questions. First, since offenders commit their crimes through organizational transactions, is there something about conventional transactions or the relationship between offender and organization which helps explain the rule breaking behavior? Is there something about the business or economic context which facilitates, provides opportunities for or even generates rule breaking? Second, since some mechanisms of control are formally in place, is there something about the nature of deviant transactions which limits or neutralizes control? Is there a mismatch between type of control and type of deviance produced through economic transactions?

These questions are explored by examining one form of rule breaking through organizations—property-casualty insurance frauds. The two general questions about crimes committed through organizational transactions can be asked more specifically for property-casualty insurance frauds. First, since insurance fraud offenders use the insurance process to obtain benefits unlawfully, to what extent do insurance organizations and activities influence the construction of false claims. Second, to what extent do the processes of deception and the relationship

between deceiver and insurance organization influence abilities and incentives to detect and control fraudulent behavior.

In the following chapters I argue that the insurance mechanism provides opportunities for individual deviation and fraud by insurance claimants because of the inherent ambiguities and uncertainties in the insurance product and process. The lack of certainty with respect to individual losses permits policyholders to shape loss circumstances and reports to their advantages. Offenders who engage in processes of image manipulation are often able to neutralize the fixed structures of conventional claims process and fraud control. The uncertainty which permits the manipulation of false images also limits the ability to attribute fraudulent motive to a given set of claiming behaviors. Finally, control, like fraudulent behavior, is mediated through the insurance organization. Insurance goals of claim service often supercede fraud enforcement goals. Fraud effects are diffused throughout the insurance system further limiting the incentives for fraud control.

Implicit choices regarding how much and what types of fraud can or should be tolerated and/or controlled are made by insurance actors as they perform their insurance tasks. By isolating the relationships between fraud, fraud control and insurance process, I hope to bring those implicit choices to the foreground of public debate. As the insurance institution spreads to cover more and more of the uncertainties and

complexities in our society, the negative effects of insurance, as they are manifest in fraud and abuse, beg further analysis. This exploratory inquiry into the manufacture and control of fraudulent insurance claims is a first step in that process.

3.0 METHOD OF ANALYSIS AND DATA COLLECTION

Since insurance fraud can be usefully conceptualized as rule breaking committed through or mediated by conventional insurance transactions and organizations, the study of such behavior is appropriately focused on the interaction between insurance process, fraud and fraud control. Focusing on transactions and their outcomes, rather than on individuals or organizations, provides an empirical context for such an inquiry. One can consider how insurance organizational structures affect common interaction strategies, including deception. Conversely, one might consider how the structure of deception affects control processes.

This exploratory inquiry into insurance fraud and its control is ethnographic in the sense that it is holistic, but, unlike more traditional ethnography, the analysis is not confined to a specific setting. The research is designed as a generic analysis of the system of insurance fraud and its control. It is not a study of a particular agency nor an analysis of a specific set of cases. "Ferreting Out Fraud" is a study of processes and how those processes are influenced by institutions, not a study

of institutions nor individuals.

My research is informed by other studies of crime in industry which stress the important role industry structures—in particular, legal, economic, organizational and normative components—play in encouraging deviant behavior. (See, for example, Faberman, 1975 on the automobile industry; Denzin, 1977 on the retail liquor trade; Needleman and Needleman, 1979 on fraud in the securities industry; and Pontell, Jesilow and Geis, 1982 on practitioner fraud in the Medi-Cal program.) These studies of criminogenesis argue that some criminal behavior can be analyzed as a "predictable product of an individual's membership in or contact with organizational systems." (Needleman and Needleman, 1979; 517—a point also made by Vaughn, 1982)

My approach to the study of insurance fraud also bears some similarities to recent criminological research which borrows from the human ecology school. Cohen and Felson (1979) in the clearest articulation of the approach consider the interdependence between the structure of illegal activity (predatory violations such as rape, robbery, assault and personal larceny) and the organization of everyday life.

My analysis differs from the studies above in that my focus on structural opportunities for fraud does not ignore or minimize the importance of human agency. My analysis does not assume that offenders are passive agents, but that they act to manipulate the targetted system to their advantages and attempt to neutralize

efforts to control their fraudulent behavior. I am arguing for something of a synthesis between the structural and interactive approaches to the study of deviance.

The research was limited to property-casualty insurance frauds as a matter of choice. Fraudulent claims against automobile, homeowners' and commercial policies are included, while claims against disability, health and life policies are excluded. Other forms of social insurance are excluded from my analysis as well. (See Chapter Two for a more systematic discussion of the kinds of insurance policies covered under this research.) Several factors influenced my choice of fraud type. Because I was interested in the interrelationship between private and public sector activity, I chose private sector insurance frauds rather than frauds against public systems. Since arson and auto theft frauds were openly discussed in the media, I believed that information might be more readily available for these fraud types than for many others. Finally, the structural division of the insurance industry into property-casualty and life sectors, with companies specializing in one or the other, dictated that I choose among sectors.

Although insurance fraud appears to be widespread, it is conducted in an atmosphere of secrecy. (In this respect this study is similar to Reisman's study of bribery (1979) and Sherman's study of police corruption (1978) and suffers from some of the definitional problems cited in their work.) Because frauds

are typically hidden from view, to study them one must often rely on control agents' identification of fraudulent behavior. Thus, in some cases, the activities of enforcement agents were not only a subject of inquiry, but enforcement agents became resources for understanding fraudulent transactions as well.

As will become clear throughout this analysis, the fraud control system is often composed of many different actors, working at different levels, yet focusing on the same sets of events. In order to draw a picture of the multiple levels of enforcement agents and their potential for conflict and cooperation, data were gathered from representatives of as many enforcement agent types as could be identified. In-depth attention was focused on those agency types which deal exclusively with insurance fraud activities (see appendix A).

Data on fraudulent activity and its control were obtained from a variety of sources. Seventy-two interviews were conducted with insurance claim managers, policyholders, fraud investigators employed directly by insurance companies in special investigative units, private investigators, industry-supported investigators as well as with prosecutors and other law enforcement personnel concerned with the fraud problem. Data were collected from fifty-eight case files reviewed during a ten day field site visit with the Florida Division of Insurance Fraud. Case files were also reviewed during a sixty day observation field/site visit with a private investigative agency. Secondary sources, fraud

manuals and insurance texts, biographies of fraud investigators and claim managers, histories of insurance companies as well as newspaper accounts (popular and trade) were used to gather data on fraud and its control. [Note: Newspaper accounts are fairly reliable sources for data on fraudulent activity. Insurance fraud has been the subject of several media exposés which have been followed by indictments and convictions of named offenders. I have learned that many of the newspaper articles were written either directly from the indictments or from the press releases of the investigative agencies involved. While they may exaggerate the quality of participation by the particular agency, the indictment facts stand.]

One important caveat must be introduced. This research examined only (1) insurance claims singled out as likely frauds and considered for further investigation, although in many cases no further action was taken; and (2) in a few instances, claims which claimants admit were fraudulent but which the insurer recognized as legitimate. Unfortunately, this research is limited in what it can say about successful frauds—frauds which pass through the system as if they were legitimate. Nevertheless, we can use discovered fraud to make inferences about successful ones.

The great advantage to an academic inquiry of this kind is the oversight and distance it permits the researcher. Because I was not grounded in a particular organizational locale, I could

view the system from a broad perspective, a view not typically afforded to those directly involved in day-to-day affairs of fraud and fraud control. My analysis of the manufacture and control of fraudulent insurance claims is a synthesis of all my field experiences and the experiences related to me by my informants. It is to those experiences that this research owes its greatest debt.

CHAPTER 1

FABRICATED CRIMES, CONTRIVED LOSSES, AND OTHER DECEPTIVE ACTS

Insurance fraud offenders obtain insurance benefits by wilfully deceiving those allocating compensation. In so doing, fraud offenders manipulate the meaning of the insurance relationship and transform a system of compensation into a system of gain.

The insurance mechanism is a means for sharing and, thus reducing, individual uncertainty. A group of individuals, subject to the same perils (e.g. fires, auto accidents, the threat of suit because of damage to another), contributes to a shared "risk pool," organized and administered by a private insurance company, enabling those who suffer from the named perils to recover from their misfortunes.

"The uncertainty which characterizes the single risk is exchanged for the relative certainty of the combined risks. . .this must be considered the prime function of insurance." (Gephart, 1917;27-28)

Individuals experiencing such losses recover by claiming from insurance companies sums which are sufficient to restore them to

their financial statuses prior to their losses.

The insurance commodity, a policy or contract, establishes the insurance relationship. Unlike durable goods exchanged in the market, the insurance product is intangible and contingent. In return for premiums policyholders receive the promise of protection should they be subject to some named event. Individuals trust that by paying an insurance premium their assets are protected. Those who assume risk (the insurance companies) trust that the risks they assume are fortuitous—beyond the control of policyholders. (Denenberg, 1968) [1]

Fraud offenders undermine the insurance relationship by manipulating loss events, images and reports. Insurance personnel are deceived by fraud offenders into believing that claims represent compensable losses when they do not. A Florida man, for example, filed a personal liability claim against his parents' homeowner's insurance policy. He claimed that he sustained injuries when he fell in his parents' bathtub. If true, a fall of that kind would be compensable under a homeowner's insurance policy. In the course of their investigation, however, claim evaluators learned that the man had not injured himself in the bathtub as he stated, but in an auto

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1. Pfeffer (1974;209) refers to insurable risks as ". . .the perils to which the individual is objectively exposed at any time." (my emphasis) This does not mean that risks are random. Individuals often take measures to change the relative probabilities that risks will occur.

accident not covered by an insurance policy. Since the auto accident was not covered, this individual constructed a scenario to make his non-compensable loss appear to be one covered under an existing insurance contract.

Opportunities for manipulating loss events and reports are often generated within or by the insurance relationship since exactly what is bought and sold—the perception of security based on contingent claims service—is not well-defined, and cannot be well-defined, at the outset. The uncertainties associated with specific loss events provide fraud offenders with latitude for manipulating and shaping those events. Attempts to reduce aggregate uncertainties through the insurance mechanism open up new possibilities for individual deviation and fraud. Finally, the social organization of deception and the flexibility of image manipulation permit fraud offenders to subvert the fixed structure of insurance process and neutralize control.

The relevance or appropriateness of defining insurance fraud as a problem of social deviance is questioned by public attitudes toward fraud. While arson is clearly viewed as a social problem worthy of intense scrutiny, other frauds, for example ditching a car into the lake and then reporting it stolen are often not viewed as particularly troublesome to many insurance consumers. In fact, it appears that "ripping off" the insurance company is considered by many as legitimate behavior. Individuals see little need for controlling some frauds because "everybody does

it" and "my doing it will not make much of a difference." Insurance fraud is perceived as a way to get something back from insurance companies. From that perspective fraud is almost an entitlement awarded for having participated in the private insurance system.

By perceiving fraud as an entitlement, something due to us for participating in the system, we often ignore the insurance company role in "granting" such "benefits" in the first place. Under what circumstances do companies, wittingly or otherwise, "permit" or "tolerate" fraud? When do they take steps to control fraudulent behavior? By ignoring insurance companies' participation in the production and control of fraudulent claims we minimize their part in defining where and when the fraud problem exists and how and when it should be controlled. For example, the insurance industry may conceive of arson fraud as a problem of a few "unscrupulous" landlords who use fire to maximize profits and ignore their own participation in facilitating or providing opportunities for fire to be used in this way. If companies tolerate some frauds and not others, this selective system of enforcement requires further inquiry. Who are the beneficiaries of fraud tolerance?

Perceiving fraudulent behavior as a system of individualized "just desserts" also ignores the significant consequences of collective action. Estimates of the dollar losses attributed to fraud run in the billions. A representative of the American

Insurance Association noted that fraudulent claim costs could exceed \$11.5 billion a year (The New York Times, July 6, 1982). In comparison, dollar losses from reported crimes of robbery, burglary, larceny and motor vehicle thefts were estimated at \$9.03 billion in 1980 (Insurance Facts, 1981). These significant fraud costs are distributed throughout the insurance system, often back to policyholders in the form of higher rates [2]. Companies unable to absorb fraud costs or unable to pass those costs to consumers or other insurers may become insolvent and, thus, place their legitimate policyholders at some risk.

Fraud effects also are absorbed directly by those involved in the deceptive losses. Claim evaluators who are deceived may lose their confidence or even their jobs. Buildings are needlessly burned and lives lost in fraud fires. Unwitting accomplices to fraud may suffer personal distress at their involvements should they be discovered. Finally, society, as a whole, bears some costs as deception and secrecy undermine trust relationships.

The complexity of fraudulent behavior and the wide range in fraud consequences beg for an analysis that can recognize different degrees of fraudulent activity and point to factors that might account for the persistence of fraud within the insurance system. The conceptual model of fraud and its control

2. As noted elsewhere (Brill, 1982;63) higher premiums place disproportionate burdens on policyholders. Insurance is a form of regressive tax. Lower income policyholders pay a larger share of their disposable income for insurance.

developed in this study highlights variations in fraudulent behavior that can be used as a starting point for informed public debate on the costs and benefits of fraud and fraud control. For example, the model allows one to distinguish frauds that take place after a loss has already happened in order for individuals to take advantage of the loss situation from frauds where the advantage to individuals comes only after their direct participation in creating the losses themselves. By isolating points at which deception and insurance process come together, the model draws out the seemingly symbiotic relationship between deception and insurance and, thus, may inform debate on the utility of current and proposed strategies for fraud enforcement.

1.1 INSURANCE FRAUD DEFINED

Statutory definitions of insurance fraud such as Florida's False and Fraudulent Claim statute include, as criminal violations, a vast array of false or misleading statements. For example the Florida statute (817.234) states that

"any person who, with the intent to injure, defraud or deceive any insurance company. . .presents or causes to be presented. . .prepares or makes any written or oral statement that is intended to be presented to any insurance company in connection with, or in support of, any claim for payment [or] other benefit pursuant to an insurance policy, knowing that such statement contains any false, incomplete or misleading information concerning any fact or thing material to such claim; is guilty of a felony of the third degree."

Interviews with claimants, claims personnel and fraud investigators suggested that any useful definition of fraud had to distinguish the simple exaggerated claims from those that are constructed deliberately. They associated different degrees of rule breaking with false claiming. Some claim inflation is expected by the insurance organization and condoned by most actors. Manufacturing a loss in order to claim benefits to which one is not entitled, however, is considered a more serious violation of the insurance relationship. One claims manager commented,

" . . . You know, we all have a little larceny in our hearts, although we don't commit the act intentionally. Once the act is committed, we have a tendency to overestimate the damages. That's one of the reasons we have insurance adjusters. That's the term—adjust figures back so that both parties are fairly treated. We have gone from that to the bold, committed act [of fraud]." (interview no. 6.)

The distinction between inflated claims and fraudulent ones is underscored by recognizing two ways in which one can profit from losses covered by insurance policies. The first way is to exaggerate the value of a loss. As the above quote indicates, a certain amount of exaggeration is generally expected and a rather formal bargaining mechanism has been developed to reduce its effect. The second way to profit from insurance is to orchestrate the conditions of losses in order to deceptively claim insurance benefits. In the second case, the case of fraud, individuals ask to be compensated for losses, or parts of losses, they played a role in constructing. Since issues of value are

perceived differently than issues of legitimacy, a useful definition of fraud must separate claim inflations (expected, if not condoned by the insurance system) from fraud, the manufactured appearance of an insurable loss.

Insurance fraud can be defined as the manipulation of loss circumstances and reports (including who, what, where, when and how losses occur) in order to claim insurance benefits that otherwise should not be forthcoming. Losses may be ineligible for insurance coverage for one of several reasons: the loss may not be covered under an existing insurance contract; the loss may never have occurred; or the loss may have been intentionally created simply to commit fraud. Since fraud offenders must convince insurance personnel that their claims represent compensable losses, the key factor in the deception is the manufactured appearance of an insurable loss [3].

While separating fraudulent activities from claim inflation may be analytically easy, in practice, there are many obstacles to recognizing behavior as "intended deceit" rather than "expected exaggeration." The fine and arbitrary line between claim inflation and fraud often blurs the behavior in the real world.

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3. My definition of insurance fraud is consistent with the elements of white-collar crime cited by Edelhertz, *et. al.* (1977;21-22) They claim that there are five elements to white-collar crime: (1) intent to commit a wrongful act; (2) disguise of purpose; (3) offenders' reliance on the ignorance or carelessness of the victims; (4) victim voluntary action to assist offender (e.g. issuing a settlement draft); and (5) concealment of the offence.

Interestingly, while insurance activities are oriented to evaluating whether a claim is compensable—i.e. whether the claim meets the contract criteria—or whether claims are inflated, claim processors are not necessarily equipped to determine whether or not a loss happened in the way the policyholder claimed. In the words of one claim manager,

"If I gave you the story of a loss and I told you to examine this piece of information for the purpose of deciding whether we should or should not pay it, you'd come to one conclusion. But, if then, I changed the perspective and told you I wanted you to examine the same situation to determine if it's true, you'd come to another." (interview 6)

Thus, while claim personnel argue for a distinction between claim inflation and fraud, it is not clear that insurance activities are well-designed to recognize that distinction in practice. Additionally, some claims personnel believe that complacency regarding claim inflation may actually encourage policyholders to cross over from simple inflation to outright fraud.

1.2 FRAUD INCIDENCE

Problems of definition and recognition translate into methodological difficulties in studying fraud and estimating incidence. As is true for most rule breaking situations we only discover a fraction of actual rule breaking behavior. The problem of determining insurance fraud incidence is compounded further by the lack of centralized accounting mechanisms. Many diverse agencies, public and private, are responsible for fraud

investigation.

In general estimates of insurance fraud ranged from ten to twenty percent of all claims filed, although it is never clear exactly what gets counted in these estimates. There is at least a perception that fraudulent behavior is increasing. Many noted that particular schemes were dominant at different points in time. For example, some commented that arson fraud has been a problem only at selected periods, usually around business recessions. The American Insurance Association, an umbrella organization for insurance companies, estimates that fifteen to twenty percent of insurance claims are fraudulent, an increase from a decade ago when fraudulent claims were estimated to account for only five to six percent of all claims filed. (The New York Times. July 6, 1982)

The All-Industry Research Advisory Council, a research organization serving insurance companies, conducted a survey of 1,544 adults to examine their attitudes toward the property-casualty insurance industry. Respondents were asked whether they knew anyone who had made a false claim. Seventeen percent (17%) declared they did. Analysts report that those knowing someone who had filed a false claim were most likely to be aged twenty-five to thirty-four and to have incomes in excess of \$30,000 (AIRAC, December, 1981; 15-17).

1.3 OTHER CONCEPTS/MODELS OF FRAUD

1.3.1 MORAL HAZARD

The possibility that the insurance mechanism might increase loss experience and consequence has been recognized by other social scientists, particularly economists, as a form of moral hazard. The literature identifies two types of moral hazard (Dionne, 1981). The first type occurs when policyholders substitute insurance for protection. For example, rather than buying additional locks to guard against thieves, homeowners purchase insurance to provide compensation in the event that a theft occurs. Since policyholders reduce self-protection, the potential for losses increases. The second type of moral hazard occurs when policyholders increase consumption of services simply because insurance pays for them. According to the economic theory, policyholders have no incentives to control inflated, or even fraudulent, charges for services provided to them because of the insurance subsidy (Pauly, 1968; Arrow, 1968 and Marshall, 1976).

The theoretical concept of moral hazard assumes that the relationship between insurance and increased losses reflects problems of efficient allocation of economic resources. The economic problem of moral hazard can be corrected, at least theoretically, by more efficient distribution of risk through the market. To reduce moral hazard insurance consumers should absorb more financial risk, either by paying higher rates or by becoming

partners in the insurance policy through co-insurance clauses and high deductibles. Having absorbed more of the risk, policyholders will have greater incentives to control inflated or fraudulent costs and to protect themselves against losses.

The model of fraudulent behavior proposed in this research suggests that frauds against insurance companies cannot be explained simply as a problem of allocating risk through the market. Higher premiums or deductibles might control some frauds, but increase the possibility of others. For several years insurance experts have suspected that the potential for losses increases as a function of higher premium rates. Researchers at Peter Merrill Associates have introduced the concept of "premium retrieval" to capture that relationship [4]. They argue that policyholders attempt to recover portions of their premiums, often in dishonest ways, in order to obtain desired returns on their "investments." (Peter Merrill

4. Peter Merrill Associates studied the statistical relationship between auto theft rates and increasing premiums. Traditionally, researchers have inferred that the strong correlation between theft rates and premiums was due to rate relief— auto insurers passing on the increased cost of theft to policyholders in the form of higher rates. Researchers tested the hypothesis that the relationship might work in the other direction as well. Using a series of least square regressions they found statistical support for increased theft rates as a consequence of increased premiums. From this they inferred that "premium retrieval" (policyholders attempting to recover a portion of their premium investments in dishonest ways) is a real and important factor in motivating auto theft (p.40). While one can question their methodology and their inferences, I believe it is significant that some segments of the insurance community are aware that high premiums might increase, rather than decrease, losses, including fraudulent losses.

Associates, 1980;40, also cited in the Massachusetts' Governor's Task Force on Auto Theft, 1980;28).

Furthermore, it is not clear that high premiums will deter fraud offenders in cases where the payoff is considerable. Fraud investigators interviewed in this research suspect that potential arsonists, unable to purchase insurance in conventional markets, are willing to pay significantly higher premiums in specialized markets simply because the return on their investments remains substantial.

Moreover, the concept of moral hazard does not adequately explain how and why fraud offenders are able to manufacture loss circumstances and reports to their advantages. The economic model cannot explain why frauds occur in some situations and not others, nor exactly how insurance process facilitates the use of deception. To understand the behavioral variation in fraudulent activity one needs to examine the opportunities to distort or manipulate loss events and reports allowing offenders to deceive insurance personnel into providing compensation when it is not due.

1.3.2 LACK OF CONTROL

The insurance fraud problem also has been conceptualized in terms of lack of control. Control may be lax because of poor risk selection (insuring fraud prone individuals), or too little enforcement by investigators verifying claims or conventional law

enforcement prosecuting fraud offenders [5]. While I cannot discount the positive effects of more control, the assumption that we can select out or control fraud either at the application stage or when claims are filed is problematic for several reasons. Control, like fraudulent behavior, is mediated by the business of insurance. Future fraud offenders are often hard to identify before frauds actually occur. Finally, it is not clear that insurance companies wish to control the behavior of their policyholders/clients in all situations. Organizational goals to maximize profits may supercede enforcement goals, for example [6].

My analysis suggests that opportunities for fraud will persist because of the uncertainties in the insurance relationship which facilitate the manipulation of events and images. The insurance context and the nature of deceptive

5. There appears to be an interesting shift in industry position over the last decade. At the time Ross (1970, revised 1980) conducted his study of insurance adjusters the public policy issues were unfair claim denials and insurance availability. Companies responding to public criticisms that they were too quick to deny claims were happy to project the image that, when in doubt, claims were paid. Now when arson and fraud are at the forefront of public debate and insurance companies have been accused of lax claim settlement, companies are less comfortable with their images of quick claim payers. Insurance officials seem eager to argue that they are forced to pay questionable claims because of unfair claims practices legislation which limits the time they may investigate claims. This issue will be addressed in more detail in Chapter Seven.
6. Interestingly, the concept of moral hazard which I argue does not adequately explain an individual's fraudulent behavior, may help explain company reaction to fraud. Companies may tolerate fraud losses because they have mechanisms to share the consequences of those losses with others.

transactions combine to facilitate fraud and neutralize control. These issues will be addressed in the chapters which follow. First, I examine what it is that fraud offenders do.

1.4 TYPES OF DECEPTIVE CLAIMS ACTIVITY

Fraud offenders manipulate loss circumstances and reports in order to obtain benefits to which they are not entitled. Insurance personnel are deceived into believing that fraud offenders' claims represent compensable losses when they do not. Since insurance claims are accounts of victimization (fire, thefts, injuries, etc.) covered by (i.e. eligible for compensation from) insurance carriers, the key factor in the deception is the manufacture of an insurable loss. A successful fraud projects a credible image of this type of victimization.

Insurance frauds can be differentiated by the ways in which fraud offenders construct fraudulent loss scenarios. There are three general categories of action used to defraud insurers.

1. exploiting losses which have already happened.
2. inventing stories of losses which never happened.
3. physically creating losses.

These differences reflect different ways to manipulate loss events and reports and point to different ways deception and insurance process are intertwined. Losses which actually happen, but which are ineligible for insurance compensation without the deception, are distinguished from losses which never happen but

appear to, and from losses which are created by fraud offenders.

Policyholders are not the only actors who can instigate frauds against insurers. In all three categories distinctions can be made between cases where policyholders or claimants are part of, or at least privy to, the deceptions on their behalves and cases where policyholders are the unwitting accomplices, their insurance policies providing the means by which others instigate frauds against insurance companies.

1.4.1 EXPLOITING LOSSES

Fraud offenders exploit losses by distorting loss details in order to make the losses appear to be eligible for insurance compensation. The data indicate three ways in which individuals exploit losses. (1) Extending damages (2) Past posting losses or (3) Multiple dipping.

1.4.1.1 Extending Damages- -

Policyholders or third parties involved with losses and their consequences (doctors, lawyers, auto body shop owners, etc.) can extend damages by adding new damage (e.g. adding dents or creating additional injuries) or by falsifying records or overtreating injuries so that it appears as if the damage was greater than it was in fact. Extending damage differs from inflating claim value since the physical loss, not simply the value of the loss, is exaggerated.

In 1975 North Carolina's Insurance Commissioner related the following story to the International Claim Association. A large furniture manufacturing concern filed an insurance claim covering fire damages to their factory. The claim submitted to the insurance company was unusually large considering the size of the fire. Subsequent investigation exposed the manufacturers attempt to defraud the insurer. Just prior to the fire, the company had designed and manufactured a new line of furniture. Unfortunately, the design was faulty and the units were defective. The unsalable pieces were stored in a nearby warehouse. After the fire, a quick thinking, company employee brought the defective units out of storage and placed them in the fire damaged area. He saturated the defective pieces with water and, then, submitted a water damage claim to his insurers. (O'Neal, 1975)

An investigation by reporters from the Chicago Sun Times disclosed that unscrupulous doctors and attorneys in that area took advantage of motor vehicle accident victims, some of whom were not even hurt, in order to construct fraudulent insurance claims. Other metropolitan areas, for example Los Angeles, Miami, New York, Boston, Baltimore as well as others, report similar schemes [7]. Doctor-lawyer teams engaged in this form of deceptive activity employ "runners" or "ambulance chasers," persons who, through a variety of means (police scanners, informants in the police department, patrol of likely accident sites, etc.) discover motor vehicle accidents, appear at the

scene and attempt to entice the accident victims to engage the services of particular lawyers. The lawyers, regardless of the extent of injuries (some accident victims have none) refer their new clients to doctors who are also ring members. Doctors set up treatments exceeding what would be necessary for the specific injuries involved. They coach their patients in exactly what to say should they be examined by insurance company doctors. (See, for example, the US attorneys case against Drs. Rosenthal and Hershenow cited in the Boston Globe 4/23/81.) Usually the treatments involve some hospitalization, but in order to avoid suspicion, the office visits are kept within appropriate limits. One doctor told an accident victim, actually a reporter for the Chicago Sun Times and totally without injury, that he should be hospitalized for about ten days. The doctor said

"A couple of years ago Allstate Insurance Company did a study and they found that these kinds of injuries usually result in ten to fourteen days in the hospital. So, that's about the right amount." (Chicago Sun Times Special Report 2/11/80;7.)

Sometimes the exaggeration can be taken to extremes as, for example, in one instance where a doctor recommended surgery for a non-existent injury allegedly suffered by one of the Chicago Sun

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7. All types of organizations responding, in some degree, to the insurance fraud problem have encountered this form of fraud. Company claims departments, fraud bureaus, federal strike forces and even investigative journalists, have discovered this type of activity within their jurisdictions. A variation on this scheme has been around probably as long as motor vehicle insurance. As early as 1930, local bar associations convened to inquire into the practices of ambulance chasing, faked accidents and improper settlements (Botein, 1937).

Times reporters investigating the scam.

How far will fraud offenders go in extending damages? We can speculate that the preferred approach to extending damages is one in which no new damage actually occurs, but where the appearance of extended damage is successfully projected. However, when damages are extended we can expect to see differences when the losses involve increasing risk to people or inanimate objects. One can imagine that wrecking a car would be far easier morally than breaking someone's leg. Nevertheless, we can see from the example above that at least some doctors are not deterred from performing unnecessary treatments, even surgery, at some risk to unsuspecting patients. [8]

1.4.1.2 Past Posting -

Past posting occurs when potentially insurable losses occur and there is no coverage on hand, although coverage is possible to obtain. The loss victims wait to report their losses until the necessary insurance is purchased. Claims are filed after the insurance goes into effect.

In one Florida case a man claimed that his insured van

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8. One claims manager suggested that while people are willing to lie about the state of their property, they are unwilling to lie about their physical health. In part, the issue is one of expertise. One needs a doctor to determine that one is sick, while it requires little specialized knowledge to know that a car frame is dented. This particular claims manager suggested, however, that people are unwilling to lie about their bodies because of strongly held beliefs that one's body is sacred.

caught fire in April, 1980. Investigators checking into the claim discovered fire department and towing service records indicating that the fire had actually occurred in March, a day before the insurance was purchased (case no. 70).

A Massachusetts policyholder avoided purchasing collision coverage for his vehicle until it was absolutely needed -i.e. when he ran his car into a telephone pole causing extensive damage. The car was towed to a local body shop. The insured asked the body shop owner to postpone damage appraisal until he returned the following day. He then used a second set of plates to reinsure and re-register his car with a different insurance company, this time with full collision coverage. When he returned to the body shop the next day he replaced the old set of license plates with the ones he used to re-register his car. An appraisal dated a day after the accident (and, a day after the new insurance was purchased) was assessed for the car with the new license plates. (interview February, 1982.)

An interesting example of how one can exploit losses, retroactively, comes from Brooklyn, NY. A man reported that, as a result of an automobile accident, his leg was broken in three places. Personnel from his insurance company became suspicious when they tried to get repayment (subrogation) from the insurance company covering the other vehicle involved in the accident. According to that company, the accident was a minor fender-bender and was unlikely to cause the injury claimed. After an

investigation, the claimant's insurance company determined that the man's leg was not broken in the accident, but was broken five hours later when his common-law wife threw him down a flight of stairs. The man was indicted on several counts of larceny. (ICPI Reports August/September 1979.)

1.4.1.3 Multiple Dipping- -

Multiple dipping occurs when claimants recover, more than once, for a single loss. This can be accomplished by making the same claim several times either at the time of loss (i.e. making the same claim with a number of companies) or over several years. Multiple dipping also covers those situations where policyholders receive insurance compensation for stolen property, later recover the property and keep both the property and the settlement for themselves.[9]

The Florida Division of Insurance Fraud reported an unsuccessful attempt at double dipping by a Tampa attorney who, without the knowledge of his client, submitted physical damage claims for the same accident to two different insurance companies. The first company settled the claim. The second company denied the claim after learning of the first payment.

9. Technically, when you receive compensation for total losses (e.g. stolen property) the insurance company takes title to the property. Should it be recovered, it belongs to the insurance company who has the right to dispose of the property as it sees fit. It is not clear, however, to what extent insurance companies will act to facilitate the recovery of stolen property.

The attorney pressed for payment on the second claim and was subsequently arrested.

In a similar case reported by the Insurance Crime Prevention Institute an insurance agent used a client's legitimate claim in one year to defraud other insurance companies in the following years. Once a policyholder had a claim, the agent would switch that person's policy to another carrier at time of policy renewal. Subsequently, he would alter the data on medical bills paid by last year's carrier and submit them to the new carrier. The settlement checks were sent directly to the agent who forged the policyholders signatures to cash them.

1.4.2 INVENTING STORIES OF LOSS

Fraud offenders invent stories of losses which never actually happen to claimants and their properties. Sometimes stories of insurable losses are invented to cover-up some other activity, for example, when policyholders sell their jewelry and claim it was stolen. Stories are invented in two ways: (1) Losses are "set-up." Policyholders purchase props, e.g. already damaged vehicles, to create loss scenes. (2) Losses are fictitious, constructed only on paper. Sometimes the risk covered by the insurance policy exists and only the stories of loss are invented. Other times, both the risk and the loss are paper constructions.

1.4.2.1 Setting-up Losses- -

Policyholders manufacture losses by setting the stage and acting out dramatic plays. The losses never happen, they just appear to happen. Three men from North Carolina were convicted on insurance fraud charges for setting up accidents. A wrecked automobile was passed between the three men. Each man used the already damaged vehicle to set up accident scenes and file accident claims. The auto was pushed, pulled, or driven to "accident" sites. A tow truck was called immediately and the car was towed to a nearby garage (thus, establishing the place and time of the accident.) The police were never called to investigate [10]. The insurance company paid the claim, but no repairs were ever made. The car was passed on to the next man and the scheme repeated. (ICPI Report July/August 1980.)

People will often go to great lengths to insure that their "make-believe" losses appear real. In one case reported by the Insurance Crime Prevention Institute a man was paid \$200 for punching, bruising and marking up actors staging auto accidents. Actually, faking injuries is one of the oldest insurance scams on the books. A 12 member gang involved in generating fraudulent insurance claims was arrested in 1932 for staging automobile accidents.

10. This is not unusual in these types of claims. Generally, you would be required to go to the police department to fill out an accident report. If the report merely indicates that you drove your car into a tree, there would be little investigation.

"Such a little thing as breaking a leg or arm did not stop them. It was general practice to scrape off the skin with sandpaper, to inflict bruises with clubs and to inject drugs to produce unconsciousness." (Weekly Underwriter 1932; see also Mane, 1944.)

Due to medical advances many of these methods would be subject to easy detection today. However, as one can see, the approach has changed little.

Losses can be "set up" simply by producing damaged property. An investigation, code name "Detroit Phase One," directed by the Organized Crime Unit of Suffolk County, Massachusetts resulted in 139 indictments on insurance related charges. Seven Corvettes were repeatedly used, sometimes as often as ten times, to file twenty-seven false claims. Fraud offenders substituted damaged and repaired parts depending on whether insurance personnel were examining the wreck or the repair. [11] The scheme went as follows:

"One of the principles obtained insurance coverage for the 1975 Corvette and usually within a month and sometimes on the same day reported an accident.

The insurance company assigned an appraiser to inspect the car. He routinely photographed the damage and returned at a later date to verify that the work had been done. The insurance company then paid the claim which averaged \$4300 per 'accident.'

According to investigators, after the first claim had been paid, coverage would be obtained from another insurance company and another accident claim would be made. Damaged parts used in the first claim would be put back on the car."

(Boston Globe 10/25/80)

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11. A Corvette was used because its fiberglass body and parts can be easily installed or removed.

In a separate Massachusetts case a policyholder collected for the same auto damage in four separate accident insurance claims, only the first of which was real. A company adjuster and independent appraiser were also indicted in this case for accepting bribes to settle damages (interview July, 1981).

1.4.2.2 Paper Constructions- -

These manufactured losses appear on paper only. No loss scene exists to investigate, only paper documentation that the risk existed and the loss occurred. Frequently, paper loss schemes involve theft losses. Theft leaves no evidence for a loss adjuster or appraiser to inspect. The property is legitimately missing.

A defendant in a Florida insurance fraud case told his wife that her car had been stolen. He reported the theft to the police. She reported the theft to the insurance company. As required, she submitted the car title to her insurer. Later, she claims, her husband told her that the car wasn't really stolen but had been in an accident and was now in storage. In fact, the investigation revealed, her husband had sold the car. The scheme fell apart when the man to whom he sold the car complained to the State Attorney because he couldn't get the title from the defendant. Because the loss claimed by the insured never really happened, this scheme differs from attempts to exploit losses by distorting loss details (case no. 16).

Paper car schemes are fairly common because the insured property is rarely, if ever, inspected before the policy is issued, and the property identity or biography can be easily manufactured through phony titling. Paper car schemers purchase titles of vehicles virtually destroyed in previous losses (salvage) and acquire the necessary documentation to put the cars "back on the road." Theft insurance for the imaginary cars is obtained and soon thereafter theft reports are filed. Since the cars never existed, they are never recovered. The Massachusetts' Governor's Task Force on Auto Theft noted that

"In a sample taken from the files of one insurance company, of 400 new policyholders who purchased automobile theft coverage, an investigation revealed that 15 percent of the automobiles did not exist and were insured solely for the purposes of defrauding the company." (Massachusetts' Governor's Task Force on Auto Theft, 1980;xxiv.)

Some fraud investigators believe changes in state title laws have made it more difficult to build paper cars, others believe that the practice continues, although they expect in some new form.

As physical and social distance widens and society becomes ever more dependent on paper documents for proof of existence, we might expect to see fraudulent claims of this sort increase. Cargo ship scuttling, a popular marine insurance fraud, is a case in point. Cargo frauds were more cumbersome in previous decades when the fraudulent scheme depended on the substitution of equal weight boxes for actual cargo in order to make shipping manifests look correct.

"Nowadays with vastly more streamlined documentation procedures, an unscrupulous shipper may not have to produce a cargo at all. As long as the documents are in order to say that a cargo was loaded. . . and. . . insured, the shipper has a valid claim if the vessel goes down. It is extremely difficult to prove him wrong." (Far Eastern Economic Review February 6, 1981;35.)

Another form of paper loss, the paper accident involves cars that may or may not exist but accidents which never happen. Because there are no loss scenes to investigate, paper accidents often require inside involvement by loss adjusters who can fill out the necessary accident reports and loss evaluations. According to a Postal Inspector investigating a Texas accident fraud operation, the inclusion of a loss adjuster into the fraud ring changed the operating scheme from one in which accidents were staged to "paper accidents" which could be reported without going through the motion of setting up loss scenes. (ICPI Reports May 1972.)

Insurance personnel invent loss stories as well. According to Florida's Division of Insurance Fraud, a former claims representative was arrested for using his position to allegedly manufacture and then pay fabricated "slip and fall" claims. The claims representative created dummy claim files on non-existent claims and authorized payment to a waiting accomplice. (Florida Division of Insurance Fraud "Insurance Fraud Report", 80-3.)

1.4.3 PHYSICALLY CREATING LOSS

Fraud offenders create losses that would not have occurred without the intervention of policyholders and their agents. Although there have been instances where spouses have been murdered for life insurance benefits and workers have dismembered themselves for disability and workers' compensation benefits, the majority of created losses reviewed in this study were associated with property and auto claims.

1.4.3.1 Creating Losses Directly- -

Fraud offenders manufacture insurable losses directly by causing the losses themselves or by paying someone else to create the loss for them. The most visible of the created losses are arson losses. Buildings, vehicles and boats have all been burned with the intent to defraud insurers. Motive for these fraud fires vary. Some fraud offenders are simple businessmen purchasing rundown property, insuring it for more than it is worth and burning it down. Others see fire as a way to get out of bad financial situations, shrinking inventories, bad debts, etc. Policyholders may set the fires or they may pay a middleman, a "torch," to set the fire for them.

Arson is a fact of life in virtually every major metropolitan area in the country. In one of the most successful arson prosecutions in Massachusetts, thirty-three persons were indicted in Suffolk County for their participation in a large arson-for-profit conspiracy involving over twenty properties. Real estate brokers, lawyers, insurance personnel and even a member of the local arson squad were indicted and convicted. Although the details for each of the fires covered by the indictments differed, the general approach was the same. Properties were purchased for nominal consideration and traded between friends, each time the property value increasing, although there were no substantive changes to the property. Insurance was purchased for the inflated amount and eventually the building burned. Sometimes the owners were merely "straws" or fronts for the real owners. Straws would own the properties and the insurance would be carried in their name. The true owner would be listed on the insurance policy as holding the mortgage. Should insurance investigators implicate the owner in the arson, the mortgagee's right to recover would be protected. [12]

12. Under the mortgagee clause of insurance policies, the interest of the mortgagee is protected. Even when the property owner is determined to have contributed to the loss, the mortgagee still retains the right to recover the amount of the mortgage. In the Suffolk County arson conspiracy it appears that banks used that automatic protection to their advantage. Although the connection was never made in court, investigators on the case as well as a journalist suspect that at least one bank foreclosed properties and sold them to known arsonists who eventually burned them down. (Massachusetts Lieutenant Governor's Task Force on Arson, 1980.)

Middlemen, in particular persons who profit from repairing loss damage, can create losses as well. Mel Weinberg, the prime figure in the ABSCAM sting operation, started his early con career (c. 1950) with a profitable insurance scam. Weinberg used a slingshot to break the windshields of cars he knew were insured through his friend, an insurance agent. The victims of Weinberg's slingshot reported their losses to their agent who would recommend repair at Weinberg's father's plate glass business. (Greene, 1981.) Many insurance policies won't cover that kind of damage anymore, however, glass repairers continue this scheme in order to attract customers. The New York Times (January 23, 1982) reported that a plate glass repair businessman was arrested after trying to generate new business by breaking the windows of all his neighbors' cars.

Injuries may also be created to cover up for other created losses. Again, from the files of the Insurance Crime Prevention Institute we learn of a case in which a New York man, indicted on charges of arson and mail fraud, caused injury to himself in an attempt to cover his participation in an arson-for-profit scheme. According to the ICPI,

"Fearing difficulty in having his claim for the fire. . . approved, he and a companion went to Wheatfield where, the indictment charges, that E- had the companion shoot him in the arm. He hoped in this way to convince the insurance companies involved that he had enemies out to get him."(ICPI Reports June, 1980;8.)

1.4.3.2 Creating Losses Indirectly- -

When fraud offenders create losses indirectly they cause innocent third parties to manufacture an insurable loss that would not have occurred without the offender's intervention. A classic example of this fraud scenario is the contrived motor vehicle accident. Officers of the California Highway Patrol are teaching their fellow officers about the operation of what they call the "set-down." The "set-down" scheme operates when an unsuspecting motorist, Jane, is driving down the highway and suddenly a car pulls into her lane and reduces speed. Jane finds herself following closely when another car, the "excuse car," pulls alongside, usually in the adjacent left lane of traffic. [13] At a predetermined signal the "excuse car" swerves in front of the other two and speeds away. The driver of the first car slams on his brakes causing Jane to "rear-end" his car. Everybody agrees to what has happened. Jane admits the accident is her "fault." The occupants of the wrecked car complain of sore backs and necks and file insurance claims with Jane's company. Usually this type of created loss is well organized into what an Officer of the Highway Patrol called a "pecking order of payoffs." At the bottom are the accident participants who are paid a flat fee for their participation. "Cappers," the recruiters, line up drivers and passengers and supply the cars. At the top are medical people who allegedly treat the victims and

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13. It is called an "excuse car" because it gives the driver of the first car an excuse for suddenly using his brakes. It pulls away quickly before anyone can identify it.

the attorneys who file claims on their behalves. (Los Angeles Times. August 7, 1980).

Included in the list of indirect losses are those which are caused with the knowledge, if not active participation, of the fraud offenders. When policyholders leave cars in front of junkyards known to strip parts and later report the cars stolen they indirectly cause the loss. (Buck, 1978.) A typical "insurance give-up" or "steam" operation was uncovered in August, 1979 when a Braintree, Massachusetts salvage yard owner and dozens of "otherwise honest" policyholders were arraigned on charges of receiving stolen property and concealing motor vehicles to defraud insurance companies. According to investigators involved in the case,

". . .there were car owners who paid \$200 to a middleman to 'steal' their cars and to owners of automotive shops which purchased the parts of the 'stolen' cars. The owners of these cars would then file stolen car reports and file claims to collect the insurance." (Boston Globe August 28, 1979;19.)

1.5 FACTORS INFLUENCING THE INCIDENCE OF FRAUDULENT ACTIVITY

While it is nearly impossible to document the relative frequency of the various types of deceptive claims activity, one can suggest different factors which might influence the incidence of one type of insurance fraud over another[14]. These include: relative moral threshold for deception, degree of planning

required and culpability for fraudulent behavior. Each factor is described below.

1.5.1 MORAL THRESHOLD

Fraud offenders' commitments to particular forms of deception may depend on their own thresholds of "acceptable" dishonesty. Survey literature suggests that the specific nature of deception makes a difference to individuals' senses of propriety. A recent survey in Psychology Today revealed that while 44% of the respondents claimed they would drive away after scratching a car without telling the owner, only 26% said they would keep ten dollars extra change at a local supermarket. (Hassett, 1981). In a study of bribery Michael Reisman developed a conceptualization of zones of acceptable bribery. He defines a bribal zone not as a "zone of a legality or amorality but of

14. Although type refers to the process of deception involved and does not refer to policies or physical substances, we note that different physical and economic environments provide different objects used to compose fraudulent claims. Thus, we might expect to see variations in type of physical loss correlated with some aspect of the environment. Decaying inner city properties may be more prone to arson-for-profit, for example, than suburban homes. On the other hand, one might expect to see more burglary claims in suburban areas than in central cities.

Insurance availability will also influence the type of loss used to defraud insurers. Obviously one wouldn't make a phony burglary claim if one didn't have the appropriate theft insurance policy. Individuals who do not own property have little chance of making a fraudulent fire claim. Because of its nearly universal availability, the incidence of frauds against auto policies may be higher in absolute terms than the incidence of frauds against some other more selective form of insurance. A weighted measure of incidence per policies in force would be required.

different legality and morality." (Reisman (1979;136) In the insurance context we might expect that physically creating injuries carries a different moral weight than omitting details on a claim form. Although many individuals may find the latter acceptable, only a handful would be expected to condone dismemberment for insurance profit or creating losses that could harm innocent third parties.

Moral threshold may be influenced by insurance company structure and character as well as by insurance activities. Smigel and Ross (1976) and Vaughn (1980) note that large bureaucracies —e.g. insurance companies— are likely targets for certain types of crime simply because of their organizational reputations and characters. Smigel (1976) surveyed attitudes toward stealing from small and large businesses and from government. Most respondents, according to Smigel, preferred to steal from large businesses rather than smaller ones because large businesses were "impersonal, powerful and ruthless." (Smigel, 1976; 22) [15].

The lack of face to face contact in insurance process may lower the threshold for deception as well. Insurance business is often transacted over the phone or through the mail, and often involves a number of different organizational actors. Since

15. Even when the insurance company is a relatively small one, policyholders may perceive of the insurance company as if it were a larger business. There may be a tendency to think of the insurance industry as a whole, rather than on a company by company basis.

fraud offenders need not relate to specific targets/victims, it may be easier, morally, to engage in deceit.

Vaughn (1980) notes that the collective definition of organizations as exploitative often makes them susceptible to crimes. The perceived wealth of the insurance organization, for example, may ease any moral doubts about filing fraudulent claims. Not only might offenders believe that insurance company profits make companies legitimate targets, but that policyholders have contributed directly to those profits with virtually no benefits to themselves. These policyholders may seize a chance to "cash in." Consider the following letter sent to Ann Landers.

"I am a high school freshman who rides to school on the bus. A few months ago my bus was rammed in the back by a truck. Luckily nobody was injured.

When my mother heard about the incident, she made me pretend that my back was hurt so we can collect money from the insurance company.

I don't feel very good about it because I know that what we are doing is dishonest. When I mention my feelings to my mother she tells me to shut my dumb mouth—that the insurance companies have plenty of money and anyone who doesn't get what they can out of them is a fool. . ."

Thus, some fraud offenders may justify their fraudulent behavior as legitimate considering the circumstances (see Sykes and Matza, 1957 on justifications used by delinquent boys to explain their deviant behavior). Policyholders may take a "sour grapes" stance as justification for their increased use of deception. Believing they were "burned" on their first claim

(i.e. they have not received what they felt they deserved), they are deceptive on their second. Sometimes the deception is merely an attempt to break even. Other claimants may deny that they are engaged in illegal behavior because they do not believe that any injuries have been inflicted. Still other fraud offenders may simply justify their actions because "everybody does it." Finally, increased use of deception may accompany the realization that there are few sanctions placed on deceptive behavior.

1.5.2 DEGREE OF PLANNING REQUIRED

The three fraud types require different degrees of planning and access to people/events needed to construct fraudulent claims. Policyholders who exploit losses do so without the benefit of preplanning since losses are chance events. The loss occurs irrespective of fraud. Even when fraud offenders exploit losses of unsuspecting policyholders with well-designed and thought out fraud schemes (see, for example, the Chicago Sun Times example cited above), they must rely on chance events of policyholders to carry them out.

Opportunities to exploit losses are typically generated from the claiming process when interested parties coach claimants on appropriate manipulation strategies [16]. Ambulance chasers find accident victims and entice them to engage the services of

16. The claiming process includes all processes leading up and including the filing of a false claim. Thus, included in the claiming process are loss documentation systems outside insurance control.

particular lawyers who then coach these victims in their pursuit of insurance dollars. Police officers may act as insurance fraud brokers as well. Consider the following exchange related by one insurance claimant. The police were responding to a complaint that a pocketbook had been stolen from a car left unattended for less than two minutes outside the victim's home. Without the advice of the police officer this loss would have been ineligible for insurance compensation.

Officer: Was the door locked?
Victim: Well, no.
Officer: Do you own this house? [Tries to establish the possibility of homeowners insurance.]
Victim: Yes
Officer: Then, the door was locked. [Otherwise, not covered.]
Victim: Are you asking me or telling me?
Officer: Telling you. How much money was in the purse?
Victim: \$100
Friend: We have a \$100 deductible.
Officer: How much money was in the purse? (raised eyebrows)
Victim: \$200
Officer: Okay (Interview December, 1980.)

Since the questions claims processors ask may, unintentionally, provide clues on how to work the deception, offenders may learn how to deceive as they make their way through the claims process [17].

Created losses and invented stories, on the other hand,

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17. Lipsky (1981; 61-65) notes that street-level bureaucrats are able to convey information about how to work the system to their clients. Although Lipsky argues that selective client coaching is a source of a street-level worker's power or control over potential clients, in the insurance context client learning may actually work to undermine the system of street-level control. This would appear to be particularly true when the client is more powerful than the street-level worker.

require substantial planning if they are to be successful. Unlike exploited losses where policyholders seize opportunities which emerge after losses, offenders who employ the other two schemes actually manufacture the losses or appearances of losses. Insurance and loss details are worked out well in advance of the claims.

Interviews with claims personnel suggest that despite the relatively high visibility of created losses, in particular arsons, a greater proportion of frauds involve individuals who take advantage of loss situations. These "otherwise honest" offenders "drift" into and quickly out of this particular form of rule breaking behavior.

1.5.3 RELATIVE CULPABILITY FOR FRAUDULENT BEHAVIOR

Fraud incidence may be influenced by the risk of fraud detection (see Chapter 5 for a more extensive discussion of discovery). Since frauds are, among other things, economic transactions, fraud offenders may assess the costs of pursuing different forms of fraudulent behavior. Their calculations will most certainly include the likelihood and consequences of getting caught.

Although the likelihood of being caught when exploiting losses may be higher than when inventing stories or creating losses, the consequences of being caught may be so much less as to make it a better risk overall. It appears that fraud

offenders who exploit losses are less culpable for their offences than those who pursue other fraud types.

Limited culpability is associated with: (1) company preferences for recognizing fraud and sanctioning such activities as well as (2) offenders abilities to neutralize their fraudulent behavior. Insurance company preferences for fraud enforcement appear to depend on the nature of the claim and the claim evaluator's ability to separate the intent to defraud from conventional claiming behavior. Exploited losses, for example, typically involve relatively small dollar amounts and are hard to distinguish from "expected" claim inflation. Given small dollar amounts, insurance personnel may prefer to avoid expensive sanctioning devices and choose to limit their claim liability through less expensive negotiation. If, as suggested earlier, opportunities for exploiting losses are often generated directly by insurance claims activities, companies may decline to enforce the rules against fraud if such enforcement directly or indirectly implicates the insurance organization as well as the offender. Public police often prefer not to get involved at all. In making these choices social control agents implicitly deny the seriousness of the offences. (See Chapter Six for more on sanctioning.)

Individual culpability can also be limited when offenders neutralize control by justifying their fraudulent activity as innocent mistakes. Because the losses actually took place, fraud

offenders who exploit losses can deny any intended wrongdoing and walk away from questionable claim items without compromising the entire claim. This form of neutralization technique is far harder when offenders pursue the other two fraud types since many more claim and insurance details are constructed deliberately.

1.6 ADDITIONAL QUESTIONS

Up until this point the analysis has focused on factors which might help account for individual decisions to manipulate loss events and reports in order to claim insurance benefits that would not be forthcoming without the deception. I have suggested conditions which might facilitate fraud by making deceptions easier, both technically and morally. I have not focused on what motivates individuals to commit fraud in the first place. To do so requires research into offender characteristics which was not part of the original research design. The remainder of the thesis examines more specifically the influence of the insurance organization on fraudulent behavior and fraud enforcement.

Chapter Two, "Trading the Insurance Commodity" examines the relationship between the insurance business and fraudulent behavior. To what extent does the "business of risk" open up possibilities for individual deviation and fraud? I argue that opportunities for fraudulent behavior can be found in the ambiguity of the insurance product. Policyholders take advantage of that ambiguity to shape perceptions of their need. Techniques

of risk spreading and transfer diffuse fraud effects and often minimize interests in the disposition of individual claims. Possibilities for deception increase when concerns for attracting insurance business supercede tight control over the insurance process.

The relationship between the claims process and opportunities for fraudulent behavior is explored in greater detail in Chapter Three, "Claims Making." Since claims service takes shape only after a loss, fraud offenders can shape loss circumstances and reports to their advantages. While insurers can predict that one building out of a hundred will burn, they cannot predict, with any degree of certainty, that a particular building will burn, nor what shape the associated loss will take. Uncertainties about what should be renders individual deviations hard to recognize. Efforts to control the uncertainties of claims process through routinization open up possibilities for client learning. Claimants find out what is required to construct a legitimate claim and use that information to construct a deceptive one. Lack of insurer oversight also opens up avenues for abuse. Finally, the practice of negotiating claim value sets an adversarial tone to claim processing which may provide moral opportunities for fraud.

Chapter Four, "Spinning Webs of Deceit" examines exactly how the opportunities for fraud are realized. The precise methods or techniques used to manipulate loss circumstances and reports as

well as the organization of fraudulent activities are described. This chapter considers how the processes of deception affect the structures of fraud control. I argue that the social organization of deception and the ambiguity in fraud method (deception or mistake?) limits control.

Chapters Five, Six and Seven consider components of discretionary rule enforcement. Issues of discovery, investigation and sanctioning are treated separately.

Fraud Discovery is analyzed in terms of structural opportunities to detect false claims. Two questions inform the analysis in Chapter Five, "Discovering Deceit." To what extent do insurance actors and organizations influence opportunities to discover fraud? How might deceptive activity limit systems designed for fraud detection? I argue that the structural vantage points of claims processors and other potential discovery agents limits the types of fraud that can be discovered within the insurance context. Technical constraints, lack of certainty with respect to claimants' intent and offenders' abilities to neutralize discovery mechanisms limit fraud exposure as well.

Chapter Six, "Unravelling Deception," examines the investigatory strategies used to pull apart deceptive claims. The three categories of action used to defraud insurers—exploiting losses, inventing stories and creating losses—raise different questions that need to be addressed in fraud investigations. The strategies used to address these

question are described in detail and empirical examples are given for each. By describing existing strategies, defining their scope and requirements for success I indicate some of their limits in investigating certain types of fraud.

Chapter Seven, "Dealing with the Deceivers," examines sanctioning options available to social control agents and the extent to which the insurance context and the nature of fraudulent transactions influence those options. Like much white-collar crime, enforcement in the insurance context is not limited to a simple yes/no decision. A number of enforcement reactions are possible. False claims can be ignored, mitigated through claims adjustment, denied, or criminally prosecuted. I suggest conditions under which each enforcement option might be applied.

CHAPTER 2

TRADING THE INSURANCE COMMODITY

Insurance frauds, as well as other business-related crimes, take place within the context of ongoing, business transactions. Conventional insurance organizations and agencies provide the vehicles through which these frauds occur. Because insurance fraud offenders use insurance transactions to commit their offences, questions are raised about the relationship between insurance activity and fraudulent behavior. To what extent do the structures of insurance activity influence claimants' abilities and incentives to engage in fraud?

The business of insurance is grounded in perceptions of risk, protection and service. The perception of risk, for example, is as important to the functioning of the insurance commodity as any objective criteria of risk. Policyholders purchase theft insurance when they perceive that they are in some danger of being robbed. Since commodity sales depend, in part, in perceptions, rather than objective needs and events, there is room to manipulate what is being bought and sold—security, investment, indemnification, or protection in the event of some

defined contingency. While the insurance industry can shape risk perceptions and manipulate the meaning of the services they provide, the persistence of fraud suggests that policy holders can also shape perceptions of their need. Loss events and reports can be manipulated so that it appears as if a claimant has been subject to a named contingency compensable under an existing insurance contract when, in fact, no such compensable loss occurred.

This chapter examines the insurance product and suggests reasons why "the business of risk" generates or facilitates opportunities for promoting false images of loss. A brief description of property-casualty insurance products and markets is followed by a discussion of each of the following insurance operations: selling the product, assuming risk (including companies' efforts to pass along the risks they assume), spreading the risk and investing premiums. The following chapter examines the claims process and highlights aspects of the service delivery context which provide opportunities for fraudulent behavior.

2.1 THE MARKETPLACE

Insurance is a technique for reducing uncertainty. Individuals reduce uncertainty by transferring some risk to others. Those who assume risk reduce their uncertainties by pooling risks together. Risk pooling increases the

predictability of contingencies.

Insurance scholars have developed two alternative models of the insurance function. The traditional model of insurance is that of trustee. Insurance is a fund accumulated to meet uncertain losses (Bickelhaupt, 1980 and Mehr and Cummack, 1980 for example). Insurance exists as a business because of the economies of scale inherent in reserve accumulation (Marshall, 1974). [1]

Another model of insurance function considers insurance as a system of brokerage or a trade in contingent claims (Ginsberg and Kunreuther, 1980; Marshall, 1974; Arrow, 1973; Zeckhauser, 1973 and Kihstrom and Pauly, 1971). The second approach stresses the reciprocity and mutuality of insurance contracts and, I believe, more accurately describes the property-casualty insurance industry today. Insurance companies assume individual risks, pool them together and then spread the risk to others through a system of reinsurance. Insurance companies are third party mediators who trade in contingent claims.

Uncertainty about or discrepancies between what is being bought and sold--protection or investment--might influence behavior. Consumers may perceive of insurance as a form of

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1. Insurance regulation is predicated on this model. Regulators are concerned with assuring that companies have funds sufficient to cover losses. Insurance regulation is concerned, first and foremost, with insurance company insolvency and its adverse effects on insurance consumers (Patterson, 1927, and Pfeffer and Klock, 1974).

protection or as an "investment" from which the purchaser can expect some desired return [2]. Claim personnel may recognize insurance simply as a means of indemnification, i.e. a means to restore the claimant to his or her financial position immediately before the loss occurred. Thus, while claim personnel may recognize their role as providing compensation equal to the value of a property at the time of loss, claimants often believe that insurance should provide compensation sufficient to replace the property. Conflict over insurance goals may set up an adversarial relationship, and, in some cases incentives for fraud. Believing they have been defrauded by their insurance companies in the first place (not receiving what they thought was purchased), "otherwise honest" claimants may see no moral wrong in rule breaking on their parts. Interestingly, insurance companies may set up that conflict by the kind of advertising it uses to encourage individuals to purchase their product.

2.1.1 THE INSURANCE COMMODITY

The insurance commodity is a contract (policy) that establishes the insurance relationship.

"In contrast to [tangible goods] whose qualities can be seen and felt, the only external manifestation of insurance is a contract, having no intrinsic value. .

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2. As Tobias(1982) notes that assumption may be radically incorrect. Insurance is an extremely low yield investment strategy. He notes for example that for every dollar we collectively deposit in a savings bank, we withdraw \$1.05. For every dollar we deposit in auto insurance we withdraw \$0.62 and for every dollar we deposit in fire insurance we withdraw \$0.54. (p. 72)

." (Federal Insurance Administration 1974; 50)

In exchange for a premium, individuals agree to participate in a risk pool. Those who assume the risk agree to indemnify individual policyholders should they be subject to the named contingency. Indemnification assures sufficient compensation to restore individuals to their previous financial statuses. True to the principles of indemnification, no individual should profit from a loss [3].

The insurance relationship, a contractual agreement between policyholder and insurance carrier, is based in trust. Individuals trust that by purchasing insurance their assets are protected. Those assuming risk trust that the risks they assume are, in fact, objective risks—-independent contingencies [4].

"The parties to an insurance contract agree that when the actions of nature become known those most favorably affected will transfer resources to those who turn out to be less fortunate. If the contract is to provide protection in this way, it is essential that there be (at least substantial) independence in the actions nature takes with respect to different insured individuals." (Kihlstrom and Pauly, 1971)

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3. Replacement cost insurance has been introduced as a new twist, but has only slightly modified the general principle of indemnity. Replacement cost insurance allows recovery equal to the amount it would take to replace the property losses. Traditionally, insurance policies provide for the recovery of actual cash value—replacement cost minus depreciation. Replacement cost insurance, thus, provides enough compensation to actually replace the items. Nevertheless, the principle of indemnity holds. No individual should profit from a loss.
 4. The theoretical basis for insurance, neo-classical models of utility and welfare assume the independence of events as well as equality among individuals making choices.

The contractual obligations between insurance companies providing coverage and individuals at risk are set forth in the insurance policy. Policy language tends to be standard among companies and policy forms are often regulated by state insurance commissioners. Some policies and/or provisions within policies are, in fact, statutory (fire insurance policies, for example). Other policies contain standard provisions to which companies voluntarily comply. Riders, endorsements, limitations and restrictions amend standard clauses for a given policy contract.

Several states have adopted so-called "easy-read" policies designed as "plain English" versions of complicated insurance documents [5]. In an effort to make the contractual language of insurance policies more understandable to lay consumers policy language has become more broadly and often ambiguously defined. Claim discrepancies are often treated as differences of opinion rather than as breaches in contract since there are wide ranges in interpretation. Broadly defined policy language, thus, affords to those who wish to deceive sufficient room to manipulate the system without jeopardizing their positions as claimants (interview no. 6) or, in fact, claim servicers. (See Windt, 1982 for a discussion of the legal basis of settling ambiguities in insurance contracts.)

5. Consumer Reports notes that all but eight states have developed easy read policies for homeowners insurance. (Consumer Reports August, 1980).

2.1.2 COVERAGES EXTENDED

The number of perils subject to risk pooling has grown immensely since the first insurance contracts were written to cover maritime risks in fourteenth century Italy (Holdsworth, 1917). Industrialization saw the extension of insurance coverage for such things as fire—late 1700s, accidental injury—1845, travel—1869, theft—1885, and even untimely death (Carr, 1967;6).

The twentieth century has been one of great product diversification and expansion of the insurance population. Casualty insurance associated with the new forms of transportation, particularly the auto, was introduced. Although temporarily thwarted by the Depression, the non-life insurance market gathered momentum during the Second World War and continued through the sixties. The twentieth century also saw the rise of social insurance systems, and through compulsory insurance statutes, (e.g. auto liability and workers' compensation) the expansion of the insurance net to capture a broad spectrum of individuals (Post, 1976). Today, insurance can cover just about anything—movies, investments, defective products, inventions, hazardous waste facilities—anything that is perceived to be risky.

This research focuses solely on property and casualty insurance. Property coverages are extended for damage or destruction of property due to specified perils, i.e. theft, fire, windstorm, vandalism, etc. Casualty (also known as liability) insurance covers policyholders' exposures (primarily in the form of civil suits) in the event that they cause damage to the properties or persons of others. Particular policies which include more than one type of coverage are referred to as multi-peril policies.

TABLE 2-1 TYPES OF COVERAGES EXTENDED

PROPERTY COVERAGES

Auto-physical damage
 Homeowners
 Fire and Allied Lines
 Commercial Multi-peril
 Inland Marine
 Ocean Marine
 Burglary and Theft
 Extended Coverage
 Boiler and Machinery
 Glass
 Aircraft

CASUALTY COVERAGES

Auto-Bodily Injury
 Worker's Compensation
 Auto-Property Damage Liability
 Misc. Bodily Injury
 Misc. Property Damage
 Fidelity and Surety

The distinction between property and casualty coverage also reflects a loss claimant's position vis-a-vis a particular insurance contract. In the case of property losses, individuals make claims against their own insurance policies. Because policyholders are first parties to the insurance contract, policyholders' claims for damages to their properties are first party claims. In the case of casualty losses, claimants are not

policyholders, but rather, some third parties who, through the actions of the policyholders, suffer losses. Casualty claims are third party claims. Thus, claimants may be clients (i.e. policyholders) who must be served, or they may be third parties whom companies serve on behalf of their policyholder/clients [6].

Insurance products are also differentiated by whether they cover personal risks (i.e. your home, your car, your health) or commercial risks (your business). Although a single company may write both personal and commercial business, some companies are stronger in one than the other. Even within specific categories, companies will specialize so that Company A will insure taverns and Company B movie theatres.

2.1.3 INSURANCE COMPANIES

Nearly three thousand individual companies were responsible for the 95.7 billion dollars of property-casualty premiums written in 1980 (A.M. Best, Aggregates and Averages, 1981). Four types of insurance company compose the market and are

6. One might expect that claims service differs with respect to whether claimants are also policyholders or not. We might also expect that, if a tolerance for fraud exists, frauds perpetrated by clients may be tolerated more often than frauds by third parties. Unfortunately, the empirical research undertaken here can not address that question directly. The data on frauds and fraud investigations includes cases that have already been singled out as potential frauds and thus worthy of more intense investigation. We must note, however that Webb, et. al. (1981;282) argue that fair play and decency legislation has transformed adversarial practices with respect to third party claims into legal duties and, thus, discrimination against third parties is less likely.

licensed by state departments of insurance: stock companies, mutual companies, reciprocal exchanges and syndicates or Lloyds associations [7]. Stock companies are traded on the major stock exchanges and, as a result are able to attract external capital funds. Underwriting surplus and profits are returned to the stockholder owners. Mutual companies are owned and controlled by their policyholders. Underwriting surplus and profits are, theoretically, returned to the policyholder/owners at the end of the year. However, in fact, ownership is so dispersed as to have little real meaning [8]. Lloyds association are unincorporated syndicates of individuals who accept portions of particular risks. Brokers write the policies and sell shares to syndicate members willing to assume specific risks. Lloyds of London is

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7. Some corporations have begun to assume their own insurance costs through the formation of captives. Corporations with larger potential losses buy or form their own insurance companies (captives) to service their particular needs. Some captives write only their parents' business, others have become full-fledged insurance companies in their own rights. A majority of the captives are based outside the United States, primarily in Bermuda, where tax and regulatory environments work to the parents' advantages. As of April, 1979 over one thousand captives were operating. Insurance executives have been slow to appreciate the force of these new insurance organizations, according to a study in Institutional Investor (April, 1979) because they have mistakenly believed tax maneuvers are corporate motives for forming captives. In fact, this study claims, "the motivation is a fundamental dissatisfaction with the insurance market" (p. 100). Self funding of risk through self-insurance has grown from six percent of the commercial market in 1970 to twenty-two percent of that market in 1980 according to a study by Conning and Company. (The Weekly Underwriter, January 10, 1981)
 8. Andrew Tobias notes that out of the 18.4 million Prudential policyholders eligible to vote only 323 did so and virtually all who did were Prudential employees (Tobias, 1982;40).

the largest organization of this type. Reciprocal exchanges are unincorporated, non-profit organizations formed to exchange individual risks between organization members.

Stock companies write the greatest share of the property-casualty insurance business, approximately seventy percent, and compose the largest share of the market. (A.M.Best. Aggregate and Averages. 1981). Entry into the insurance marketplace depends on a company's ability to meet capital and surplus requirements outlined by state statute. States differ in their requirements.

In addition to the numerous coverages available from companies licensed directly by the state, unusual and/or large coverages are offered by "non-admitted" insurers [9] willing to write "surplus" business. Surplus business includes coverages for unusual risks or risks with high loss potentials that no licensed company would accept. Surplus coverage can be a source of secondary coverage (i.e. coverage above and beyond that which would be available from the standard market) as well.

Because data on surplus line companies are extremely limited, coverages extended by these companies have been excluded

9. An admitted company is licensed and authorized in a given state. Non-admitted companies are often foreign companies (US companies licensed in other states) or alien companies (companies incorporated in foreign countries). Although non-admitted insurers are not licensed by the state, and, thus, not subject to state regulations, the agents and brokers who produce (sell) the business are state licensed and regulated.

from the analysis. Nevertheless, as Massachusetts' Lt. Governor O'Neill's Task Force on Arson suggests, low visibility and freedom from state regulation can thwart efforts at fraud detection and control when insurance coverages are provided through "non-admitted" companies. For example, when surplus lines provide secondary coverage for a property it may provide a screen for the owner's motive for arson.

"Nominal coverage from an admitted carrier on a building with an incendiary fire may cause public investigators to discount the owner's involvement; however, additional coverage from a surplus carrier is generally more difficult to identify and could be hidden as a source of overinsurance." (Lieutenant Governor O'Neill's Task Force on Arson, 1980; II-B-21)

Task Force members believe that arsonists are now insuring properties, ineligible for coverage in standard markets, through surplus line carriers. Although surplus coverage is more expensive, the return on investment to arsonists continues to be substantial.

TABLE 2-2: PROPERTY-CASUALTY NET PREMIUMS WRITTEN *
(000,000)

	1946	1950	1960	1970	1980
STOCK	1,729	5,137	10,527	22,429	66,875
MUTUAL	443	1,506	3,899	8,979	23,203
RECIPROCAL	50	199	522	1,432	5,472
LLOYDS	5	23	22	24	65
total	2,227	6,865	14,970	32,863	95,701

* Net premiums represent premiums retained by insurance companies and does not include payments for reinsurance.

Source: (Best. AGGREGATE AND AVERAGES. 1981, and as cited by Pfeffer and Klock, (1974;232) for 1946-70)

Table 2-3: NUMBER OF COMPANIES OF EACH TYPE **

STOCK	1156
MUTUAL	318
RECIPROCAL	61
LLOYDS	40
total	1575

** These figures represent insurance companies OR groups. Insurance groups which compose a number of different companies are counted only once. A total of 2,953 individual companies comprise the property-casualty market.

Source: (Best. AGGREGATES AND AVERAGES. 1981)

2.1.4 COMPETITION

Since insurance is a service industry, companies compete on the price and quality of service they provide. The most important competitive variable in terms of potential for fraud and abuse is service performance. To perpetuate an image of quality service insurance companies may, in some instances, liberalize claim settlement processes and, inadvertently, open up avenues for the manipulation of false loss images. However, to understand the significance of the service variable one needs to examine the relative effects of other competitive variables. Both price and non-price variables (e.g. risk selection, policy packaging) affect the availability and quality of insurance, and, thus, opportunities and incentives for fraud.

2.1.4.1 Price -

The intensity of price competition often depends on the cyclical position of the insurance market at a given time and other non-insurance factors (e.g. interest rates, or large disasters). A period of heavy losses often leads to increases in the price of premiums which, in turn, leads to underwriting profits (premiums incomes exceed loss expenditures). Improved profits, industry-wide, ultimately lead to price competition as new companies enter the market. Price competition sets the stage for decline. (Hammond, 1980; 163) [10].

Currently, competition in property-casualty insurance for commercial risks is keen. Price wars have ensued for the last four years, according to a recent Business Week analysis (November 8, 1982).

"The insurers are victims of their own spectacular success in the late 1970s. The 1974-75 recession produced a debacle in the business that so alarmed state regulators they granted insurers big rate increases to ensure their solvency. With this balloon to help, insurers' profits soared when the economy turned around. Earnings swelled further from lucrative investments as interest rates climbed. The record of the past five years show that insurers averaged a handsome 17% return on investment, vs. about 14% for all industries.

Such gains have attracted a flock of new players, some of them formidable foreign companies, which have pushed their way into the market by cutting prices. The cuts have prompted established insurers to trim premiums in an effort to hang on to market share. In some insurance lines, rates have dropped as much as 35% in the past two years."

Price competition is less important in the personal property-casualty line as fewer companies compete for the business. The personal property-casualty market is far more concentrated; a few large companies write a substantial part of the business. In addition, price cuts mean less to the personal insurance consumer, according to State Farm president, Edward B. Rust and, thus, may not be as significant a factor in insurance choice.

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10. The first half of the nineteenth century, for example has been categorized by a pattern of cut-throat rate cutting, large fires, insolvencies, associations of companies and then price wars to get the cycle going again (Brearely, 1916, Gephart, 1917, Nelson, 1930, Bennett 1955, and Stanford Research Institute, 1976).

"To one of our [personal] auto customers who is paying a \$250 premium, there is nothing dramatic about someone coming in with a policy priced at \$230," he says, pointing out that rate-cutting can produce savings above \$100,000 for commercial customers" (Business Week November 8, 1982;95).

Custom, tradition and state regulation also have limited the extent of price as a competitive factor in many cases (Pfeffer and Klock, 1974). State regulators who must approve rates set by companies, control the extent of competition in a given state. For example, in Massachusetts a single pricing structure for automobile insurance is in effect. As a result, companies do not compete on the basis of the prices they charge for automobile policies. In other instances smaller companies which do not have the loss experience necessary to calculate rates join together into rating bureaus. Loss data is combined and appropriate rate structures are calculated. To the extent that companies rely on these bureaus they may be less likely to compete with other companies using the same price determination mechanisms.

2.1.4.2 Risk Selection -

The insurance company tradition of using risk selection as a means of obtaining profitable business has reduced the importance of price competition in some sectors of the market. Selection competition refers to the abilities of insurance companies to affect their successes, not by the price and quality of their products, but by selecting customers in a way that gives them an

advantage over their rivals (FIA, 1974;18). For example, in the 1950s when the automobile insurance market experienced tremendous growth, new "direct writer" companies were able to compete, in part, because of their policies of risk selection. (See section 2.2 below for a discussion of "direct writers", companies which sell insurance directly to the insurance consumer and, thus, bypass the agency system.) Direct writer companies sought specific customer groups. For example, State Farm directed its marketing to farmers and Allstate to blue collar workers (SRI, 1976;21).

2.1.4.3 Policy Packaging -

Non-price competition, other than risk selection, focuses on products and services offered (Pfeffer and Klock, 1974). Companies compete in terms of the combinations of coverages they combine in a single policy. Currently, insurance companies are selling "umbrella policies" which combine heretofore separate types of coverages or which provide new limits on traditional coverages. Companies also compete in terms of the distribution of their products. As we will see in the following section on insurance sales, companies may employ any one of a number of marketing approaches. Some companies rely on personal agents to sell their products, while others sell their insurance policies through the mail. Companies compete along the payment schedules they require as well. Some companies insist on the total premium payment at the outset of the policy period, other companies have

set up installment plans for payments.

2.1.4.4 Service -

The most important non-price competitive factor in terms of potential for fraud and abuse is service. Unlike price or packaging, concrete and tangible measures, service performance is often based in perceptions and reputation. Service competition has centered on loss control—advising policyholders on loss prevention strategies—and loss adjustment. The key factors in claim service are "promptness, fairness and acceptability" of loss adjustments (Pfeffer, 1974; 235).

In their efforts to promote a positive reputation in claim service (prompt, fair, and acceptable loss adjustments), companies may liberalize their claim settlement procedures. The scanty literature on the history of loss adjustments (see for example, Nelson, 1930 and Swift, 1975 and any one of a number of company histories) suggests that during the late nineteenth century business competition often led to liberal claim settlements. Liberal claim settlements were an effective tool for assuring future business when faced with active competition. Woodland's (1979) history of the New England Agency Mutuals indicates that corporate policies regarding sales influenced claim settlement orientations. Woodland notes that after the Chelsea, Massachusetts fire of 1908, the New England Mutuals paid off losses in order to establish themselves as credible

competitors with the larger, stock insurance companies.

"Our mutual companies were a unit in their position that every claimant should have prompt and fair treatment, and in more than thirty cases our companies waived serious technicalities for the purpose of paying claims which seemed equitable, even though not legally compulsory." (Woodland, 1979;44)

Although the relationship between liberal claim settlement and fraud can only be inferred, I argue that opportunities for fraud arise when companies compete on the basis of claims service. In following corporate policy to avoid negative company reputations (e.g. being too tough on claims), individual company personnel may err in the opposite direction and, unintentionally, tolerate fraud. Liberal adjustments may actually encourage fraud should there be another claim. In an address before the Insurance Society of New York, in 1916 George Branson suggested the following relationship which is likely to hold true today.

". . . the loose adjustment makes for gross contempt for the insurer and often opens the door to dishonest practices upon the assured by his own representative in an attempt to participate in the spoils." (Branson, 1916;5)

The idea that companies see their competitive advantage in terms of claims service, and, by inference, in the potential for liberalizing claim settlement processes, is borne out in the industry response to arson and other forms of insurance fraud. Companies do not take individual positions on fraud. (One exception might be Aetna which has taken a relatively strong public position on arson.) Most public efforts are joint efforts,

(e.g. the All Industry Committee for Arson Control, the Coalition for Auto Insurance Reform in Massachusetts and the advertising campaign waged by the American Insurance Association, an umbrella organization for insurance companies.) Although arguments of economy might apply, my research suggests that individual companies might be avoiding tough positions on claims because they want to maintain their competitive service posture. The importance of a company's competitive position with respect to claims service also is evident in the reluctance of individual companies to swear out criminal complaints against known insurance fraud offenders, in cases other than arson. It appears that public prosecution of insurance policyholders occurs, for the most part, only when companies join together or when industry organizations (e.g. the Division of Insurance Fraud in Florida) stand as complainants. Thus, no individual company need be singled out as the complainant in a criminal action.

2.2 SELLING THE INSURANCE PRODUCT

As is true for any commodity, marketing plays an important part in both defining and selling a product. Successful sales depend on consumers' convictions that a product is useful or needed (Kornhauser and Lazarsfeld, 1955) [1]. Changing risk perceptions is central to the development of insurance.

". . . risk exists only in the perception of an observer—that is, what otherwise exists as a natural condition becomes a risk when someone observes that condition and perceives it to be of danger to a person or property." (Post, 1976;25.)

Individuals need to be convinced that they are "at risk" and that insurance can provide some measure of security or protection. Attracting a large consumer population is particularly important to the insurance business because profits depend on accurate predictions of expected losses. Good predictions require a sufficiently large number of exposures.

Despite its pervasiveness, experts agree that people are reluctant to purchase insurance. In testimony before a Senate Subcommittee on the Flood Disaster Protection Act, the former director of the Federal Insurance Agency (FIA), George Bernstein commented,

"Most property owners simply do not buy insurance voluntarily, regardless of the amount of equity they have at stake. It was not until banks and other lending institutions united in requiring fire insurance for their mortgagors that most people got around to purchasing it. It was also many years after its introduction that the now popular homeowners insurance caught on. At one time, too, insurers could not give away crime insurance, and we just need to look at automobile insurance laws to recognize that unless we force that insurance down the throats of the drivers, many thousands of people would be unprotected on the highways. People do not buy insurance voluntarily unless there is pressure on them from one source or another." (as quoted in Ginsberg and Kunreuther, 1980;)

Studies of insurance purchase indicate that perceived

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1. The relatively new mortgage protections insurance being sold is an example. Recognizing that many young homeowning couples need two incomes to support their mortgage payments, companies now offer insurance in the event that one or the other spouse dies and leaves the other to make the payments alone. It is not clear that without marketing people would have perceived of this "risk" nor whether they would have seen insurance as a form of protection for such a contingency.

seriousness of hazard (or risk) and knowing someone who already has insurance are the dominant factors differentiating insurance purchasers from non-purchasers [12]. In their study of flood insurance, Ginsberg and Kunreuther (1980) speculate that friends and neighbors play a subtle, but important role in risk recognition and decisions to purchase insurance. They question, as do I, the role commodity sellers (insurance producers) play in creating perceptions of need and encouraging individuals to purchase their products [13]. To what extremes will insurance salespersons go to sell their products? Interestingly, the same intangibility in the insurance product which permits the manipulation and shaping of risk perception may be used by policyholders to shape perceptions of their need—e.g. insuring a house for more than it is worth, establishing the profit motive for fraud.

Insurance companies sell their products either directly to the insurance consumer (direct writers) or through third party agents or brokers (the agency system). The insurance literature

12. The role of personal influence in the adoption of new products has been established in studies of innovation acceptance.

13. The tension between the two models of insurance function—funds holding or contingent claims—carries over to the area of insurance sales. Are insurance salespersons selling investment or protection? What do consumers believe they are buying? In her insightful study of the life insurance industry, Viviana Zelizer (1979) traces the marketing transformation of life insurance. Initially a system of family protection, insurance reached its commercial zenith as a system of sound investment around the turn of the century.

refers to agents who sell insurance as insurance "producers." The notion that those who sell are also those who produce emphasizes the intangible, contingent product being sold. The only "commodity" production is the sale. An insurance adage, "insurance is sold, not bought" stresses the importance of marketing and salesmanship.

2.2.1 AGENTS

As representatives of insurance companies and sellers of the insurance product, insurance agents have significant control over the quality and quantity of insurance business. Agents sell insurance policies, classify risks, assign appropriate rates and pass along the policies to the companies they represent for approval. In return, the agents receive a commission. Since agents are often on the scene to evaluate risks, while company officials are not, agents have tremendous influence over the amount and kind of business an insurance company writes.

Agents have binding authority which permits them to issue memorandums of insurance pending delivery of the formal policies. Since the agent "binds" the policy, the consumer can get immediate coverage, often before the policy has been officially approved [14]. Agents also have limited authority allowing them to settle small claims.

Most agents work for a commission which tends to fall around ten percent of the premium written. Insurance agents are licensed and regulated by state departments of insurance. They must pass a written exam and obtain insurance company sponsorship. The Chartered Property and Casualty Underwriter (CPCU) is the professional designation ascribed to an agent who has passed examination by the related professional society.

Agents are of two types, independent or exclusive, depending on the number of companies they represent. An independent agent is appointed by more than one company to sell policies and perform limited underwriting and claims service. Independent agents own and control the insurance policies written through them and, thus, they own the policy data and the right of renewal. Technically an agent can move a policy from one company to another he or she represents. To underscore the agents' positions vis-a-vis the insurance contract some states require agents to sign or countersign policies. An exclusive agent, on the other hand, represents only one company. They reserve the ownership, use and control of policy records for the insurer.

The discretionary authority afforded to agents to issue policies led to insurance expansion and development during the nineteenth century. However, the decentralized agency system also created great avenues for abuse as companies had less

14. This would appear to be a significant area for abuse. Unfortunately, data are not available to determine how often frauds (fake accidents, burned buildings) occur during this preliminary period.

control over the risks they assumed. Lack of control over agents' decisions created two major fraud problems which persist today. Agents' discretionary authority to issue policies led, in some instances to the insuring of fraud prone risks and overinsuring—insuring property for more than it is worth. Both conditions set up incentives for fraud.

The physical distance between agent and insurance carrier increased opportunities for agency participation, witting or otherwise, in frauds against the companies. Many of the agents' discretionary judgments went unchecked. Agent potential to facilitate frauds became all too apparent to the Royal Exchange Assurance office in England in the 1860s, for example. In this case, an agent had submitted a claim for a fire which was,

" . . .from beginning to end, a pure piece of fiction, excepting the mere fact that the owners and occupiers named really have an assurance in this fire office." US Insurance Gazette. 1861; 254)

There was no house, there was no fire and, probably, the persons named on the policy did not exist. The agent had manufactured a completely false claim. Lack of insurer oversight opened up possibilities for fraud and abuse.

Agents' commission are perceived to be highly correlated with overinsurance. Eager for commissions, agents insure property for more than it is worth in order to receive a higher premium dollar. Overinsurance, historically, has been cited as a motive for arson [15].

Alexander Campbell in his early work (1902) on insurance and crime (the first to deal with insurance fraud as an important social problem) critiqued company administration of the agency system.

" . . .the amount at risk by fire insurance companies [enlarged by the agent commission system] if those companies are not properly administered, stands as a great bribery fund to reward the careless and the criminal for losing their own property and endangering the property and lives of others. . ." (Campbell, 1902; 147)

Those responsible for assuming risk for the individual companies, the underwriters, also were concerned with attracting enough premiums to cover policyholders' losses and to ensure company profits. Thus, they were not an effective check on agents' discretionary judgment (Merritt Commission, 1911 and for more current analysis, US Senate Committee on Governmental Affairs, 1978).

Thus, while decentralizing insurance sales through the agency system led to great diffusion of the insurance product, it was not without some real costs. Companies have recently tried

15. In an address on incendiarism delivered at the eleventh annual meeting of the fire underwriters association of the northwest in 1880, H.E. Palmer claimed that

"During the past five years, 1875 to 1879 inclusive, the fire losses in the United States alone have amounted to the neat sum of \$353,018,125. Of this amount fully thirty-three percent is directly chargable to incendiarism or overinsurance. . . .No legislation against incendiarism can by any possibility be effective that will not deal primarily and vigorously with the cause of it, viz, overinsurance." (Proceedings of the 11th Annual Meeting of the Fire Underwriters Association of the Northwest, 1880;117)

to check agent abuses by renewing agency contracts on the basis of an agency's loss-ratio (amount of losses to total premiums written). However, company control over agents is limited. Since agents own the policies they write, they can choose with which companies they will place their clients' business. When an agency represents a number of companies, the insurance company finds itself in a position of wooing the agent simply to retain business. In the current competitive insurance market, individual insurance companies have begun to establish profit sharing programs with their agents in order to win additional favors from the independent agents.

2.2.2 DIRECT WRITERS

Companies which have their own production (sales) force, are called direct writers. They use a variety of sales techniques. Some try to attract new business through the mail. Anyone who owns one of the major credit cards has been inundated with insurance plan offers. Although a relatively new phenomenon, they are a growing force in the industry. While Direct Writers accounted for slightly more than a quarter of the auto insurance market in 1955, by 1978 their share had grown to over fifty percent (IMA Ed and Research, 1977;11). Direct writers are also making inroads in the commercial markets, long the province of the independent agents and brokers.

"Over the past ten years, they've grabbed 12 percent of that business [personal property-casualty] bringing their total [market] share to 57 percent and leaving

the independent agents with only 36 percent of the market. . .The direct writers have already snatched away 21 percent of the commercial market." (Hill, 1981;94-95)

2.2.3 BROKERS

Insurance brokers represent policyholders, not insurance companies. Brokers are commonly utilized in the larger metropolitan areas, particularly for commercial business, and for placement in the specialized markets. Unlike agents, brokers do not have authority to provide insurance services such as binding or small claim settlement. Brokers deal with any insurance company (or agent acting on behalf of a company) that will provide their clients with the most advantageous insurance packages. In return, the brokers receive commissions.

Brokerage firms have been increasing in the past few decades—often taking over independent agents in their paths. The top twenty brokerage houses have taken over one thousand independent agents in the past decade (Hill, 1981;85). Two factors account for this trend— the increase use of surplus insurance sold only through brokers and a growing corporate consumer concern for risk management which argues for the individual packaging of insurance products.

2.2.4 SELLING INSURANCE OR SETTING UP OPPORTUNITIES FOR FRAUD?

Opportunities for fraud and abuse arise if, in their quest for sales, insurance salespersons provide insurance when no need, in fact, exists. By providing for economic compensation in the event of a contingency when the contingency was not a likely event, insurance salespersons undermine the insurance function. Since incentives to gain from the insurance relationship are present when potential insurance compensation is greater than the value of the risk insured, insurance sales personnel may contribute to the generation of false claims if they overinsure property or provide insurance when there was no risk. Should policyholders believe that they were "forced" to purchase insurance that they did not want, they may take advantage of a loss situation in order to affect a return on their premium investment.

2.3 ASSUMING RISK

Insurance companies reduce the uncertainties they face by pooling together the risks they assume. Techniques of risk spreading and transfer—pooling risks, classifying them and predicting likely outcomes—minimize the importance of and interest in individual dispositions and deviations. Some frauds may be tolerated as long as the total fraud effect is deemed acceptable by company officials.

The insurance mechanism operates by applying the law of large numbers to selected and pre-classified risks. Dealing with large numbers of homogeneous observations, improves insurers' abilities to forecast claim costs. (Hammond, 1980, Houston, 1968, Dennenberg, 1968 as well as standard insurance texts such as Bickelhaupt, 1980; Mehr and Commack, 1980 and Pfeffer and Klock, 1974). By accepting only risks which conform to certain standards, classifying them and estimating probabilities of loss, insurance companies increase the certainty that they will have collected enough revenue (in premiums) to cover total claims of loss they expect to be filed.

2.3.1 RATE SETTING AND CLASSIFICATION

Using the law of large numbers and laws of probability, insurance actuaries estimate the likelihood that a risk of a certain type will experience the contingency insured against. Assuming these probabilities of loss, premium rates are set in order to provide sufficient revenue to compensate policyholders experiencing losses, to pay the expenses of doing business and to produce a reasonable profit for the company. (Bickelhaupt and Magee, 1970).

Except in two states, rates are set by companies or rating bureaus. Some companies are too small to have their own statistical base for rate making and, thus, rely on industry-wide rating organizations. States which have uniform rates for

certain policy categories (e.g. automobile insurance in Massachusetts) rely on a single rate making body. Most states require that insurance commissioners approve the rates set. [16]

The mechanisms by which insurers reduce the uncertainty and risk they assume (classifying risks and predicting probabilities of loss) also open up fraud possibilities in so far as they create distance between those at risk and those assuming risk. The development of the corporate form of insurance organization transformed the business of insurance from a personalized system of risk sharing to a depersonalized system of risk distribution where those at risk were unfamiliar and unknown to those assuming risk. Opportunities for individual deviation and fraud increased as concern for aggregate outcomes replaced concern over

16. Rates are calculated by company actuaries who combine similar risks and estimate the likelihood and severity of losses. The two primary factors when estimating appropriate rates are (1) aggregate claim frequencies and (2) aggregate claim severities measured by the cost (or estimated cost) or claims. Four rate making approaches are employed by property-casualty underwriters: Class, Judgment, Experience or Retrospective rating. Class rates combine objects with similar characteristics and assign rates based on the average degree of risk. When risks are grossly dissimilar and do not fall neatly into risk classes, rates may be determined at the underwriters' judgment. Experience rating is based on the prior experience of the individual or group. Retrospective rating adjusts the premium paid under an experience rating system to reflect the insured's actual experience.

Basic rate setting standards include: (1) rates reasonable and adequate for classes of risks to which they apply, (2) no rate should discriminate unfairly between risks facing essentially the same hazards, (3) consideration shall be given to past and prospective loss experience, all factors reasonably attributable to classes of risks and a reasonable underwriting profit. (Bickelhaupt and Magee, 1970)

individual ones and physical and social distance separated policyholders from the insurer.

The earliest insurance transactions in the United States resemble what we now refer to as self-insurance. Merchants joined together to transfer risks among themselves. Much of the business was transacted in coffee houses where merchants agreed to indemnify each other by signing their names under the description of the risk (hence, the name underwriters). Merchants who had property at risk would approach a broker who would issue a policy in return for a premium. The brokers sold shares of the policy to other merchants. Those who assumed the risks were aware of the particular characteristics of ships they insured and the nature of the risks they assumed.

With the development of underwriting associations in the mid-1700s, insurance was taken out of the direct hands of the merchants. Underwriting associations,

" . . . combined two of the requisite insurance functions: they served as both the brokers and the acutal writers, the role previously filled by other merchants. In so doing, the new underwriting firms secured both the broker's commission and the underwriting profits resulting from the excess of premium receipts over insured losses." (Post, 1976;39)

Still, rates were fixed on a case by case basis. Those assuming risks remained fully aware of the risks undertaken. Opportunities for misunderstanding between policyholders and their insurers were minimized (Nelson, 1930;17).

The development of the corporate, publicly-owned insurance company, dominant by the mid-1800s, separated those at risk from those evaluating and assuming risks. The newly formed stock companies were owned and controlled by a broad based group of stockholders unrelated to the risks insured. Wide company ownership minimized the risk to individual owners and expanded the capital base allowing these companies to take on larger, and more profitable, risks.

Insurance became a specialized industry apart from other forms of commerce. As insurance personnel became a distinct professional group, merchants were freed to pursue other non-insurance interests. Salaried company employees developed the technical expertise to produce lower insurance rates and to perform other insurance functions. As companies began to accumulate underwriting data, new "scientific" techniques for risk assessment replaced merchant consensus as the base for insurance decisions. Sophisticated statistical analyses replaced personal intuition in decisions to accept risk in cases where risks were more or less standard and loss exposures relatively high.

Insurance companies continued to refine their underwriting and statistical rate making processes in order to increase the certainty that claims would be paid and profits made. In so doing, companies subjected the risk assumption process to more specialized, yet also more routine, rules and procedures.

Personal auto insurance underwriting is now considered sufficiently routine as to warrant computerization (Hammond, 1980;162).

Nevertheless, "underwriters," the insurance personnel who select, classify and assign rates to individual requests for insurance coverage often make their decisions under conditions of great uncertainty. Underwriters have limited information about particular risks.

". . .the underwriters knowledge of the physical and moral characteristics of the risk under consideration is imperfect. Regardless of whether the underwriter has a description of the risk or has personally inspected the risk, it is virtually impossible to collect and assimilate all of the physical and other facts which have some bearing on the desirability of the risk for the coverage desired." (Launie, et. al, 1980; 48)

Classification of risks conforms to standards about types and quality of risks corporate policymakers choose to accept. Corporate policymakers also set retention limits which determine the extent to which they are willing to put a company's assets at risk. Since information gathering incurs additional costs, additional data are obtained only if the cost is "commensurate with its place in the decision." (Launie, et. al, 1980;49) Decisions to look closely at a particular risk thus often depend on its relationship to the aggregate picture. Thus, a company's willingness to render insurance coverages depends on the probability of loss for similar risks, the amount of surplus funds available to cover losses which do occur (capital) and the

expectation of an underwriting profit (premiums to exceed losses). Aggregate outcomes inform individual decisions.

2.4 SPREADING RISK

Insurance companies may reduce the uncertainties associated with claims filed against them by spreading the risks to other companies or syndicates. The two methods generally available to reduce individual uncertainty—pooling and transfer—apply here a well. Through pooling, insurance companies share the costs of high risk business that state regulators have mandated must be carried. Insurance companies can also transfer a percentage of high risk business to other companies. Just as individuals transfer the risks to third parties (insurance companies), insurance companies transfer their risks to business enterprises which specialize in reinsuring insurance business.

Risk spreading diffuses fraud effects and limits incentives for controlling fraud as companies can share the risk of claims filed against them. In fact, the reinsurance mechanism appears to set up a condition of "moral hazard" for insurance companies [17].

17. Arguments for moral hazard (Pauly, 1968; Marshall, 1974 and Dionne, 1981) typically focus on individual consumer behavior. As I noted in Chapter One their argument does not provide an adequate explanation for consumer decisions to commit fraud. It may, however, explain lax enforcement on the part of those insurance companies threatened by the perils of fraud.

2.4.1 POOLING HIGH RISK AND SHARING COSTS

For specialized risks, companies writing insurance in a particular state join together to share or pool the risks that one individual company does not wish to bear alone. In some instances the pools are formed voluntarily. In others, the pools are mandated by statute. Falling in the later category are the two types of organizations most frequently encountered in the literature on insurance fraud: the FAIR (Fair Access to Insurance Requirements) Plan and Assigned Risk Plans for auto insurance.

2.4.1.1 The FAIR Plans -

The FAIR Plan concept emerged in the late 1960s when the Hughes Panel, the President's National Advisory Panel on Insurance in Riot Affected Areas, convened to discuss insurance availability in inner cities. The Commission found substantial insurance redlining and insurance company reluctance to write policies for inner city properties. Concluding that insurance was a necessity, the "cornerstone of credit" and that "communities without insurance are communities without hope," panel members devised a plan to spur insurance availability. (National Advisory Panel on Insurance in Riot Affected Areas, 1968) The Urban Property Protection and Reinsurance Act was enacted in 1968. The federal government agreed to assume some of the insurance costs associated with riots and civil disorders in

return for insurance companies' participation in approved state plans to extend insurance coverage to inner city properties [18].

The FAIR Plans provide fire and homeowner coverage to inner city properties which no other insurance company in the "voluntary" market will write [19]. They are insurers of last resort. Theoretically, the FAIR Plan provides insurance coverage at a cost no higher than that obtainable in the voluntary market

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18. At the time, the insurance community did not want to accept the financial burdens of riots since, they argued, riots were socially contingent events. In testimony before the Hughes panel, the president of the Insurance Company of North America commented,

"It is clear that we are undergoing a social revolution in which deliberate destruction of property has been utilized as a tool to achieve social aims. A private enterprise system of insurance cannot survive unless law and order is maintained and wilfull destruction of property is suppressed. . .Catastrophic losses of the type here under discussion are not the product of natural elements, but of social change. The cost of social change should be borne by all segments of society. Presently insurance companies are being asked to bear a disproportionate share of the burden. (Hearings, President's National Advisory Commission on Insurance in Riot-Affected Areas, 1968;3)

They continued to pressure the state to pick up some of cost. Riot reinsurance is a means for insurance companies to pass on the costs of riot coverage to the state.

19. Note that excess or surplus line insurers discussed above are not considered part of the voluntary market. Inner city property owners might be able to obtain coverage through excess or surplus line insurers although at a much higher rate.
20. Critics of the FAIR Plan argue that the insurance availability afforded by the Plans has not ended insurance discrimination against inner city properties. More stringent investigations, additional surcharges and more limited coverage than could be expected in the voluntary market enables insurance companies to retain their practice of selective discrimination. (Federal Insurance Administration, 1978 and Works, 1977 for example)

[20]. By placing all "undesirable" business in a pool companies can share the costs associated with this "residual" business. Each company is assessed an amount equal to the proportion of the total state business they conduct. Data are not available to calculate the proportion of inner city insurance business written through the FAIR Plan.

The FAIR Plans are overseen by boards of directors who represent the major property insurance interests in the states. The Boards of Directors establish organizations for daily Plan management. Insurance company executives perceive the Plans as "service organizations" for the insurance industry (interview no. 2). They are not government programs as generally believed. The FAIR Plan system provides a means for the insurance industry to comply with public policy to extend coverages to inner city properties without direct regulation by government officials.

The FAIR plan programs experienced a substantial amount of arson losses in the late seventies and came under sharp attack during Senate committee hearings on the arson problem [21]. Most of the criticism centered on lax underwriting and overinsurance (insuring a building for more than its worth), and careless or indifferent claim investigation. Critics of the insurance industry and the FAIR Plan suggested that because the costs of risks were spread among so many companies, there was no incentive

21. Note that the high correlation between FAIR Plan coverage and fire loss is to be expected given that the FAIR Plan covers properties not insured through the voluntary market and, almost by definition, they are more fire vulnerable.

for companies to screen out "fraud prone" risks or to investigate their claims. They suggested that FAIR Plan guidelines for underwriting criteria could be tightened and still fall within the intent of the law (see the Illinois Legislative Commission,1978). In response to these criticisms, the National Committee on Property Insurance, the umbrella organization for the FAIR Plans, has developed an anti-arson action plan to tighten underwriting procedures and screen out arson prone properties. The FAIR Plans have also increased efforts to investigate suspicious fire losses. It is too early to assess the efficacy of such measures. Information is not available to determine whether similar plans for tightened underwriting practices and increased claim investigation have been created for other non-fire risks nor whether insurance companies are making similar efforts for the risks they voluntarily carry.

Two factors account for the centralization of anti-arson effort in the FAIR Plans. First, the FAIR Plans have experienced the largest concentration of arson losses. Second, the pooling mechanism permits the sharing of costs associated with anti-arson efforts. No one company need foot the fraud enforcement bill alone [22].

2.4.1.2 Automobile Plans -

Every state and the District of Columbia has established an automobile plan to accommodate persons who have difficulty in obtaining insurance through the voluntary market. In all states, but one, Maryland, private insurers participate directly in the plan [23]. Each insurance company must accept the motorists assigned to it. The companies retain the profits and absorb the losses from the assigned business. A company's direct participation in the plan is in proportion to its share of voluntary business. Two alternative plans for assigning high risk business have developed: a Reinsurance Facility and a Service Carrier Pooling Plan, sometimes referred to as a Joint Underwriting Association.

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22. The All Industry Research Advisory Council, an organization formed by the property-casualty insurance industry to provide research on matters of risk and public policy, conducted a closed claim study of 13,418 residential and commercial fire claims exceeding one and five thousand dollars respectively. The results of their study published in March, 1982, revealed that arson was suspected in thirty percent of fires associated with residential property covered under the FAIR plans and with only eleven percent of the residential properties covered under voluntary market policies. The arson percentages were slightly higher, forty percent for FAIR and twenty-seven percent for voluntary market, when commercial property fires were examined. This same study concluded that fourteen percent of the arson fires covered by the voluntary market policies could be attributed to arson-for-insurance profit. Interestingly, similar calculations were unavailable for FAIR Plan arsons (AIRAC, 1982;11)
23. In 1973 Maryland set up a state operated plan, the Maryland Automobile Fund. Even here private insurers subsidize some of the losses. Similar state-owned funds are common for workers compensation coverage.

Under a Reinsurance Facility Plan an individual auto insurer provides coverage and services to all those who apply. but transfers the cost of undesirable policies to the facility. The Facility reimburses the company for any losses suffered by those clients. All companies share in the Facility losses since they are assessed for them in equal proportion to the total business they write. Massachusetts, North Carolina, South Carolina and New Hampshire have such facilities. The Reinsurance Facility has been subject to some of the same criticism applied to the FAIR Plan, particularly careless claim evaluations and limited incentives to improve on loss prevention techniques (Massachusetts Governor's Task Force on Auto Theft, 1980).

Under a Service Carrier Pooling Plan a few companies agree to write and service all the assigned business. To assure access, every insurance agent writing in the state must represent one of the servicing carriers. As is true for the facility, losses and expenses incurred in servicing the assigned business are shared by all the companies, but unlike the facility, companies specialize in assigned risk business.

In comparing the performance of the two assigned risk plans, one study of auto theft found that Reinsurance Facilities experience greater losses. From 1974 to 1978 states utilizing Reinsurance Facilities experienced a greater growth in auto theft rate than states utilizing other mechanisms to accommodate high risk business (Peter Merrill Associates, 1980;40). In both

cases, sharing costs opens up possibilities for fraud in so far as it diffuses fraud effects and limits the incentive for fraud control.

2.4.2 TRANSFERING RISK THROUGH REINSURANCE

Reinsurance is another means of spreading the risks associated with the business of insurance. The assumption is that like any business, insurance businesses face perils of insolvency and overcommitment for which insurance can be provided. In return for a premium, a reinsurance company agrees to indemnify an insurance company for losses it may sustain under policies it has issued.

The concept of reinsurance dates back to the earliest insurance contracts. The first reinsurance company was not established, however, until the mid-nineteenth century (Ibsen, 1975;34). Reinsurance is typically sold through brokers who match the insurance company (primary insurer) with companies or syndicates willing to assume part of the insurers' risks.

Two types of reinsurance are common: treaty and facultative. In the case of facultative reinsurance, insurance companies reinsure specific risks. For example, an insurance company might issue a policy covering a movie production. Rather than assuming all the risk associated with insuring that movie production, the insurance company might reinsure some portion or all of that initial policy. Treaty reinsurance is a

comprehensive contract which covers some percentage of insurance company business. An insurance company might reinsure twenty-five percent of its automobile policies, for example, or all of its assigned risk business (see above). Unfortunately, data are not available to determine what proportion of total property-casualty insurance policies are reinsured. We do know, however, that most of the reinsurance business involves treaties. Eighty-four percent of the property-casualty reinsurance business assumed in 1981 was treaty reinsurance (Reinsurance Association of America, 1982).

Reinsurance increases an insurance company's capacity to accept risks. This follows from the law of large numbers applicable to insurance in the first place and in economies of scale. It is safer to write a number of small risks than a few large ones. The larger the insurer, the larger the amount of risk a company can assume. Reinsurance adds to that amount and, therefore, increases a company's capacity (Baker, 1980). Thus, availability of reinsurance in a competitive reinsurance market has the potential to alter the risk-taking behavior of insurance companies. Reinsurance allows insurance companies to take on business that they might not otherwise accept, and sometimes, business that they shouldn't accept. The existence of reinsurance causes underwriters to ignore prior probabilities and, thus, sets up a situation of moral hazard for insurance companies.

The reinsurance business also opens up many possible avenues for abuse. Just like insurance, the business of reinsurance is based in trust. Companies trust that their assets will be protected. However, reinsurance agencies (companies, syndicates or even individuals) are not publicly known or regulated. Primary insurers rely on publicly regulated intermediaries to place their business with reputable reinsurers. The reinsurance tradition of "good faith agreements among gentlemen" appears to be breaking down in today's competitive market. The reinsurance industry has many new, and not well-known, players. (Wall Street Journal December 8, 1982, Journal of Commerce December ,1981) Seventy-five percent of the industry does not know who their reinsurers are and depend completely on intermediaries, according to an investigator looking into the current crisis in the reinsurance market. (Wall Street Journal December 8, 1982)

Recent scandals have shaken the reinsurance market as it has been fraudulently used to siphon funds from insurance companies facing insolvency. (See, for example the scandal surrounding the POSA Group (Brenner, 1982) and Kennilworth (Wall Street Journal December 8, 1982)). Unscrupulous intermediaries agree to place business with reinsurers and, instead, place the money in their own bank accounts. Because of the secrecy surrounding the reinsurance market no one is the wiser until the initial company experiences serious losses. The company then discovers that the reinsurance premiums it has been paying have not really gone to the purchase of reinsurance at all.

Reinsurance creates another type of fraud problem, not typically discussed in the literature, but more important to our discussion of insurance fraud. When companies reinsure a percentage of the business they write, they diffuse the effects of losses, even fraudulent ones. Companies have less incentive to protect themselves because of the reinsurance mechanism. Thus, insurance companies experience a form of moral hazard, usually attributed to individual insurance consumers.

2.5 INVESTING THE INSURANCE PREMIUM

Even an oversimplified understanding of the way insurance companies make money (i.e. through investment) is important to discussions of fraud since underwriting decisions about which risks to accept are indirectly tied to potential investment outcome. Accounting and investment are critical corporate insurance activities. A portion of insurance accounting practices are mandated in the states insurance codes, emphasizing the quasi-public character of the insurance company. Typically the requirements are structured to provide the regulatory agencies with sufficient information to assess company solvency and performance. Other accounting practices conform to standard business criteria for management decisions, tax purposes, etc. As Andrew Tobias (1982) rather glibly put in his book on insurance, The Invisible Bankers "There are only two things as complicated as insurance accounting, and I have no idea what they are." (Tobias,1982;26.)

A second, and probably equally baffling, insurance function is investment. Investment departments manage company portfolios. Although investment income tends to be downplayed in discussions of insurance companies' health, it is an important force. In 1980 property-casualty insurers total investment income less investment expenses and before taxes was eleven billion dollars up from slightly more than nine billion a year before (Insurance Facts 1981;16.) The investment experience of property-casualty insurers in the recent climate of high interest rates yielded an industry-wide investment profit higher than all other industries (Business Week November 8, 1982) Investments optimize company income and capital gains. The capital involved is substantial.

"The capital underlying the operation of the State Farm Mutual Automobile Insurance Company, at year-end, 1980 \$4.6 billion, was greater than that of either Citicorp or Bank of America, double that of the Chase Manhattan Bank." (Tobias, 1982;14)

Good relationships between investment departments and their underwriting counterparts are critical to optimizing profits since both functions place insurance company assets at risk. (Pfeffer, 1974; 385)

Several claims managers interviewed in this study suggested that some companies write business on what is referred to as a "cash flow basis". This means pricing coverage low enough to bring in premium dollars to invest. It could also mean less careful risk selection. (Although no claims manager thought that his company operated on this basis, many mentioned the

hypothetical possibility.) Recent analysis of the current crisis in the property-casualty insurance market also recognize this trend (see, for example, The New York Times November 17, 1982 and Business Week November 8, 1982).

The cash flow investment strategy could lead to two developments associated with fraud. (1) Overinsurance—insurance coverage for more than the property is worth—may bring in the premium dollar but is also cited as one of the primary motives for insurance frauds such as arson. (2) Companies may accept risks that underwriters recognize to be potential frauds anticipating that if fraud occurs, the claim can be denied or the loss figure adjusted so that an overall increase in premium dollars and returns from investments more than offset the expected losses [24]. In the meantime, a building may have been burned and people injured in the attempted insurance fraud.

2.6 THE BUSINESS OF RISK AND FALSE CLAIMING

Insurance is the business of risk. The uncertainties associated with particular risks are reduced by transferring and/or spreading some part of an individual's risk to others. In this chapter I have indicated ways in which the mechanisms employed to reduce risk open up possibilities for individual

24. A recent analysis suggests that when the "combined ratio" (premium income to losses and expenses) reaches 114 you are past the point when investment income can offset losses (New York Times November 17, 1982) This figure indicates, however, that investment income provides insurance companies with a substantial cushion for their losses.

deviation and fraud—new forms of hazards. In Chapters Five, Six and Seven I discuss insurance company attempts to control deceptive behavior.

Despite control efforts, this analysis suggests that fraud will persist because of the image making quality of the insurance product which provides room to create perceptions of loss as well as risk. Physical separation between those at risk and those assuming risk and the positions of financial intermediaries (commodity sellers) also open up new fraud possibilities. Competition for insurance business may lead to practices such as liberalized claim settlement and, thus, by inference, to fraud. Corporate concern for aggregate outcomes as expressed in underwriting profits (ratio of total premiums collected to total losses) may supercede concern over individual claim dispositions. Some frauds may be tolerated as long as claim activity remains within acceptable limits. The promise of substantial profits from the investment of premiums may lead to less careful risk selection and the insuring of fraud prone risks; investment income offsetting any losses. Finally, risk spreading, the major concept of insurance, may provide a relatively risk free environment for fraud operators. By reinsuring policies they issue, insurance companies diffuse fraud effects and limit their incentives to actively prevent and/or protect themselves from fraud.

CHAPTER 3

CLAIMS MAKING

Insurance claims personnel enforce the rules of the insurance contract. They separate clearly compensable claims from the more questionable ones. This chapter describes the activities and organization of claims processing in order to highlight opportunities for fraudulent behavior even in organizations where claim verification and control are major activities.

Decisions to compensate losses affect not only the claimants who suffer losses, but also insurance organizations whose assets are tapped and claims processors whose working conditions and job mobility are affected by their decisions. Fraud offenders take advantage of the conflicts and uncertainties in bureaucratic organization and procedures of claims process to successfully construct false images of insurable losses.

Workers in large service bureaucracies who carry out the agencies' mandates—e.g. service delivery— have been conceptualized by Lipsky (1980) and others, e.g. Prottas (1979), as street-level bureaucrats. As defined by Lipsky, street-level bureaucrats are

"Public service workers who interact directly with citizens in the course of their jobs and who have substantial discretion in the execution of their work."
(Lipsky, 1980;3)

Teachers, police officers, public health and welfare workers and even insurance adjusters (Ross, 1970 revised 1980) have all been conceptualized in this way. A similar, slightly more specialized conceptualization of low-level bureaucrats providing essential services is that of gatekeepers. Gatekeepers are functionaries who are in positions to allow or disallow individual's access to particular services. A physician is a gatekeeper to the extent that she diagnoses a patient as sick and eligible for benefits (Stone, 1979).

The research on street-level bureaucrats suggests that organizational and situational pressures (e.g. inadequate resources, conflicting rules and incentives, ambiguity in performance measures) influence the way in which bureaucrats conduct their business, and, thus, the way policy is formed. Although minimizing the importance of clients and their abilities to manipulate the system (crucial to general discussions of fraud), the concept sensitizes us to certain features of street-level work—discretion and information control—which are

important to our discussion of claims processing and fraud. Prottas (1979) in particular focuses on the way street-level bureaucrats transform client data (typically stories of misfortune) into organizationally useful data.

The bureaucrat, the agency expending resources and the client each have stakes in classification decisions and, to a limited extent, each tries to influence the process (Prottas, 1980). [1] Most studies of bureaucratic process (Lipsky, 1980, Prottas, 1979 also studies of police as street-level workers, e.g. Smith and Visser, 1981) suggest ways in which street-level work produce structural discretion to the processors' advantages. For example, claims adjusters might use their discretion to disallow a claim on the basis of relatively questionable grounds. My analysis suggests, however, that the advantage may work in the other direction as well. Insurance claimants control significant claim information and may take advantage of the ambiguities in claim classification categories and in claims process itself to manipulate loss images and reports.

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1. Street-level bureaucrats who are also professionals (doctors, lawyers, police officers) face additional pressures stemming from conflicts between professional norms and bureaucratic requirements (Stone, 1979). The "political arena" of conflicting interests and bureaucratic pressures create contingencies influencing the organization's collective behavior. The studies tend to conclude that street-level bureaucrats develop distinctive coping mechanisms which enable them to handle conflicts and contradictions within their work settings. For example, in order to expedite claims, bureaucrats will often generate broad categories of behavior or clients so that they may process their clients' claims quickly.

This chapter explores insurance claims processing as a form of street-level work. I consider how the activities of street-level bureaucracies might generate opportunities for unintended or deviant outcomes. After describing processing organization and actors, I will examine in more detail claims processing activities. Each section will indicate ways in which the process of insurance service delivery and the relationship between claimant/clients and the service organization open up avenues for abuse.

3.1 THE STRUCTURE OF CLAIMS PROCESSING

The structure of insurance claims processing sets up opportunities for deception in so far as it establishes disincentives for fraud control. Limits on control may create a relatively risk-free environment for fraud operators. Complicated and time-consuming bureaucratic procedures developed to handle unusual or suspicious claims may actually discourage claim evaluators from treating non-routine claims in any other way than routine. Similarly, workload constraints may discourage other claim evaluators from pursuing fraud investigation. The discretion afforded to claim evaluators working in the field, away from supervisory personnel, also opens up avenues for abuse. Powerful claimants may use their influence to shape claim processors' decisions regarding specific claims.

3.1.1 ORGANIZATIONAL SETTINGS

Claims processors may work for insurance organizations which include a full range of insurance functions or they may work within organizations that specialize in claim service and contract to insurance companies on a case by case basis. Although data were not available to systematically test differences in reward structures, several possible variations are suggested in the literature and from my interviews. Ross (1970 revised 1980) suggests that differences in management structures exist for independent and staff employees. He argues that, contrary to popular conceptions, the average claims processor is rewarded, not for claim denials, but for terminating claims. The fastest way to terminate a claim is to pay it. Thus, processors in his study were pressured to settle claims. This observation was confirmed in my interviews. Independents, on the other hand, often work on a per diem basis which decreases pressures to settle claims quickly. Independents, therefore, may be more likely to spend the extra time investigating a claim they suspects may be false.

Different paths of career mobility also may influence individual decisions to spend time investigating claims. Many of the staff adjusters enter insurance companies with the idea of making a career out of their employment. To that end they may be extremely conscientious. Independent adjusters may or may not feel the same pressures. Job frustration and lack of commitment

could lead to less efforts and, by inference, less fraud control as well.

3.1.1.1 Claim Departments -

All insurance companies have some form of claim department, although the composition of the department varies depending on company size. In the very small companies the claim department may consist of one company vice-president who reviews loss assessments written by outside contractors and who authorizes claim settlements. In the larger companies, with local branch offices, a formal bureaucracy for claims processing, headed by a local vice-president, was typical. Claim departments in the larger companies are functionally separated by type of policy line.

Some of the larger insurance groups, composed of a number of individual companies, have one claim department to service claims made with any one of the individual companies. Sentry Insurance Group which includes thirteen different companies including the Sentry Insurance Company, has a single claim department with several regional branches to service claims filed with any one of the thirteen companies.

The larger insurance companies might also provide claims service for corporations which are otherwise self-insured. Self-insured firms contract with insurance companies to handle only claims processing. The insurance company helps evaluate

liability, however, the pecuniary obligations remain with the self insured firms.

3.1.1.2 Service Organizations -

Companies which have only minimal capacity for claims servicing use the services of one of a number of claims service organizations that are contracted on a case-by-case basis. Even companies with large claims departments may utilize these specialized organizations to handle extraordinary risks. The General Adjustment Bureau (GAB) and Underwriters Adjusting Company are two of the larger, nationally organized, private companies which provide claims adjustment services on a contract basis. Smaller independent adjusting firms are available as well. As of May 1974 the National Association of Independent Insurance Adjusters reported that 460 member companies employed 2500 adjusters processing over 1.8 million claims (Swift, 1975;6-9.)

Other "umbrella" organizations provide service to member companies as well. For example, the Mutual Fire Insurance Association of New England, composed of twenty-four, small, New England mutuals writing property insurance, offers claim information and advice to members investigating major losses, questionable claims or unusual coverages. The Property Loss Research Bureau (PLRB), maintained by one hundred mutual insurance companies, has developed claims handling procedures to

assist processors in detecting and evaluating insurance fraud and provides trained investigators to assist in arson fraud investigations. A similar claims service is provided by a section of the American Insurance Association.

3.1.2 CLAIM PROCESSORS

The claims process is composed of a number of different activities. Tasks include reviewing notices of loss submitted by policyholders, examining and verifying policy coverages (i.e. property covered, perils insured against, extensions, exclusions, etc.), determining the cause of loss and company's liability, determining the extent of damage and, eventually, negotiating a settlement. Suspicious claims require more intense scrutiny. Official statements are obtained from the relevant parties to the loss when there are questions regarding claim details. The claims processing organization is also responsible for setting up company reserves, sums of money sufficient to meet reported losses as well losses incurred but not yet reported [2].

In the smaller companies one or two individuals are responsible for all tasks. However, in the larger, bureaucratic

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2. Claims personnel sometimes estimate loss reserves on a case by case basis. However, more typically, formulas are used to estimate loss reserves (e.g. average cost by claim type). Liability claims which often drag on for years, with less certain outcomes, present additional problems for estimating loss reserves, solved, in part, by statutory formulas prescribed by state regulators.

insurance organizations the claims processing function is performed by a number of different employees. One person, for example, might collect the initial claim information, while another inspects the loss scene and still another evaluates the dollar value of the claim.

In the following section I will describe the possible claim processors. The actors described here are responsible for moving a policyholder's claim through the insurance system [3]. In a later section I will describe the activities of claims processing.

3.1.2.1 Providing Claim Inputs -

Most insurance texts fail to take into account that policyholders/claimants are the backbone of the insurance claims process. Claimants provide the "inputs" for claims process. Although, theoretically, a significant piece of the insurance organization, policyholder/claimants are more conventionally treated as outsiders to the insurance organization. By treating claimants as outsiders, however, one minimizes the significance of the interaction between claimants and processors to claim outcomes.

3. Titles associated with individual positions tend to vary among companies so that one company will call an adjuster a claims service representative, while another might call an equivalently positioned actor a desk adjuster. I have tried to conform to labels available in insurance texts, although there are some discrepancies among texts and labels I encountered during the field research.

Individuals who suffer losses and make claims against insurance policies are of two types: first party or third party. First party claimants submit claims against their own insurance policies. Third party claimants submit claims against the policies of others who are, allegedly, liable for their losses. In the case of third party claims, the policyholder is not the individual who experienced the loss, but the individual who is supposedly responsible for the claimant's misfortune.

3.1.2.2 Support Players-Counsel For Claimants -

Public adjusters may be hired by claimants to help them prepare claim documents. Unlike claim service representatives who evaluate claims of loss on behalf of insurance companies, public adjusters are hired by claimants to advocate and support their claims. If a loss was a large and complicated one and the claimant needed specialized advice, he or she might seek the services of a public adjuster. Since public adjusters work on a commission basis, they tend to advocate for the highest settlement possible.

Several investigators interviewed suggested that, in their search for the highest settlement, some public adjusters inflate claims and entice claimants to commit fraud (also see, for example, Battle and Weston, 1978). Although public adjusters have been indicted for their participation in arson conspiracies, it seems a little unjust, and perhaps, a little too convenient,

to single out public adjusters as the primary villains. It is the responsibility of insurance company claims representatives to review claim documents, to adjust settlements accordingly or if the claim is not warranted, to deny it. Insurance companies, it seems, must bear some of the burden when public adjusters have helped to inflate claims and, in some cases, to pursue fraudulent ones.

Some claimants choose to have counsel represent them in the course of their claiming activities. Once counsel is retained all future contact between the claimant and the insurer must be mediated through the attorney. Whether or not the claimant is represented will influence the amount of claim settlement. Ross' (1970 revised 1980) study of the liability claims process indicates that claimants represented by counsel tended to have higher claim settlements, overall.

3.1.2.3 Mediators Between Claimants And Companies -

Although not all individuals purchase insurance through independent agents, a proportion who do inform their agents that claims will be filed before filing their claims with the relevant insurer. Some agents have discretion to settle very small claims. As the initial contact point and often intermediary between claimants and companies, agents are in unique positions to promote, knowingly or otherwise, a false claim of loss.

As the first claim evaluators, however, agents may also be the first to suspect fraud. Despite their vantage points, incentives to detect and report fraud do not appear to be universally provided nor effective. Agents represent a number of companies and traditionally have not shared in the costs or profits of insurance company operations. Since they have not shared in the consequences of losses, they have had limited incentives to control losses or frauds, other than their own personal interests in doing so. In fact, as indicated earlier, certain agents, historically, have overinsured property in order to reap a higher commission. Overinsurance has been cited as a precondition for insurance frauds, particularly arson.

The recent competitive insurance market has prompted some insurance companies to take steps to improve their agency relationships, and, by so doing, to create new incentives for fraud control. Recognizing that agents can place business with any one of the companies they represent, insurance companies have devised schemes to encourage agents to place the business with them. Several companies have offered profit-sharing plans to their agents. In addition to attracting business, these plans may actually create incentives for agents to be more careful in selecting risk and to take greater efforts to control fraud. It is too early to assess whether these goals will be realized.

3.1.2.4 Company Representatives -

Individuals responsible for evaluating claims, determining companies' obligations to pay claims and negotiating settlements when appropriate can be usefully classified under the general heading of claims service representatives. As claim evaluators, these personnel are responsible for assessing claim legitimacy. The uncertainties in claim situations and discretion afforded to claim evaluators is often manipulated by fraud offenders as they manufacture false images of loss.

There are two main types of claims representatives: desk and telephone adjusters, or field adjusters. Individual companies may have different combinations of claims representative working in their departments. One company might employ primarily desk adjusters with only a few adjusters working in the field. Other companies might deploy most of their adjusters in the field. A single individual may work as both desk and telephone adjuster. An adjuster might work one or two days at a desk in the office and the rest of the time in the field.

In addition to distinctions based on position or title, claims service representatives are also distinguished by their authority to settle claims. Authority is defined in terms of a dollar limit on an individual's discretion to settle a claim. Some adjusters can settle only those claims under \$500. Others can settle claims up to \$10,000. Authority is not restricted to

claims service representatives, but can apply to branch offices as well. A claims manager for a branch office of a large insurance group noted that his branch, operating in a large metropolitan area, only had authority to settle claims less than \$150,000. Claims of more than \$150,000 had to be referred to the home office for disposition (interview no. 11).

In some companies, particularly those companies which use independent adjusters, the adjustment process (verifying coverage and investigating losses) is separated from payment processes. Examiners review the adjusters report and determine payment. In other companies adjusters complete the entire process themselves.

3.1.2.4.1 Telephone Or Desk Adjusters -

When policyholders have losses they usually inform their insurance companies by telephone. Many of the larger insurance companies have toll-free, twenty-four hour telephone numbers available to their policyholders for loss reporting. The past decade has produced a surge in the use of telephone adjusters (Swift,1975). While some telephone adjusters are merely telephone receptionists who provide initial contact, take down preliminary facts and, then, refer the claim to someone else, other telephone adjusters follow a claim from its initial intake through the entire claiming process.

Desk or telephone adjusters process the smaller, routine claims that are referred to the claim department. Virtually all business with the claimant is conducted over the telephone. Recorded statements are taken over the phone and loss details are verified orally. In instances where police reports, claim notices, or verified receipts are required, they are secured through the mail. The adjuster need not leave his or her desk in order to process the claim (hence, the name "desk" adjuster).

Because telephone or desk adjusters handle only the most routine types of claims, standard operating procedures and check lists have been developed for efficient claim handling. Stream-lining claim processing through routinized telephone procedures, and even computer handling, has been a controversial undertaking in a business that prides itself on customer service. Critics of the new standardized techniques argue that customers prefer personal treatment. Additionally, they argue, the lack of inspections may increase the chance for exaggeration and ". . . some of the less experienced claims representative may unwittingly be viewing claims as a sort of social program, instead of the discharge of a contractual obligation" (Swift, 1975;TA-3). Lack of personal oversight may, in fact, increase opportunities for fraud and abuse. Advocates argue that the excesses are not substantial and are more than offset by efficient claims procedures—the ultimate concern of the policyholder.

In most companies, if telephone or desk adjusters suspect that a claim is fraudulent, they refer the case to a higher level or transfer it to the appropriate department (e.g. a special investigative or internal security unit). It is not clear, however, how many frauds are detected given such high claim volumes, and greatly standardized claim procedures. Telephone adjusters rarely have the time or access to information which would enable them to give a claim the detailed scrutiny which claims personnel argue is necessary to detect fraud. Similarly, since telephone adjusters handle only the smallest claims, it is likely that the claimed amount is too small to warrant the cost of detailed investigation. Claim managers clearly stated that if it cost more to investigate a claim than to pay it, in most cases the claim would be paid.

3.1.2.4.2 Field Adjusters -

Claims service representatives who have direct personal contact with claimants are field adjusters. Although the overall duties performed by these officials are similar to those performed by desk adjusters, higher settlement authority is typical for adjusters working in the field. Because they handle larger and less standard losses, field adjusters often conduct individual loss evaluations and have more discretion to interpret claim facts. Typically, an adjuster will spend one half to two thirds of his time out in the field interviewing claimants and witnesses, examining damages, etc. The remaining time is spent

writing reports and documenting the claim file. When fraud is suspected a supervisor or a fraud specialist might be called in for consultation. The adjuster will continue his or her activities depending on the higher official's judgment.

Adjusters' discretion lie in their interpretations of claim facts. Their decisions reflect their abilities to balance often conflicting demands of supervisors, claimants, claimants' attorneys as well as workload and professional requirements. As noted earlier, Ross (1970, revised 1980) found that, contrary to popular conceptions, adjusters were rewarded for terminating claims, not denying them. One claims manager interviewed in this study commented that his motto was "Do it, Document it, and Dump it." (interview no.17). Since investigations often prolong inevitable claim settlements (most claims are settled out of court eventually), and since investigations often cost more than companies are willing to bear, adjusters may respond to suspicious claims by negotiating lower claim settlements in the first place. (See also, Ross, 1970, revised 1980;128).

Companies' policies to fight fraudulent claims through claim denials may be counteracted by reward structures for claims personnel which emphasize minimizing the time and expense of claims process. If so, terminating claims through settlement when fraudulent intent is not immediately clear may be perceived as the fastest way to gain company approval for individual performance. Of course, some adjusters are "hot dogs" for whom

ferreting out fraud is the most interesting part of their work. These individuals may investigate all suspicious claims simply because they like doing so and prefer to do what they like rather than what they ought to do for company advancement [4].

Adjusters have significant control over information used to evaluate their performance and can use that control to balance or neutralize the demands of their supervisors. Ross (1970, revised 1980) notes that adjusters answer to supervisors through their claim files. Since claim files are constructed and controlled by adjusters, Ross concludes,

" . . . The supervisor exercises control not over the real world, but over the file, and the file may be influenced by the adjuster's personal need to minimize the conflict element in his role." (p.59)

Limits on supervision afford to adjusters a significant amount of discretion in claims handling performance and outcome. Thus, if they suspect fraud, they may ignore it and even construct the claim in such a way that supervisors will not, or can not, question their judgments.

Adjusters' discretion in the field also may yield power over their claimants/clients. Street-level bureaucrats can take advantage of ambiguous rules and discretion afforded to them by their work to enforce or not enforce rules as the situations [5]

4. And, if they are good enough—that is, deny many claims and have the denials stand up in court—they may still achieve success in the company, should they want it. Note that this appears to a somewhat more risky way to advance through a company.

5. Prottas provides a similar example from welfare work.

apply. An adjuster's power rests in the unpredictability of his/her decisions. Although claimants may know friends or relatives who have been paid for inflated or fraudulent claims, they cannot be certain that their behavior will produce a similar reaction [6].

On the other hand, powerful claimants are able to subvert adjuster discretion and use it to their own advantage. The possibilities of adjuster pay-offs or bribes offered and accepted for settlement of fraudulent claims are described in the following chapter. In addition to obvious manipulations through pay-offs and coercion (e.g. extortion or blackmail), deception allows for more subtle subversion. Stories can be twisted and facts distorted. Ambiguity which, on the one hand, gives power to adjusters, can also work to the claimant's advantage. Claimants can use that ambiguity to force settlements for claims when they are not entitled to them.

3.1.2.5 Outside Appraisers -

Insurance companies may employ inhouse or outside appraisers who examine damages and determine dollar equivalents. Note that this figure is not necessarily the same as the settlement figure. Appraisals are adjusted up or down depending on the loss and/or

6. Ditton's (1977) study of employee theft recognized the arbitrary system of enforcement as a significant source of management control over the workforce. Employee theft could be treated as a perk, as pilferage or as out and out theft.

policy contingencies. In some cases an independent appraiser is called in when there is disagreement over the settlement amount. Opportunities for the manipulations of adjusters' decisions noted above apply to company appraisers as well.

3.2 SUBVERTING CLAIMS PROCESSING AUTHORITY

My analysis suggests that the organizational structure of insurance claims processing may contribute to opportunities for the manipulation of loss images and reports. The differentiation and segmentation of insurance tasks and processors who perform them provide multiple access points for fraud offenders to manipulate parts of the process without subverting the whole [7]. The powerful discretion afforded to claim evaluators may be manipulated by equally powerful offenders who can take advantage of uncertainty to shape images of insurable loss. The discretionary authority to settle claims opens up potential for abuse since supervisors can exert only limited control over adjusters' decisions. Powerful claimants may use their influence (influence which is often stronger, and more persuasive, than that provided by the insurance organization) to shape claim decisions. Finally, to the extent that claims processing organizations set up disincentives for fraud investigation and control, a relatively risk-free environment is often created for

7. See Katz, 1978; Vaughn, 1980 and Altheide and Johnson, 1980 for other discussions of the way task differentiation and bureaucratic form act to facilitate image manipulation, shield deviant activities and neutralize control.

fraud operators.

In the following section I will examine specific claims processing tasks. Not only does the organizational structure of claims processing open up possibilities for fraud and abuse, claims processing activities, themselves, often facilitate the projection of false images.

3.3 THE ROAD TO FRAUD

In addition to deciding whether or not claims are compensable, claims processors must also project images of servicing the needs of policyholder/clients. Insurance is a service industry and, thus, maintaining a perception of good service is important for attracting new business and retaining old.

Claims processors must balance the often conflicting goals of maintaining good client relationships and limiting claim costs as they pass through the five steps of claim process. These steps include: claim filing; examining the insurance policy and verifying coverage; investigating the claim; assessing the loss; negotiating a claim settlement and claim recovery. Although typically all five steps are completed, there are occasions when one of the steps may be omitted, for example if the claim is small, there may be no investigation.

Maintaining good relationships with claimants is perceived as an effective way to insure a positive claim outcome. For example, many insurance companies impose an immediate contact rule— usually within twenty-four hours of the initial intake of claim information (Webb, et.al. 1981 and Swift, 1975)—in order to facilitate a congenial atmosphere in what is potentially an adversarial relationship. Insurance experts suggest that delay in contacting third party claimants, in particular, can negatively affect claim outcomes. By failing to create timely contact with claimants, adjusters may

" . . .create ill will, anger and distrust. The claimant will be much harder to deal with. Furthermore, the lapse of time festers trauma over the circumstances surrounding the loss and inflates the amount of money which the claimant feels entitled to recover for settlement." (Webb, et. al. 1981;315)

A claims processing textbook includes a chapter on "Motivation Principles and Claims Handling Techniques" intended to inform claims personnel of "special techniques" for "better communication." In fact, this chapter teaches claims personnel techniques for controlling claim negotiation. Techniques for "obtaining favorable behavior" include small compliments, eye contact and other interactive techniques for creating a relaxed environment. Claims personnel interviewed in this study confirmed the basic premise behind these methods. They say that an adjuster has to "sell" the claim settlement. How you sell may depend on the attitude of the buyer. In all cases the adjuster must assert his or her position and then bring the claimant

around.

"Highbaugh [author of a somewhat dated text How to Control the Human Element in Claim Handling and Elsewhere (1938)] likens the role of the insurance claims representative in such a situation to that of the anaesthetist and surgeon team. When the anaesthetist and the surgeon approach the patient on the operating table, the anaesthetist must keep the patient in a manageable state while the surgeon proceeds with the operation. The claims man [sic] must perform both functions. He first must calm the claimant. Once the claimant is docile, the claims representative proceeds to reason with him to attempt to influence his actions." (Rokes, 1967)

Despite the emphasis on building positive client relationships, the activities and orientations of claim evaluation are not well designed to facilitate the necessary congeniality. Organizational pressures to limit claim costs often lead claims processors to question the legitimacy of a claimant's story and the validity of a claimant's assessment of his or her loss. In so doing, claim personnel often set up an adversarial relationship between themselves and their clients [8].

Policyholders play the game as well. A survey commissioned by Sentry Insurance Group of auto and homeowner policyholders revealed that forty-seven (47%) percent believed that policyholders try to collect more than they are entitled to in

8. Personal experience suggests that the adversarial tone to the relationship between claims processor and claimant transcends particular situations. I recently had occasion to submit an insurance claim. Despite, or perhaps because of, all I knew about the claims process, I found myself ready to do battle as soon as the adjuster asked the first question regarding the claim.

loss settlements. This survey confirmed that many policyholders believe claim settlement practices are negotiations in which each side acts to gain. Forty-three (43%) percent of the automobile policyholders surveyed—"only two out of five, according to the report— believed that companies settle for the full amount. Another twenty-eight (28%) percent felt that companies pay as little as possible (Louis Harris and Associates, 1974).

Nevertheless, when policyholders who had claims were asked if their insurance company was unfair in loss settlements, only one out of four felt so. A Consumers Report survey of homeowners claimants also found a majority of claimants to be satisfied with their treatment (Consumer Reports September, 1980.) Despite the low percentage of dissatisfied claimants, the authors of the first study introduce the following observation

"While questions of "fairness and full value" inevitably solicit subjective evaluations, the results of the attitudes and opinions surveyed clearly indicate policyholder dissatisfaction with the way companies settle claims." (my emphasis Louis Harris Associates, 1974;32)

3.3.1 PRESENTING LOSS IMAGES--FILING CLAIMS

The first step in claim process is claim filing. It is the policyholder's responsibility to notify the insurance company that a loss has occurred. It is here that claimants have their first opportunity to project manufactured loss images. Some policies require "immediate notice," others "timely" or "sufficient" notice. Despite the differences in language, the

courts interpret this requirement to mean that the claimant must give notice of a loss in a timely fashion so as not to prejudice the insurer—i.e. close enough to the loss events so that "fair" evaluation of the loss is assured. (Webb et.al. 1981;302). Oral notice is usually sufficient for the more routine claims. If the claim is complicated or the coverage unusual, claims personnel may require written notice as well. Many of the companies use the same "Property Loss Notice" form, (also known as the "ACCORD" form) to collect initial claim data.

Claimants are also responsible for submitting "proof" of their losses. Written proofs are not required for all claims. Again, for the more simple claims, claims personnel may waive the proof of loss requirement. Proofs of loss ordinarily include facts about the loss and the risk, individual interests in the risk (owners, mortgagees and other lien holders), detailed accounts of losses (items stolen, injuries sustained) as well as estimates of loss value. Receipts, invoices and bills for medical treatment may also be required depending on the company and/or policy. Companies with special investigative units for automobile claims have developed a standard form, an affidavit of vehicle theft, which claimants are required to complete before settlement will be made.

In addition to notifying insurance companies of their losses and submitting loss documentation, claimants are required under the terms of their contracts to cooperate with insurance company

personnel in their efforts to settle losses (Webb, et. al, 1981). Property losses must be available for insurance company inspection should that be required. Property claimants are also required to take necessary precautions to prevent additional damages (e.g. protecting fire damaged property by boarding up windows). Fraud investigators interviewed in this research countered claimants' refusals to cooperate with threats of claim denials based on their lack of cooperation. It is not known, however, how often non-cooperation has been upheld by the courts as a justification for claim denial. As a threat, however, it has proved effective.

3.3.2 ESTABLISHING THE RULES—VERIFYING COVERAGES

Adjusters examine the insurance policies against which claims are made in order to clarify the companies' and policyholders' obligations. Although many insurance policies are standard, special clauses, extensions, exclusions and policy riders can produce substantial deviation from conventional forms [9].

Claims representatives verify that the claim contingency is, in fact, a peril covered by the insurance contract and that the specific location of the loss is one that is covered. The

9. The most important of these clauses for discussion of arson is the mortgagee clause which designates payees. The loss payee under a mortgage clause has independent rights separate and apart from the insured. In contrast, a loss-payable clause guarantees the payee only those rights afforded to the insured.

adjuster must also identify the "insured." Although generally a straightforward procedure, on occasion a number of insureds are covered under one policy. Claims personnel also identify parties who have "insurable interests" in the loss. Insurable interest is defined as a relation between an individual and the risk insured such that, in the event that the contingency occurs, the individual would suffer financial and economic harm. Banks holding mortgages have insurable interests in those properties. Claims representatives also must determine which types of property or financial interests are covered and which are not. For example, if an income producing unit is destroyed by fire, the claims person must determine whether rental losses due to rents not paid are covered under the homeowners or fire insurance policy.

Establishing the cause of a loss is the key to determining company liability and, thus, is a central task in the claims process. Under some policies, for example, one must produce physical evidence of a "break" in order to receive insurance compensation. An irate policyholder told me that she was unable to recover for items stolen out of her car because claims personnel found no evidence of a break. She claimed that her car had been stolen and later recovered by the police (a theft of a vehicle and its contents according to official police statistics) [10]. Claims processors, however, argued that she was not covered under her homeowners policy, which includes theft of contents from a locked vehicle, because there was no evidence of

a break (interview 54).

3.3.3 VALIDATING LOSS CONDITIONS

It is hard to generalize about claim investigation. (A more thorough discussion of the investigation of fraudulent claims can be found in Chapter 6). Differences in investigation intensity reflect differences in loss size as well as the degree to which a claim is regarded as "typical" or "routine."

To document loss consequences claims personnel will interview claimants or their representatives, obtain official records of the loss event and contact witnesses, if they are needed. Experts may be called in when the cause of a loss is hard to determine. Fire experts may be called when there is suspicion that a fire was incendiary. Accountants may be called in to sort through a claimant's records when embezzlement losses are claimed.

Investigators gather their claim evaluation data into a written report. Repair or replacement invoices and the proof of loss (complete with receipts submitted by the insured) are included. Written and oral (transcribed) statements by policyholders, claimants and witnesses are often included in the claim report, particularly when there are questions regarding

10. Note that because insurance policies for losses sustained as the result of some criminal act (e.g. burglary) are private contracts between policyholders and insurance company, policy provisions take precedence over criminal law definitions.

liability or claim legitimacy. In some states, and for some policies, claimants may be required to give their statements under oath. Statements help preserve testimony and provide a written record for the claim file.

Claims personnel also gather secondary data to complete their investigative files. Police and fire reports, hospital records, accounting records, appraisal statements, media accounts of losses all add documentary evidence to the case.

A Polaroid camera is the hallmark of an insurance adjuster. Photographs are used to establish the locale and visual characteristics of a given loss and to supplement visual inspections. In many cases, photographs are used to depict the extent of damages. Videotapes or motion pictures of simulated losses may be created when there is a strong likelihood that the case will end up in court. Movies to document surveillance of the daily activities of disability or workers' compensation claimants are covertly made in some cases when claims personnel want to determine the seriousness of the injuries claimed.

Finally, adjusters may pursue "activity checks" or "neighborhood canvasses" to find out additional information about a loss or a claimant. Neighbors might be interviewed for their views on the claimant's financial condition, daily activities and other gossip items which could be relevant to the claim filed.

Again, not all investigative steps are taken for all claims. The amount of investigation necessary to complete the claim file is left to the discretion of the claims representatives and their supervisory staff. Claims personnel suggest that intensity of investigation is related to the size of the claim as well as to the extent to which claim circumstances can be easily verified. For the most part, however, unless fraud is suspected, the investigation requirement on first party claims is minimal.

Opportunities for false claiming arise because much of the data presented by claimants to verify and support their claims is outside the control of claim evaluators. Insurance personnel have limited control over receipts, doctors' reports or police reports, for example. Although insurance personnel can inspect loss consequences (damages), they are not on the scene to determine if the events happened in the way policyholders claim. Claims personnel must often rely on after-the-fact accounts of loss presented by sometimes interested third parties.

Fraud offenders can take advantage of both temporal and physical distance between losses and the evaluation of losses to shape or manipulate meaning. Claimants can construct intricate stories of losses which are difficult to penetrate without spending substantial time and effort on unravelling the deception. While claimants can put a good portion of their energies and resources into weaving credible stories, claim processors, who work on many cases at once, can place only

limited resources into pulling apart the many threads of deception which compose a single fraudulent claim.

In attempts to cope with the complexity and uncertainties of claim situations, insurance organizations have devised schemes to routinize or rationalize the claims process [11]. This is seen most clearly in the development of more intricate claim forms designed to categorize and classify all possibly relevant loss details. Routinization, however, has an inherent irony. It permits client learning. Knowledgeable claimants can use the more intricate claim forms and standard operating procedures to determine what is needed to fulfill the criteria of claim legitimacy. They can learn what triggers more careful claim scrutiny and can use that knowledge to construct false claims. [12]

3.3.4 NEGOTIATING COMPENSATION

The burden to prove the extent of damages rests with the claimant. Claimants must supply insurance personnel with

11. The general tendency for the administration of social control to become ever more rational in the face of increasingly complex and unpredictable rule breaking behavior has been suggested by both Spitzer (1979) and Marx (1982).
12. Routinization has other countervailing tendencies which have been recognized elsewhere (for example, Spitzer (1979) and Marx (1982)). Paul Montagna (1980) has argued that CPA's have a stake in preventing computerized financial audits systems. Efforts to deskill the audit through routinization are opposed by professional auditors because of the potential to usurp some of the professionals' power. It would be interesting to see to what extent adjusters oppose computerized claim evaluations on these grounds.

estimates, invoices, inventory lists and other documentary evidence supporting their claims for loss compensation. When a claim is small, for example, a small theft loss, a policyholder's oral statement of ownership and value is sufficient. However, in many cases the claims person will sit down with the claimant, detail all items lost, examine written verification of cost and ownership and, eventually, arrive at an acceptable measure of compensation.

In many cases settlements are extremely straightforward. The adjuster and claimant agree on the value of loss and a settlement draft is issued. In other cases, typically in liability claims, extensive negotiation is common. Negotiation centers on issues of liability (company's obligation to pay) as well as the dollar value of loss, particularly when the loss is a personal injury. How do you measure the cost of a lost leg?

It is often when negotiating settlements that heretofore good relationships between insurance company officials and their policyholders break down. Differences between what claimants view as their right or entitlement and claims persons' views of what is legitimate, given their reading of the insurance contract, become most obvious. For example, without a receipt to verify cost and ownership, some claims representatives would be unwilling to allow recovery for the specific items. The insured might protest, but it is unclear to what end. A different claims representative, on the other hand, might approve the settlement

The possibility for formal litigation exists for all claims, especially liability claims where questions of judgment regarding fault and worth are so difficult to compromise. Property claims, on the other hand, are litigated only after claim payment has been denied and the claimant sues for recovery. Few cases terminate in a court of law, however. Ross (1970, revised 1980; 136) notes that only one out of 20 liability cases were settled in court. (Note, however, that his research was conducted nearly fifteen years ago and the general trend to litigate may have increased that percentage somewhat.) The threat of litigation, nonetheless, pervades the settlement process, since any claim denied could end up in civil court sometime in the future. According to Ross, the spirit of negotiation that transcends the entire claims process is fueled by unwritten rules to avoid court. Claims processors work towards reaching agreement without recourse to formal legal process [13].

The spirit of negotiation which pervades claim handling produces an adversarial atmosphere, a game of wits where each party tries to outmaneuver the other. The bargaining over claims settlement can virtually force claimants to overstate the values of their claims in order to obtain what they believe they deserve.

13. Plea bargaining may be analogous to claim settlement as there, too, one bargains in order to avoid the formal court process. Interestingly, in plea bargaining, as in insurance claims processing, the formal system hangs in the background as a symbolic threat which can be evoked by either party to force the negotiation one way or the other.

The author of a book on insurance investigation argues that the actions of insurance claims adjusters may encourage policyholders to inflate their claims. Healy notes that the process breeds its own corruption.

"It is almost a rule of thumb that the insurance adjuster lowballs his claimant, particularly on thefts, fires and property losses. He will literally force the claimant to highball him. . . Insurance officials bring a lot of this exaggeration on themselves."
(Healy, 1975;253)

Although most claims managers recognized and were complacent about claimants' attempts to hide their deductibles by inflating claim value, some worried about the long term effect of such tolerance. Of particular concern was the possibility that claim inflation could lead to outright fraud. One claims manager commented.

"People who have a claim form an opinion. . . They do learn something. If they have occasion again, they start from a different level." (interview no. 8)

Negotiation processes open up opportunities for fraud or facilitate fraudulent practices because they are themselves deceptive. Limited deceptions, for example omitting details or holding back information, are standard negotiation strategies (Schelling, 1960; Fischer and Ury, 1982). Negotiations involve deceptions in the form of trickery, false promises and expectations as well as lies. Such deception, acceptable within the negotiating framework, may actually work to cover for deceptions regarding claim legitimacy. Fraud offenders may

threaten to take their cases to court if they are denied, even if they have no intention to do so. Claim evaluators might then respond to the court threat rather than to issues of claim legitimacy.

The negotiation process also facilitates fraud by providing a range of acceptable outcomes within which fraud offenders may operate. The boundaries of negotiation also serve as the boundaries for acceptable manipulation. Ross (1980) notes that all involved in the process—claimants as well as adjusters—formulate settlement ranges, either by formula or professional judgment, above and below which settlements must not fall. With settlement ranges in hand (Ross notes that in many cases both parties are aware of the range) fraud offenders know how far to manipulate the system without tipping the balance against themselves.

3.3.5 RECOVERING CLAIM EXPENSES

A claim department's performance is evaluated not only by the amount of money paid to claimants, but on the ultimate claim cost to the company, including the cost of processing. The money paid out in a claim can be recouped through the sale of salvaged property or through subrogation (recovery from another liable third party).

Subrogation is possible when a policyholder's liability was caused by a third party. An insurance company may attempt to recover the amount paid to a claimant from the third party who caused their policyholder to harm or injure another. For example, suppose B's car collides with C's. B's car was forced into the collision because it was hit by A's car. C files a claim for 10,000 against B's insurance policy. B's insurance company pays C. However, because A caused B to hit C, B's insurance company tries to get the \$10,000 it paid to C from A's insurance company. If successful, B's company would, in effect, pay no claim.

No fault insurance works on a similar principle. If Joe runs his car into Sally's, causing \$500 damage, Sally can collect from Joe's insurance company (as a third party claimant) or she can collect from her own insurance company (as a first party claimant). Because Sally was not "at fault," her insurance company would subrogate the claim with Joe's insurer.

When an insurance company pays a claimant for property lost or damaged, the company technically purchases the property from the claimant. Thus, for example, when a vehicle is declared "totalled", the claimant sells (gives up) the title to the car. Claims personnel attempt to reduce their total claim liability by selling the "totalled" vehicle as salvage [14]. In some instances the total amount paid to the claimant can be recovered through the sale of salvage.

In the case of motor vehicles, attempts to recover claim costs may actually contribute to future frauds. Paper cars which exist only for the purpose of defrauding insurers are created through the purchase of salvaged vehicle titles. Fraud offenders using this scheme are willing to pay extraordinary prices for the titles of these salvaged vehicles as they expect high returns on their initial investment. For example, according to one fraud investigator, a future fraud offender might be willing to pay \$1800 for the title to a Corvette when, in fact, the Corvette may be nothing more than a burned out shell. Since, it is the title, not the vehicle, itself, which is necessary for the fraudulent scheme, the fraud offender is willing to pay an inordinately high price for the salvage. Faced with pressures to limit their companies' claim costs, claims personnel may accept the highest bid for salvage even when they suspect that the ultimate use of the title is for fraud. Thus, pressures to limit claim costs open up avenues for abuse in this way.

3.4 CRIMINOGENESIS IN CLAIMS PROCESSING

Claims processing activities are best categorized as a series of negotiated decisions. Since claims are processed only after losses occur, loss evaluations are conducted on data that reflect social reconstructions of the events. To some extent,

14. Note that a car is totalled when the value to fix the car exceeds the book value of the car. This does not in any way mean that the car is worthless. Individual parts can be sold for a total amount greater than the amount the car is worth whole.

each party to the negotiation attempts to change those reconstructions to their advantage. Each party tries to outmaneuver the other. Physical and temporal distance between losses and loss evaluation provide room to shape images while limiting the other party's opportunity to verify claim details. Negotiation processes open up possibilities for fraud because they are themselves deceptive. Bargaining over claim settlement sets up an adversarial relationship both encouraging the use of deception and easing moral doubts about rule violation. Deceptions as parts of schemes to defraud are hard to distinguish from deceptions that are accepted. In addition, by providing an acceptable range for manipulations, negotiation also facilitates the manipulation of images. With settlement ranges in hand, offenders may learn how far they can distort the system without tipping the balance against themselves.

The conflicting demands of limiting claim costs while, at the same time projecting the image of servicing the needs of policyholder/clients can constrain claims processors from pursuing claims they suspect are fraudulent. Some opportunities for fraud will persist if, in their need to maintain good client relations, processors systematically ignore some types of fraud.

Profit-maximizing goals may also provide opportunities for fraudulent behavior if claim processors are discouraged from executing costly claim investigations when they suspect fraud. Finally, pressures to limit the costs of particular claims

through the sale of salvaged material may actually help to generate future frauds. Pressured to limit costs, claims personnel may accept the highest bid for salvage even when they know that they are selling the raw material for yet another false claim.

CHAPTER 4

SPINNING WEBS OF DECEIT

The previous two chapters examined the business of risk and the process of claim evaluations. I identified aspects of insurance business and claims processing which provide opportunities or conditions facilitating the construction of false claims. The high uncertainty associated with loss events, conflicting insurance goals and limits on information available to make informed insurance decisions combine to create an atmosphere of "structural ambiguity." Fraud offenders take advantage of ambiguity in order to deceptively obtain insurance benefits.

In this chapter I examine how frauds are constructed. What methods or techniques do fraud offenders use to build their deceptive claims? How are fraud offenders organized to commit their offences? The possible implications of particular methods and organization for fraud detection and investigation are discussed as well. Issues regarding fraud control are discussed more systematically in subsequent chapters on detection, investigation and enforcement. In this chapter I merely explore

how opportunities for fraudulent behavior might be realized by fraud offenders.

4.1 METHODS USED IN DECEPTIVE CLAIMS

Many methods are used in deceptive claims activity, each allows for the manipulation of information in order to falsely claim insurance compensation. The data indicate seven different methods used to file deceptive or false insurance claims. Fraud offenders exaggerate, conceal (hide away, obfuscate, make difficult to find,) alter, omit, create, forge as well as substitute elements of a claim in order to make a non-compensable loss appear compensable. These methods are employed to establish the image of victimization or to cover-up a fraud that has already taken place. The image conveyed is something other than what the fraud offender knows to be true. Some methods used in deceptive claims-making are illegal in their own right (e.g. forging documents), others could be thought of as breaches in trust (e.g. some omissions). Still other methods are simply conventional business strategies. Employed with the intent to deceive, however, these seven methods are the keys to deceptive claims activity.

One can convey a false image either by overt or covert action. Covert methods (omitting, concealing or altering) hide data which, if known, would exclude insurance recovery to the claimant. Overt methods (fabricate, substitute, and create)

project new data into the claims process, data that are needed to establish the claimant's entitlement to recovery.

Offenders engaged in any one of the three fraud types described in Chapter One—exploiting losses, inventing stories of loss or creating losses—may utilize any one of the seven methods or some set of methods to commit their offences. Each fraud type, however, is more likely to have a different combination of methods or degree of deceptive activity. Creating losses or inventing stories of loss typically requires the active projection of loss details since the losses are actually constructed by the offenders. Thus, one might see more created elements than, for example, omissions. Since one can only exploit losses after they have already occurred, we might expect a greater need to exaggerate or hide loss details in order to make the ineligible loss appear eligible for compensation.

Abilities to employ certain methods depend, in part, on available resources for confirming the images or facts presented by claimants. Lack of recognition or control may be related to bureaucratic dysfunctions. The overwhelming volume of data for any one claim precludes detailed evaluation of any single piece of data, unless there is some glaring discrepancy. Exaggerating the value of a risk at the time insurance is purchased is possible because the risk itself is rarely inspected. Those who evaluate losses are not on the scene when the loss occurs and facts often are hard to verify. If a person fabricates a

burglary and the police are called, but don't respond, or do respond but don't investigate, it is nearly impossible for a claim investigator, after the fact, to ascertain whether the burglary actually occurred.

Difficulties in controlling fraud may also be related to the nature of what is being claimed. Some methods used in deceptive claims are possible because of genuine, identifiable, knowledge gaps between event, cause and consequence. Fraud investigators often cannot prove that an insured's accident could not have caused the damage claimed, or that a loss could not have happened in the way it was stated. Some knowledge gaps are narrowing over time. With lab tests one can now determine whether auto damage occurred six months ago or within the past few weeks. Although advances in some medical diagnostic techniques have made it easier to detect false claims of personal injury, lacunae still remain in our abilities to prove that a sequence of events happened in one way and not another. Fraud offenders can take advantage of these "knowledge gaps" in order to illegitimately claim insurance benefits.

4.1.1 EXAGGERATE

The extent of damage or claim credibility can be increased through exaggeration so that a loss too small for insurance compensation may be perceived as compensable under a given insurance contract. The number of visits to a doctor, for

example, can be inflated in a claim. Treatment for injuries sustained in a fall can be blown up to be larger than actually necessary. The difficulty in matching damages precisely to particular losses allows a certain flexibility in what may be claimed. For example one can imagine a range of possible consequences/damages stemming from a fall down a flight of stairs. Thus, one can exaggerate the extent of injuries while still remaining within the boundaries of what might be expected. Ranges in acceptable behavior provide room for exaggeration and create potential loopholes for fraud offenders advantage.

4.1.2 CONCEAL

Insurance fraud offenders conceal data in two ways. They hide data or they may intentionally confuse or obfuscate claim data in order to make it difficult to understand or harder to evaluate. Some policyholders who submit claims for phoney burglaries actually hide property they claim was stolen. Documents which could aid claim evaluators have been hidden in other cases. When asked, policyholders might cite an office break-in as a justification for their absence [1]. Doctors who engage in automobile frauds which depend on the unwitting involvement of accident victims, avoid detection by policyholders by hiding their falsified billings from their patients. Bills are sent directly to the attorneys involved in the schemes.

1. This was an excuse used by one of the defendants charged with arson and insurance fraud in Suffolk, County, Massachusetts. (interview 65)

Since the patients never see the bills, they cannot verify whether they are correct. In a fraudulent scheme reported by the ICPI, a dental clinic added charges for services never rendered to insurance claimants. According to the NYC prosecutor involved in the case, insurance company payment procedures contributed to the scheme. Since the dental services included in the insurance payments were designated only by code number, patients were unable to verify whether the specific services were actually performed. (ICPI Reports. September, 1977)

When property ownership is concealed (for example, when "straw owners" or "fronts" are created) investigators may find it hard to establish fraud motive as it is difficult to document or make inferences about who gains from the fraudulent activity. Although the practice of concealing ownership is not illegal--straws are common to many business maneuvers--in consort with other activities, concealing ownership facilitates frauds by hiding one's intent or motive for fraudulent behavior.

Creating confusion around loss events can be used to insure that losses work to the benefit of fraud offenders. A property owner immediately reported a fire in his home to the local fire department, but intentionally gave the wrong address. Because he reported the fire in a timely fashion, the owner passed off any notion of contributory negligence while, at the same time, insuring delayed response by firefighters and, thus, a larger loss. Other arson fraud offenders are known to set their fires

on holidays when firefighting staff is low. (interview no. 60).

The ability to purchase insurance under a number of different names (corporate or personal) and aliases may conceal the identity of the offender and allow some fraud to pass unchecked. Since many of the indices used to detect fraud are based on name searches, the use of an alias decreases the chance of detection through computer matching.

4.1.3 OMIT

The act of omitting is similar to concealing, although action is not required. While concealed data would be obvious unless hidden, there is little likelihood that omitted data would be discovered unless disclosed. For example, when an auto accident occurs on private property or involves only one vehicle, it is not necessary to call the police at the time of the accident. Sometimes the police are never called. By not calling, omitting that step in the claims process, the claimant is able to control the story of the loss-event (what happened, where, etc.).

White (1975) underscored the significance of omissions in his book on claims adjusting.

"The adjuster who represents Mr. Smith's insurance company is also aware that while parties involved in accidents generally tell the truth, they very seldom tell the whole truth! It's one thing to actually tell a lie, and quite another to fail to mention something that detracts from one's case." (White, 1975;7)

Omissions with the intent to defraud are difficult to distinguish from simple errors, clerical mistakes, or other legitimate justifications for the absence of information.

Omitting data may also divert claims personnel from looking into a claim. For example, one policyholder interviewed admitted filing a false claim, eventually paid in full. In addition to exaggerating the value of certain items and fabricating the existence of others, he never mentioned that he had two previous claims with other companies, although he was directly asked about prior claims on the current claim form (interview no. 52). In the literature on claims adjusting, confirmed in my interviews with claims personnel, it is clear that prior claim experience is a flag for more careful claim scrutiny. If that holds true in this particular situation, the omission of claim data may have been critical to the success of the fraud. (More information on red flags for fraud control can be found in Chapter 6.)

4.1.4 ALTER

An ineligible loss may become eligible for insurance compensation simply by a date change. For example in cases of "past posting" (see Chapter One) one might have to alter the date of loss in order to make it appear to have taken place after insurance was purchased. Altering records also may change loss severity. A well known politician used his influence to have a police department report altered in order to increase the

seriousness of his wife's automobile accident. (ICPI Report, Jan/Feb/March, 1980;80). Altered documents can hide the identity of the claimant (e.g. changed social security numbers) or the identity of property (e.g. filing off identifying serial numbers). Altered documents can also be used to manufacture dummy claim files. Legitimate medical records, for example, can be photocopied with phoney names inserted. One can imagine that the invention of photocopy machines and sophisticated correction devices have made altering documents a far easier task.

4.1.5 CREATE

In addition to creating the loss itself (e.g. burning buildings, or self mutilations) fraud offenders may create claim data to document a loss, or to establish the consequences of a loss. These data exist (or come to exist) for no other purpose than for filing a false claim. Often times created data are the overt "evidence" of a fabrication. For example, if one fabricates a burglary one might "create" receipts and other evidence of items allegedly stolen in the theft. Or, in situations when insurance personnel invented losses and obtained payments using dummy claim files, the files themselves were actually created.

Fraud offenders creating documentation for their losses may do so through written reports or by establishing witnesses. Automobile titles and receipts for merchandise can establish

property ownership. Phoney death certificates [2] and phoney police reports have all been created in support of insurance claims [3]. Certain types of documents are easier to create than others because they lack uniformity. Receipts may look like formal computerized billing statements or a few lines jotted down on business stationery. Thus, receipts are a double-edged sword for insurance claims adjusters. While receipts help verify property ownership, they are of limited use simply because they are so easy to acquire. One claims vice-president commented.

"I don't really think people keep receipts. The one's who keep receipts you're just as suspicious of as the one's who don't. . . Those people who have had experience with claims can get them [false receipts] faster than others." (interview no. 19)

Doctors can also create documents to substantiate their non-existent treatments or to cover-up other fraudulent activities. In a large federal mail fraud case prosecuted in Massachusetts, doctors were tried for their participation in creating phoney medical reports of treatments for injuries

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2. In one case reported by the ICPI a man took out a life insurance policy for a sister who was already dead. When the company insisted on a physical exam prior to issuing coverage, the man went instead and signed his sister's name. This was possible because he was foreign born and the person filling in the forms was unaware of the appropriate gender. Later this same man claimed his sister died while visiting her parents in Jordan and produced a phony death certificate to that effect. Because it was unclear what a Jordanian death certificate actually looks like, no one noticed the fake documents at first.
 3. A policyholder working in a sheriff's office typed up her own, fraudulent theft report in one case investigated by the Division of Insurance Fraud.

sustained in real automobile accidents. In this case doctors maintained two sets of appointment books, one an accurate accounting of office activities, the second manufactured to substantiate the fraudulent billing. (Boston Globe. April 23, 1981.)

Witnesses to losses or to the consequences of losses can be created by "setting up" the alleged victimization. For example, an offender may go to a doctor's office and request treatment for a non-existent injury. In such cases the doctor becomes an unwitting accomplice, a witness to the fact that the claimant had some sort of injury.

Documentation systems, particularly those that are public, highly bureaucratized and fiscally constrained (for example, car registries) are effective tools for the construction of false claims. Although established as watchdogs and record keepers, these overburdened systems can provide easy access to false documents and provide legitimate justifications for document discrepancies. Massachusetts' claims managers note that the Department of Motor Vehicle Registry suffered massive budget cuts after local property taxes were slashed. There are few personnel available at the registry to verify automobile titles. Blank title forms have been misplaced or stolen, presumably turning up as "legitimate" documents used for fraudulent purposes. (interview nos. 18,23) One can imagine that many legitimate errors emanate from systems facing budgetary and labor

constraints. Because there are so many legitimate discrepancies, discrepancies suggesting fraudulent intent can be justified as credible bureaucratic errors.

Policyholders also create images of themselves, their property and their loss events to add credibility to their claims. In fabricated auto theft claims fraud offenders create the impression that cars exist and are operational by selling the cars, on paper, and, thus, creating car biographies. A fraud offender tried to convey the impression that a vacant building was occupied when it burned (and thus worth more) by purchasing second hand furniture and clothing and spreading it around the building (interview no. 63).

Although created documents may divert suspicion away from the fraud offender (i.e. one might not look as closely at a claim if all the supporting documentation is available), once suspicions do arise, created documents leave a trail of fraud for the fraud investigator [4]. In fact, in a majority of cases reviewed in this research, falsified documents provided the substance of criminal cases against fraud offenders. It appears that when fraud offenders create documentation themselves (e.g. create their own receipts) they run a greater risk of being

4. The same may not be true for created loss events. Take the arson example. While the evidence or trail may make it easy for the investigator to determine that a fire was set, a somewhat harder task, not always manageable from the fire evidence itself, is to determine who set the fire and why. This suggests that fraud type is somehow related to ease of discovery.

caught once suspicion is brought to bear against them. A smaller risk may be in effect when fraud offenders create the scenarios or events, but document their claims with information provided by often innocent third parties.

4.1.6 FORGE

Forged documents are used to establish a claim or to cash payments that have been obtained through other fraudulent means. In general, forgeries are attempts to cover-up other deceptions. When third parties (agents, lawyers or doctors) forge documents they usually do so in order to reap the rewards of their fraud efforts. In several cases, doctors' signatures were forged on altered or created documents [5]. A claimant's signature on a settlement draft must be forged in order to cash the draft without the claimant's knowledge.

4.1.7 SUBSTITUTE

Substitution is one method fraud offenders use to create the appearance of an insurable loss or the consequences of a loss. In a previous example we saw how new and damaged parts were installed on a Corvette depending on whether the fraud offenders were claiming that the car was in an accident or that it had just been repaired. In 1980 a claim was filed with Lloyds for \$60 million worth of oil supposedly lost when a ship went down off

5. The use of signature stamps in place of actual signatures has made this activity somewhat easier.

the West African coast. Investigation into the claim revealed that the oil had actually been unloaded in South Africa and the tanks had been refilled with sea water. Authorities believe that the tanker was deliberately sunk (Far Eastern Economic Review. 2/6/81;37).

In a Quincy, Massachusetts case a corrupt insurance adjuster, part of a phoney boat theft operation, had an entire file of pictures of damaged boats that he would substitute when needed to write up false claim reports. In another case fraud offenders switched license plates when the same car was used in a number of claims (ICPI Reports. March/April, 1979; 7). In an example cited above, license plates were substituted in order to re-register a car with the proper insurance.

Fraud offenders also substitute claim data in order to legitimate their claims. In several cases investigated by Florida's Division of Insurance Fraud, work orders, lay away receipts or estimates were submitted as bills of sale to document claims. In yet another Florida case, the fraud offender photocopied a friend's receipt and submitted it as her own.

4.2 CREATING UNCERTAINTY

I have shown how some methods used in deceptive claims activity establish the loss (created documents), while others cover-up the fraud (concealed ownership). Some methods are possible because control is lax, and others because of ambiguity

or uncertainty about the relationships between cause and event. Some methods are illegal or direct breaches of contract (forgery), while others are common interaction strategies (omissions). It is the latter category which creates the greatest difficulties in evaluating fraud. Were the claimants attempting to defraud the insurance company when they omitted a few relevant details or did they simply forget? Were the claimants confusing details of the loss in order to commit fraud or were they genuinely confused? Was the straw owner created with the intent to defraud an insurer or was that simply standard business practice?

The uncertainty surrounding many of the methods employed in deceptive claims making combines with the uncertainties in the claims process to permit fraud offenders to manipulate their meaning in certain situations. In one Florida case concerning a phoney theft of two gold rings from an automobile, the claimant, after his arrest, changed the date of the alleged theft suggesting that he made a mistake and that he had not intended to deceive. The thrust of the state's case had been the impossibility of the loss occurring on the date claimed by the defendant. The new data made the story believable, however, so the case was dropped. What looked like a case of criminal fraud, became a clerical error. One can speculate that the ambiguity as to the appropriateness of applying criminal sanctions against insurance frauds adds to the abilities of fraud offenders to manipulate the image of the offence in the manner described

above.

One could argue that the activities involved in creating losses are more overt and less ambiguous than methods used to exploit or invent stories of loss. When losses are created something physically happens. If visibility and certainty with respect to intent are important factors in decisions to control fraudulent behavior (Chapter Seven suggests that they are), holding other variables constant, we might see greater control when more overt methods are used.

4.3 THE ORGANIZATION OF DECEPTIVE CLAIMS ACTIVITY

Loosely defined, the fraudulent claim organization includes all actors and activities involved in the production of deceptive claims. Policyholders, insurance company employees, agents, brokers and adjusters are included as part of the organization. Included, as well, are actors whose primary functions are unrelated to insurance, but who might be called in to assist policyholders or insurance carriers in the claims process. Police who fill out accident reports, fire officials who make fire scene investigations act in this capacity. Finally, individuals who provide direct service to loss victims, i.e. doctors, auto repair shops, contractors and others who can expect insurance reimbursement for their services, are included.

Direct offenders are those who gain from fraudulent insurance claims and can include interested third parties as well as policyholders. Insurance adjusters can create phoney claims for policies that never existed in order to collect insurance settlements for themselves. Policyholders use the insurance system to pay for the repair or replacement of damaged vehicles. Doctors and lawyers instigate frauds against companies by manufacturing, on paper only, office visits and treatments of accident victims.

The following section provides a brief outline of organizational variation in fraudulent activity. Social control response and its success may be linked to the way in which fraudulent behavior is organized. Claims personnel interviewed in this study recognized differences between fraud organizations based on the number and status of offenders (amateurs or pros), visibility and cohesion of fraud organization.

4.3.1 COMPLEXITY

The most simple frauds are those in which only one of the actors involved in the claims process is engaged in the deceit, although others may be unwitting accomplices. In these cases the pattern of fraud leads directly to the offender. When policyholders drive their automobiles off piers and report them stolen, they must file a theft report with the police before making their claim. Although the police report becomes part of

the fraudulent package, the responding police officer is not directly involved in the deception. The policyholder, in this case acts alone. Insurance claim adjusters who create dummy claim files for fabricated policyholders and then collect the settlement drafts issued to the fabricated claimants are examples of other single actor frauds.

Claim personnel and law enforcement recognize that, typically, single actor frauds are undertaken by "otherwise honest" policyholders who realize their chance to get something back from their insurance policies. A Manchester, New Hampshire police officer who specialized in investigating auto theft frauds commented,

"Most of these people are young, middle-class people who are honest, hardworking and decent for 364 days of the year, but for that one day when they know they cannot make the car payments anymore or they need the money badly, they burn their car and report it stolen."
(New Hampshire Times. July 15, 1981;3).

In the most complex fraud organizations, all relevant actors to the claims process are involved in the deceit. Insurance producers (agents and brokers,) policyholders, public safety officials, as well as claims adjusters are knowingly engaged in the false claims activity. Some of the large arson-for-profit rings described in the U.S. Senate Committee Hearings on Arson-for-Hire, 1978 are examples of the most complex multi-actor frauds— i.e. all participants in the claims process were involved in the scheme.

The pattern of fraud in multi-actor frauds may be harder to detect since it weaves through so many different actors, each providing a form of insulation for the others. Nevertheless, multi-actor frauds have an inherent weakness which can be exploited by those wishing to break through the organization. When a chain of fraud has many links, once one link breaks, the chain itself disintegrates. According to investigators interviewed in this research, the most successful prosecutions of insurance fraud involved members who "turned" against their fellow members and provided information to investigators about organization activities.

4.3.2 VISIBILITY

Frauds differ with respect to their visibility and, by inference, their possible discovery by outsiders [6]. Some frauds require that information about fraud operations be shared among a number of individuals. In these instances the chances of security leaks and exposure increase as more people become aware of the frauds. In the example of the Chicago Sun Times investigation cited above, ambulance chasers were on the streets actively recruiting clients for participation in their fraudulent operations. Although some public safety officials engaged in the deception clearly "turned the other cheek" to what was going on, information about the operation was publicly available. The most

6. The notion of discovery does not imply that any action be taken in response. Thus, simple frauds might be discovered, but allowed to pass through the system nevertheless.

simple frauds, e.g. when policyholders ditch their cars, do not require that information about the fraud be shared and, thus, these frauds remain hidden from view.

Some frauds are hard to recognize because they are masked by legitimate business enterprises. These businesses provide insulation and cover for fraud offenders and buffer social control. Legitimate business, organized crime and even law enforcement have acted in this capacity.

Although Organized Crime was an apparent factor in only one of the cases reviewed in this study, the presence of the "Mafia" or the "Mob" has been suggested by all types of fraud investigators working in the public and private spheres and in some of the literature on insurance fraud (see, for example, Karchmer (1977). Karchmer argues that the Justice Department has recognized the existence of mob run arson rackets since the mid-sixties.

"The mob gets involved in arson scams as an outgrowth of a gambling or loan shark debt owed to the mob, or as one of the many freelance activities of mob underlings anxious to profit by burning a failing business on a contract basis. Also arson scams have grown into an organized business where the mob sells a combination package of arson and insurance frauds, and where the primary occupation of the racketeers is the arson scam." (Karchmer, August 1977;22)

The Insurance Crime Prevention Institute argues for a connection between the "mob" and insurance fraud which needs further empirical support. They suggest that

"A close look reveals that mob figures and white-collar criminals often exist in symbiotic relationship with one another. Doctors and attorneys who conspire to inflate medical claims often find that their "volume" is handsomely increased through their cooperation with underworld characters; and the underworld frequently finds itself needing the services of white-collar professionals in order to support its ventures into fraud." (ICPI Reports July/August 1980;7)

To the extent that organized crime is involved, we might find that measures of neutralization (e.g. bribes, pay-offs), typically attributed to mob activities related to gambling and narcotics (McIntosh, 1973), apply to insurance fraud as well.

The federal government inadvertently covered for an insurance fraud racket when an undercover operation to infiltrate organized crime in the construction industry backfired in 1978. "Operation Frontload" set up an FBI informant, Norman Howard [7], as an insurance broker selling construction performance bonds [8] to companies suspected of having mob ties. After persuading the New Hampshire Insurance Group to provide Howard with the necessary credentials to sell the bonds, the FBI set Howard up in business. Howard is now accused of taking nearly \$300,000 from companies and issuing worthless performance bonds during his tenure with Operation Frontload. His "victims" are suing the government. (New York Times. May 18, 1979)

7. According to FBI officials Howard had previously been instrumental in obtaining evidence about insurance and brokering frauds.

8. Performance bonds are issued to guarantee completion of construction projects should the contractors default.

The FBI has also been involved in setting up insurance fraud opportunities in some sting operations. One of five Buffalo stings financed by LEAA targetted the growing auto theft problem in that city. In particular, the sting was aimed at car owners who "steamed" their vehicles, i.e. arranged to have them stolen in order to collect insurance money. Investigators involved in the case were surprised to learn that nearly half of the individuals netted in the "steam" investigations had no prior history of criminal involvement. One has to wonder whether these "otherwise honest" policyholders would have "steamed" their vehicles had the government not provided them with the means (ICPI Reports August/September 1979;4-5).

Perhaps the most prevalent cover for insurance fraud activity and the hardest to empirically document is the legitimate business enterprise. Doctors who inflate injuries on some accident claims also run legitimate practices. Auto repair shops, part of large auto theft fraud rings, maintain legitimate businesses as well. In New York City, as elsewhere, insurance schemes involving motor vehicles often originate in larger salvage yards. Most yards are recognized by the appropriate licensing authority as legitimate auto-wrecking and parts shops. According to a detective in New York City's auto theft squad, the large volume of business conducted in a given week by one of these yards makes it easy to slip an occasional insurance fraud wreck into the system. According to a New York City police sergeant, "When the heat comes in they just fall back into the

legitimate parts trade." (Sgt. Robert Davis quoted in Bunk, New York Magazine, May 8, 1978) [9].

Even the insurance organization has inadvertently helped insulate or neutralize a fraud ring's operations. A claims adjuster's participation in an arson-for-profit ring was covered by his outstanding performance record in negotiating loss settlements (note the importance of discretion). In testimony before the Senate Committee on Investigation, an attorney central to the prosecution of a Florida based arson-for-profit conspiracy noted.

"Mr Carter [the insurance adjuster] was sort of playing a double role in that, obviously, during the conspiracy he knew what was going on, yet he was in the hub of the insurance industry in Tampa. He was probably the best known adjuster in the city. So he would, on the one hand, appear to be cooperating with the insurance company and furnish them with clues on obvious arsons or obvious people to avoid, while at the same time protecting others. And, in essence, he felt that would avoid suspicion on his part and on the conspiracy in general." (US Senate, Arson-for-Hire Hearings, p. 119)

The story reminds one of Jonathan Wild who played both sides of the fence, arranging thefts and recovering stolen property, all for a profit (Howson, 1970 as well as others). Membership in the enforcing organization, in this case organizations to enforce the insurance contract, can act, to shield or neutralize rule breaking (for a discussion of organizational cover-up see Katz, 1978).

9 . The connection between insurance company practices and the perpetuation of often illegal salvage operations has been discussed in an earlier chapter.

Specialized expertise may be a critical factor in creating deviant opportunities and shielding or neutralizing the deviance of others. Access to specialized knowledge provides fraud offenders with the proper information to manage deceptions when the fraudulent claims involve complicated loss appraisals. In one case an insurance fraud offender was a former claims adjuster who copied doctor's reports from the company claim files and used that as the basis for filing totally false and fabricated claims. Norman Howard was a former insurance broker and former law enforcement official before engaging in his fraudulent enterprises. The sophistication or technical specificity of a claim may actually work to cover a deception and to obscure meaning.

4.3.3 COHESION

One may participate in a fraud with or without knowledge that the fraud is taking place. A majority of participants in fraudulent claims probably do not know of their participation. Police officers who write up burglary and theft reports, doctors who see patients complaining of injuries, even insurance adjusters who have faith in a claimant's story may be "duped into participating in a given fraud. Some may know that they are participating in a fraud, but not care. Others may be concerned about their involvement in an insurance fraud but be powerless to do anything other than participate.

Strategies for fraud participation are the bonding mechanisms for fraud organization. Participants may be duped into participating. They may be committed to the fraud because of social ties. Others may be bribed into participating or participate as part of a pure business deal (economic exchange). Finally individuals may be blackmailed into participating or participate because of some larger cover-up. One can hypothesize that strategies for unraveling deception will reflect, in part, the nature of the bonding mechanism and that fraud organizations with stronger bonding mechanisms will be harder to control [10].

4.3.3.1 Duped -

People who are duped into participating and thus unaware of the role they play in the deception tend to be claim legitimators adding credibility to a fraudulent claim. This research can not address why it is that people are duped, but one can speculate that people are duped into believing a story because they have no reason to doubt the verity of a claim or a claimant or because they don't have the resources to make an informed evaluation of the situation. Wives have been duped into filing false claims for their husbands, according to one insurance investigator. A husband arranges for the house to be burgled while he and the wife are away for the weekend. They both return to the burgled house only she believes they have been truly robbed. The husband

10. In fact, fraud investigators repeatedly mentioned the difficulty of breaking fraud rings when the rings are bound by familiar and ethnic ties.

arranges things so that the wife is responsible for dealing with the insurance company. She doesn't slip up because she, herself, has been duped and, thus, provides a convenient shield for the fraud offender (interview no. 27).

Participants in fraud schemes may be duped into participating because they don't have any alternative explanation for the behavior other than that it is a legitimate insurable loss [11]. Training seminars for fire investigators auto theft detectives, doctors and lawyers point out the red flags, the signals of fraud, to these professionals. It is unclear whether signals of this type affect the discovery rate, but seminar organizers believe that they are positively related to fraud discovery.

4.3.3.2 Committed Because Of Social Ties -

Persons may engage in filing a false insurance claim because of friendship with the fraud offender. In several cases investigated by the Division of Insurance Fraud friends served as witnesses to fraudulent losses and to the existence and conditions of the risk immediately prior to the loss. According to the experiences of one company fraud investigator friends have limited value as covers. This investigator believed that friends

11. There is an interesting parallel here to classification problems. In the case of fires, when the cause of a blaze is undetermined, fire investigators tended to mark the "suspicious" box on the fire report form. Had there been alternative, specific categories, a more precise classification of fires might have resulted.

are quite willing to lie in statements to insurance companies, less willing to sign a formal statement, and far less willing to perjure themselves in front of a jury (interview no. 22). As an example, a Florida man was arrested for insurance fraud based on the testimony of a friend who had been picked up for receiving stolen property. The friend testified that the defendant had given him the property to sell as part of a scam against his insurance company.

Persons involved in fraudulent schemes may be committed to each other because of family ties. In a criminal case involving an arson conspiracy all three defendants belonged to the same family. In arguments presented before the judge on standards for assessing guilt or innocence in cases of arson conspiracy, the prosecutor noted that because this particular conspiracy involved family members, it was impossible to get an insider to testify for the state. The prosecutor, arguing for the use of inference in assessing guilt, also emphasized the significance of social bonding to social control activities. A similar cohesive bonding and implications for fraud investigators was discussed by the Director of Florida's Division of Insurance Fraud, but this time the reference was to close ethnic groups. He mentioned that it was harder for his staff to penetrate fraud rings which were bound by strong ethnic ties and less likely for them to come up with someone who would "turn". One claims manager interviewed in this study spent a good portion of the interview discussing a group of Hungarian gypsies who are suspected of committing a

range of insurance frauds. The Insurance Crime Prevention Insitute also ran a series about Hungarian ethnics engaged in a massive fraud ring. According to the prosecutor involved with that case,

"They are like a vertically integrated corporation. You can't get one to testify against another. They have employers who set up phoney employment verification and phoney disability reports. They go to Hungarian doctors and chiropractors. They have their cars fixed at Hungarian body shops. Some even buy their policies from Hungarian Insurance agents. (quote from New West Magazine in ICPI Report. June/July, 1979;9).

The data suggest, therefore, that strong ethnic and family ties may achieve a bonding that is relatively impenetrable for social control agents.

On the other hand, rifts in family relations can work to the advantage of fraud investigators if they know how to exploit them. After one ex-wife helped the Florida Division of Insurance Fraud successfully convict her husband, ex-wives became an important investigatory resource. In several cases worked by the Division, ex-spouses have testified against their former mates, providing information on the existence and disposition of items allegedly stolen in phoney home and auto burglaries.

4.3.3.3 Committed Because Of Political Ties -

Although the research uncovered only one example of the significance of political ties to commitment to insurance fraud activity, this example underscores the possibility that frauds may be committed for money which can be used for some political purpose.

"A ring of more than 100 individuals, many of them students from several Middle Eastern nations, is said to have filed more than \$1 million in false insurance claims against a number of American insurance firms. In one state alone, insurance companies may have paid the ring more than \$250,000 in claims. The group is well organized and operates nationally. Its members are trained in techniques of staging phony accidents and false injuries. Arson claims alone have run into the millions of dollars. Investigators fear that some of the money may have been used to finance guerrilla operations in the Middle East." (as quoted in the Washington Post, February 16, 1977 and cited in Bequai, 1978)

4.3.3.4 Economic Exchange -

One may also participate in an insurance fraud as part of a straight business proposition. When, as in a Florida case, an adjuster offers to inflate your damage inventory in return for seven percent of the profit, one could argue that your participation resembles little more than a business deal. An auto mechanic who buys your car, dismantles it and then sells the parts for four times the value of the car may be part of your phoney auto theft scheme, but for him, it could be a straight business deal.

4.3.3.5 Bribes And Pay-offs -

Participants in fraudulent schemes may be bribed into active participation or bribed into looking the other way when fraud is apparent. In the Suffolk County arson conspiracy discussed earlier, a lieutenant in the Boston Arson Squad was convicted of accepting bribes for his part in the arson-for-profit scam. He was accused of fixing fire reports so that arson fires were classified as either accidental or suspicious, but in each case classified so that the attention of the arson squad would be drawn away from the particular fire. In one case reported by the Insurance Crime Prevention Institute a man was offered money for the use of his name in a phoney medical fraud. In several Florida cases friends were paid money to lie to claims investigators.

Claims adjusters with tremendous discretion to settle claims are often the targets of bribe offers. It is not really known how often bribes are offered, let alone taken. Even adjusters who insisted that most adjusters don't take bribes acknowledged that bribes are offered. A claims adjuster for a small property mutual company told of an attempted bribe offered to one of his adjusters. The adjuster was walking around the house looking at the damage when the policyholder offered him a cup of coffee. He accepted. When the policyholder handed the adjuster the coffee several one hundred dollar bills were wrapped around the cup. The adjuster backed off and reported the bribe attempt to the

company (interview no. 10). But, if he hadn't. . . Mr. James McMullen, Director of Security Investigation for the Farmers Group Inc. (an insurance group) has had thirty-seven years of claim related experience with his company. In testimony before the Senate Committee On Investigations he said,

" . . .it is my opinion that probably about 25 percent of adjusters would succumb to proposals to participate in a profit through conspiracy." (US Senate Committee on Governmental Affairs, 1978; 132)

McMullen cited the low pay scale of adjusters as contributing to decisions to accept a bribe. The testimony suggested that an adjuster could make more money adjusting one fraudulent big time fire claim that he/she could make in a year with the company.

4.3.3.6 Extortion Or Black Mail -

Extortion or blackmail is used as a strategy to make sure that a participant in one fraudulent claim participates in another. In Norfolk County an adjuster later convicted of accepting a commercial bribe, was, according to the District Attorney, a weak man who, under certain financial pressures, agreed to settle a damage claim that he knew to be fraudulent. He received cash in return. When the "claimant" asked the adjuster to "settle" a second fraudulent claim, the adjuster tried to refuse. The claimant threatened to expose the adjuster for his first misdeed. Faced with this blackmail situation, the adjuster acquiesced (interview no. 40). The potential for blackmail was acknowledged as a deterrent to accepting bribes by

adjusters interviewed in Ross' (1970, revised 1980; 64).

4.4 ORGANIZING TO CONCEAL FRAUD

Opportunities for fraudulent behavior are realized by different organizational forms. I suggest that variation in fraud organization is correlated with the relative ease of detection and enforcement response. As we shall see in the chapters which follow, enforcement responses include: ignoring frauds (no response), recognizing fraud and attempting to lower claim value through normal claim process, denying payment of the fraudulent claim and criminal processing. Three aspects of fraud organization are particularly important to fraud control: the complexity of fraud, measured by the number and status of offenders, the visibility of fraud and the cohesion of fraud organization. Interestingly those frauds easiest to detect and control are not necessarily those easiest to prove in a court of law. In fact, many of the more easily detected frauds are detected on the basis of procedural violations which limit companies' obligations to pay, but for which criminal intent is both difficult and costly to prove.

Greater complexity increases insulation between fraud offenders and their targets and, thus, often buffers social control. Difficulties in drawing straight lines of culpability from offences to the offenders may discourage formal social control efforts, for example, criminal processing. Frauds which

are located within the context of other business enterprises are often difficult to disentangle from those legitimate enterprises, and thus, control is limited.

Complexity may increase visibility and increase the chance of detection, however, depending on the way in which fraud weaves through the organization, detection may or may not lead to sanctions. We can refine our notion of complexity to reflect differences in the way fraud organizations are constructed. Organizational complexity may be either vertical or horizontal. Vertical complexity is found in those organization which set up buffers between offenders and targets. The direct offenders are concentrated in single persons or small groups of persons. Most of the fraud organization, then, acts as supports, covers and insulators. Horizontal complexity involves the spreading out of fraudulent activities to engage more and more potential offenders. Greater visibility is a necessary component of horizontally complex fraud organizations because fraud offenders often must be recruited. Since they are more visible, we would expect that horizontally organized frauds are more likely to be detected than vertically organized ones.

The quality of cohesion in fraud organizations may affect relative abilities to penetrate the organization and to effectively control fraud. Since it is less likely that someone from within the organization will testify against other organization members, tightly bonded organizations are more

difficult to control.

CHAPTER 5

DISCOVERING DECEIT

Opportunities for fraud persist because of inherent ambiguities in insurance services. Fraud offenders take advantage of the uncertainties in claim situations and manipulate loss images in order to claim benefits unlawfully. At the same time, the methods and organization of fraudulent activities help conceal fraudulent transactions from those targetted by the rule breaking.

This chapter and those that follow examine the potential enforcement responses to fraud. Rule enforcement can be broken into three analytic components: (1) detection; (2) investigation and (3) sanctioning. The next three chapters examine these three processes as they apply to insurance fraud.

Fraud enforcement is limited, not simply because of lack of technique, but because enforcement decisions are located within ongoing business transactions and relationships. Other insurance goals often supercede fraud enforcement goals. Moreover, institutionalized enforcement agents and mechanisms are not

always well-positioned nor well-designed to detect, or investigate attempts to obtain insurance benefits deceptively. The processes of deception afford to those who deceive a certain latitude in creating advantageous conditions that effectively neutralize existing enforcement efforts.

The discovery of infractions is often ignored by those who study crime control and discretionary rule enforcement [1]. In so doing, researchers disregard the significance of discovery for business-related crimes, such as fraud, where the success of the rule violation depends on concealment of the offence as well as the offenders. While violent crimes often leave instantly obvious, although not necessarily acknowledged, traces of the criminal activity (the injured victim, the smashed window), no similar "on site" clues alert fraud targets or social control agents that crimes have occurred. By assuming discovery, social scientists neglect the processes involved in making frauds visible and overlook situations where rule violation is systematically ignored.

False claims are hard to recognize because, by definition,

1. One exception is Mawby (1981) who examines strategies to discover "low visibility" crimes and studies such as Hagan, Nagel and Albonetti, 1980 which examine the "proactive" policing of white collar crimes.

they are deceptive. A successful insurance fraud projects a credible image of compensable loss when compensation otherwise should not, or would not, be forthcoming. Since claims are contingent events, conventional claiming behavior is uncertain and unpredictable. Fraudulent claims are hard to distinguish from legitimate ones because claim evaluators lack certainty about the shapes legitimate losses should take.

How then are frauds discovered? Fraud discovery is examined in terms of analytically defined opportunities for detecting false claims. Discovery in this context means that information about a possible fraud is available to warrant an investigation, although no investigation may, in fact, occur. Opportunities refers to those conditions which permit purposeful discovery [2]. Two dimensions of discovery opportunities—location (where frauds are discovered and by whom), and technique (how frauds are discovered)—influence the incentives to look for fraud and the types of fraud that can and will be exposed [3].

Insurance organization and activities influence fraud detection in so far as they affect the location, and techniques available for fraud exposure. Insurance goals of quick claim service, for example, may limit a claim processor's access to data necessary for careful fraud evaluation and provide disincentives for exposing rule violations by claimant/clients.

Insurance activities not only influence discovery by those directly involved in the claim process, but also those outside the process who may stumble on fraud in the course of their daily routines and who might "ignore" fraud simply because it is an insurance problem. Conventional law enforcement officials may be reluctant to expend public dollars detecting fraud, including arson frauds, should they believe that insurance companies ought to be responsible for recognizing their own victimization. Similarly, public officials may not be permitted access to insurance data that would allow for easy fraud recognition without insurance company involvement.

The nature of insurance fraud activity also influences discovery opportunities by permitting offenders to change imagery during the course of their offences and, in so doing, to circumvent discovery. While discovery mechanisms typically are structured around fixed rules and procedures, frauds are often

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2. Purposeful discovery refers to action above or beyond random checking or routine audits.
 3. A third dimension, timing of discovery, may be significant, however data are not yet available to assess its importance. Fraud discovery, relative to fraud commission, may be anticipatory, simultaneous, or retrospective. Some frauds are discovered as they unfold. Other discovery strategies are aimed at detecting frauds after a claim has been filed, but before claim settlement is reached. Still other mechanisms expose fraud only after claims have been paid. In some rare cases, frauds are detected before claims are filed. In some instances discovery after the fraud is completed may actually anticipate the beginning of a new fraud, particularly if the fraud discovered is part of a larger fraud operation. One could argue that the timing of fraud discovery may influence the incentives of agents to make their discoveries known.

fluid and flexible. Offenders use that flexibility to change imagery and to neutralize discovery mechanisms.

This chapter is divided into two parts which reflect the two dimensions of discovery opportunities identified earlier. Discovery agents and their structural locations vis-a-vis fraudulent transactions and insurance process are considered first. Second, the techniques or mechanisms explicitly designed for fraud detection are examined. I consider how insurance process and fraudulent transactions influence both dimensions of discovery and, thus, the incentives to look for fraud and the types of fraud that can and will be exposed.

5.1 THE LOCATION OF DISCOVERY AGENTS

Who are the discovery agents and what can they see? What are their incentives and disincentives to look for fraud? To what extent does insurance process and the nature of fraudulent activity affect their discovery opportunities?

Incentives to discover fraud will differ according to one's organizational location or position vis-a-vis the fraud or the fraud offender. Some fraud discovery strategies are designed as managerial controls and the individuals who use them are concerned, first with supervision, and only incidently with fraud. Internal auditors, for example, review cases in order to check on the activities of company employees. In the course of their review, they may stumble on fraud. Other frauds are

discovered by claims personnel within the context of normal claims processing (e.g. agents, adjuster). In such cases the incentives to detect fraud are embedded in larger, and more routine, claims processing procedures—in particular, the verification of claim facts—and may be influenced by the quality of interaction between adjuster and claimant.

One's discovery location permits different access to discovery data and mechanisms, and, thus, to types of fraud that can be exposed. Agencies which maintain or have access to computer indices of claim histories are able to detect recurring sets of frauds across multiple fraud targets. Investigative journalists who have resources and expertise to go "undercover" can expose insurance fraud rings as they unfold. Structural vantage points, therefore, limit the types of offences/offenders that can be exposed.

5.1.1 CLAIMS PERSONNEL

Ad hoc and informal discovery is typical in the insurance context. Interviews with claims managers revealed that, despite the enormous statistical base available to insurance companies, fraud discovery depends strongly on an adjuster's "sixth sense" developed after long association with the insurance claims process and attempts to defraud it. Claim processors scrutinize claims and measure them against generally recognized categories of legitimate and fraudulent claim types. To a limited degree

(i.e. mostly for automobile frauds and only in the larger companies), systems of red flags have been developed to prod the adjuster's sixth sense into action. Even then, fraud recognition depends on an individual claims processor's discretion and resembles, in many respects, the process of typification described by Sudnow (1965). Claims processors suggest that the more fraud an individual sees, the more expert he or she will become at fraud recognition.

Although adjusters are located in positions allowing them to detect inconsistencies in current claims, they are not well situated to detect recurring sets of events that might indicate a pattern of fraudulent behavior. Since they work on single claims filed with particular companies, adjusters have limited access to data necessary to evaluate the current claim in relationship to a claimant's other claims filed with other companies. Furthermore, adjusters' interests in the dispositions of current claims may override efforts to ferret out fraud through researching circumstances of claims that have already been paid or that have been filed elsewhere.

Adjusters' distances from actual losses further limit opportunities to detect fraud. The keystone of a fraudulent insurance claim is the manufacture of an insurable loss. Adjusters are rarely on the scenes to see the losses transpire. At best, they view damages after losses have already occurred. Loss evaluations rely on reconstructions of loss events through

third-party accounts (police reports, witnesses statements) which are hard to control. Thus, the separation from loss events (measured in terms of time and distance), sets constraints on claim processors' evaluations of those events.

Despite the restrictions or limits on individual processors, the organization of a claim department may increase that department's overall potential for noting patterns of fraud. The informal subculture of adjusting increases the organizational memory of the claim department as a whole. Casual conversations among adjusters about current claims can spark recognition of other similar claims. For example, one claims manager noted that his department discovered a fraud only after he assigned a case, originally handled by one adjuster, to another. The first adjuster saw nothing suspicious in the claim. The second adjuster, however, recognized the claimant and circumstances of loss as similar to a claim that he had recently evaluated. Further inquiry revealed an instance of a policyholder trying to collect several times for the same loss (interview no.19). When claim department staff includes transfers from other companies, the unit's organizational memory increases.

5.1.2 COMPANY AUDITORS

Insurance companies have internal audit staff who seek to control fraud and other violations by employees. Auditors conduct spot checks of field office operations, review files and

look for inconsistencies in claims handling. Claims may or may not be settled at the time of their review.

Although not explicitly engaged to discover fraudulent insurance claims, auditors review many claims and, in the course of that review, may recognize patterns which suggest fraud. Auditors' incentives to expose false claims by policyholders appear to depend on professional commitments, as well as company loyalties and personal ethics [4].

5.1.3 AGENTS

As the first persons to hear about losses, insurance agents are in unique positions to suspect that something is amiss. Although historically agents have had few incentives to expose fraud by their clients, companies have recently established new profit-sharing programs changing the agency-company relationship and creating new incentives for fraud detection (see chapter three) [5].

5.1.4 ARBITRATORS

Judges or arbitrators who settle many claims may, in the course of their review, notice discrepancies or even similarities among claims which suggest patterns of fraud. A New Orleans judge reviewing auto bodily injury claims observed similarities in treatment of five men allegedly injured in an accident.

Further investigation uncovered fraudulent charges submitted by doctors treating the five claimants. The oversight afforded to judges permits them to recognize patterns of fraud which might not be recognized by claim processors working on a case by case basis (New Orleans Times-Picayune October 10, 1978).

5.1.5 COMMUNITY GROUPS

Frauds discovered by community groups tend to be frauds in which the consequences of fraudulent action spill over to third parties. Community groups are active primarily in the area of arson and arson prevention. Buildings burned for insurance profit blight entire neighborhoods and, thus local residents have stakes in fraud prevention. Although insurance fraud as a motive for arson is clearly a part of the community agenda, it is fire, not insurance fraud, which lies at the base of their concern. One of the earliest community groups formed around the arson

4. According to a text on management fraud, auditors have only limited obligations to detect management frauds. There appears to be a distinction between responsibilities for detecting fraudulent financial statements and responsibilities for detecting frauds or other illegalities immaterial to the financial statements. Obligations to expose frauds are far more limited for the later category of frauds. (Elliott and Willingham, 1980;16)
5. Some companies are trying to involve their agents directly in fraud detection. One company offers bonuses to agents for good loss ratios (losses to premiums collected). These companies argue that agents have incentives to uncover fraud since undetected frauds increase their loss experiences and, thus, their loss ratios. Since fraud directly affects their abilities to collect bonuses, they have greater incentives for control.

issue was the Symphony Road Tenants Organizing Project (STOP) formed after a number of fires in Boston's inner city areas devastated entire city blocks. Tenants in that area, already involved in community organizing, formed a group to research fire code violations and property ownership. With their basic research in hand, members of STOP pressured state and FAIR Plan officials to act against suspected arson offenders [6].

While the exact effect of community pressure cannot be measured, one can hypothesize that, in some instances, community pressure draws attention to frauds that might have passed through the system unnoticed. In another Boston case, community residents called a meeting with the Attorney General's office demanding that they investigate a rash of fires in their area. As a result of that meeting, and several others, the insurance community agreed to finance an investigation. According to investigators involved, it is unlikely that investigation into those particular fires would have been forthcoming without the well-publicized meeting with the Attorney-General (interview no.68).

Community groups have also been successful in preventing fraud fires simply by exposing the potential for fraud. In Newark, NJ a building showed all the signs that it was going to

6. There is no way of telling, for sure, whether without community pressure, extensive investigation would have resulted.

burn. (See Urban Education Systems, 1981 for arson indicators.) Tenants had moved out. Small fires had been set scaring those who remained. Stoves and plumbing equipment had been removed and services were no longer provided. Fearing that their building would burn during the night, tenants took over the building. They displayed banners listing the deplorable conditions from their windows. Community leaders believe that by making the housing violations publicly visible and exposing possible motives for fraud, they were successful in preventing the fire (interview no. 44).

5.1.6 LAW ENFORCEMENT

As they are often the first to respond to "loss scenes" (burglaries, accidents, fires, etc.), police are positioned to notice suspicious circumstances surrounding loss events which might indicate fraudulent intent. A New Hampshire police sergeant, for example, came across an abandoned vehicle and from the conditions of the car deduced that insurance fraud was involved.

"This guy took off the tires and rims and put the lugs back on carefully. Now what car thief is going to take off the rims and then put the lugs back on." (New Hampshire Times, July, 1980;1)

Despite their vantage points, it appears that instances in which law enforcement officials discover insurance fraud and pass on their suspicions to the appropriate investigative agency are

relatively rare [7]. The reasons most often cited for law enforcement's non-involvement in cases of insurance fraud are the informal or formal rules against exchanging information with private investigators or insurance company representatives. Issues of propriety with respect to information exchange between law enforcement and private interests are less relevant to exchanges between different law enforcement agencies (e.g. the Divisions of Insurance Fraud and local police). Here too, however, one finds traditional law enforcement reluctant to get involved in fraud cases. Of the 58 fraud cases reviewed as part of the field site visit with Florida's Division of Insurance Fraud only 16 (27%) cases were referred to the Division by law enforcement. According to Division personnel, that percentage reflects an increase over previous years which is credited to training efforts and greater exposure of Division activities.

Since law enforcement personnel are at the scenes of losses and, thus, are in position to notice something peculiar in the loss circumstances, efforts are being made to get law enforcement more actively involved in fraud detection. Florida's Division of Insurance Fraud has been trying to establish effective liasons with local police officers. In Massachusetts, "CARS Seminars" (Commonwealth Autotheft Reduction Seminars) are being held to train police officers in auto theft fraud detection. Although

7. Although in many jurisdictions filing a false police report is a penal infraction, there were no examples found in this research to indicate that police pursued this option when they suspect fraud.

information necessary to evaluate the success of these programs is not available, at least one fraud discovery is credited to the training program. Just two days after participating in a CARS seminar, a police officer stopped the driver of a Jaguar for speeding. Interested in trying out what he had just learned, the officer searched auto theft records and discovered that the car was listed as stolen and never recovered. Investigation revealed a trail of fraud involving this car and several others (interview no. 22).

Interestingly, the Division of Insurance Fraud's success in achieving convictions may have led to an increase in law enforcement referrals and an apparent increase in insurance fraud (at least per official law enforcement statistics). This increase cannot be explained merely as an instance of "you find what you are looking for" nor can it be attributed to changed attitudes towards insurance fraud, although these may be factors. Law enforcement may become increasingly involved in fraud detection when they realize its potential to bring individuals targeted for their involvement in other criminal matters into the criminal justice system. Prosecution of insurance fraud may increase as law enforcement personnel realize its potential as a "proactive" strategy for the development of cooperative witnesses through prosecution on the more minor offense of insurance fraud. (Hagen, Nagel and Albonetti, 1980 on the use of similar "proactive" methods for the prosecution of other forms of white-collar crime.) Insurance fraud may become a crime similar

to tax evasion, an easy way to convict someone already targetted because of other suspected criminal activity.

5.1.7 THE MEDIA

The media have been most active in exposing doctor-lawyer frauds typically involving ambulance chasing and inflated automobile bodily injury claims. The Chicago Sun Times along with a local Chicago television station exposed a large fake accident ring operating in their city. In 1976 "60 Minutes," the popular television news magazine, exposed Miami, Florida as the insurance fraud capital of the world. According to one of the insurance industry trade journals the t.v. story had

"Exposed blatant and widespread corruption which implicated not only insureds, but organized rings of doctors, lawyers, automobile repair shops whose activities were bilking the insurance industry and the insuring buying public. . ." (Snyder, 1981;6)

Not long after that story was telecast, the Florida state legislature established the Division of Insurance Fraud to investigate and prosecute insurance fraud offenders. A federal probe was initiated into a Florida doctor alleged to be a kingpin in the ambulance chasing operation. The US attorneys office launched a probe into a New Orleans doctors following an investigation by the local state insurance commissioner which was itself prompted by a series of articles in the New Orleans Times-Picayune (October 10, 1978).

Because fraud is hidden from view and information about insurance fraud, in particular, is not likely to surface without media exposure, we may be perceiving a greater influence than is actually there. This research does not provide a definitive answer, however, my analysis suggests several reasons why the media have been such significant forces in exposing fraud. Until recently, there was little organized effort, either by the insurance community or law enforcement, to expose the kinds of frauds which tend to be exposed through the media. While insurance companies were relatively successful at discovering individual attempts to defraud companies, discovery was limited to individual cases, not to larger organized rings. Insurance company officials cite insufficient resources, and legal constraints on information exchange as reasons why traditionally they have been unable to expose patterns of fraud running across different insurance companies and individuals. Law enforcement, for their part, tended to shy away from insurance related crimes, claiming to lack the resources and expertise for what they perceive as a private, insurance company problem.

Time and again, fraud investigators claimed that fraud rings were cracked by infiltration or by inside information. Investigative journalists have the resources and expertise to affect this type of discovery and, thus, are powerful forces in fraud exposure. With their noses for stories, financial resources, and often fewer constraints on their actions than would be placed on public law enforcement or even private

investigators working on civil cases, the media are in unique positions to discover certain types of frauds.

5.1.8 SPECIAL INTEREST FRAUD INVESTIGATORS

As of January 1981, three states—Florida, California and New York— had established special units to investigate insurance fraud cases. Investigators in these units do not simply react to frauds suspected by insurance personnel. They search existing data bases of claim information for patterns of activity that might indicate fraud.

In Florida, all companies are required to submit information on bodily injury, fire, and stolen property claims to the Florida Division of Insurance Fraud for input into computerized files. (More detail on Florida's Fraud Division can be found in the appendix). Division claim indices are used to detect victimization.

5.1.9 INFORMANTS

Through the information they provide, informants expose fraudulent activities that might otherwise remain concealed. Informants can be culled through law enforcement channels (secret grand juries, monetary incentives such as rewards for information leading to the arrest and conviction of. . .), or they can simply appear on their own volition [8]. Fraud informers tend to fall into four types: (1) individuals who are "turned,"

targetted or picked up for other, often minor offences; (2) "whistle-blowers" who either want out of the fraud operations or want to indict their former colleagues; (3) public spirited individuals who believe it is their duty to inform the appropriate authorities when rule violations occur or (4) regular police informants who stumble on insurance fraud operations.

5.1.9.1 Turned, Targetted Or Picked-up Offenders -

Typically, these informers are picked up for related crimes—i.e. arson or auto theft—and provide information on the kingpins of their operations. A torch charged with arson might inform on the individuals who hired him. In the Suffolk County arson conspiracy trial in 1978 thirty-three people were indicted on the testimony of one torch who "turned." After a Florida man was arrested for selling stolen stereo equipment, he agreed to testify against a friend, who he says actually gave him the equipment to sell. The friend filed a phoney theft report with his insurer (caseno. 18). In a separate case a man was arrested for possession of a stolen tractor-trailer. This man, a relative of the original owner, told police officers that the owner had arranged to have the vehicle stolen as part of an insurance fraud operation (case no. 31). Two attorneys in Baltimore pled guilty to tax evasion, a lesser charge, in exchange for testimony against other attorneys involved in a personal injury fraud ring

8. The use of informers raises issues about legitimacy and reliability of information provided.

(ICPI Reports July/August 1980;6)

5.1.9.2 Whistle-blowers -

Occasionally, insiders to a fraud operation will inform on their colleagues. An inside informant touched off investigation into an auto theft fraud operation involving a Braintree, Massachusetts salvage yard operator (Boston Globe 8/29/80). The Insurance Crime Prevention Institute reports that a chiropractor quit his job with a Los Angeles clinic and then told authorities about falsified billing schemes because "he didn't like what was going on." (ICPI Reports May, June, July, 1979;15) The ICPI also reports that an "irate" former employee of a Chicago driving school tipped local authorities to the school director's habit of inflating accident claims (ICPI Reports. March/April 1979;8).

5.1.9.3 Public Spirited Individuals -

Most investigators interviewed in this research, no matter what their auspice, cited anonymous tips as a significant source of fraud discovery. In a Florida case a neighbor told local police about a couple who had not lost their jewelry as they claimed to both the police and the insurance company, but had stored those items at a relative's home instead. The case was referred to the Division of Insurance Fraud for investigation (case no.13). In another Florida case neighbors told officials of the state employment bureau that a man receiving workers'

compensation benefits was actually working. Again, the Division investigated (case no. 64). Insurance companies receive tips about false claims or information about where allegedly stolen items can be recovered. People call, for example, and inform claims representatives that "the car they are looking for can be found on the corner of Cherry and Cedar" and then hang up the phone (interview no. 20). Because these tips are anonymous, there is little information about who these people are and what motivates them to inform. How often these tips result in further investigation or how accurate or reliable data are cannot be determined given existing data sources.

5.1.9.4 Police Informants -

Police informants on other matters may bring insurance frauds to the attention of local law enforcement. The Insurance Crime Prevention Institute was asked to cooperate in an investigation after an insurance carrier paid \$500 for information on a murder and insurance fraud operation. According to ICPI, the informant had taken his information to the police before selling it to the insurance company (ICPI Reports May/June/July 1979). An ex-convict was approached by a fire insurance claimant who wanted to kill one of his employees for cooperating with the Bureau of Alcohol, Tobacco and Firearms. The ex-convict took that information to the authorities and began working for them in an undercover role to expose the arson conspiracy (ICPI Reports. June, 1980).

5.2 THE EFFECTS OF LOCATION ON DISCOVERY OPPORTUNITIES

Discovery agents differ in their structural location vis-a-vis fraudulent transactions and the claim process. One's structural position creates different incentives to look for fraud and permits exposure of different fraud types and fraud offenders. Claims personnel, for example, are able to notice discrepancies in claim facts, but are limited in recognizing the claim as part of an on-going pattern of fraud involving many companies. A claims personnel's incentive to look for fraud is associated with job pressures and rewards that emerge directly from the insurance organization. The nature of claims processing as street-level bureaucracy is often inconsistent with fraud exposure and control. According to Lipsky's (1980) assessment of street-level work, the routinization typical to street-level functions reduces a bureaucrat's chance to discover unique circumstances requiring flexible responses (1980;122). Thus, by the nature of their work, claim processors are often limited in fraud discovery and response.

Although conventional law enforcement is structurally located to notice inconsistencies in loss events which might indicate fraud, they appear to have few incentives for making that information available to the appropriate investigative agencies. It would appear that police officers either are not convinced that insurance fraud is a crime worthy of their attention or are unaware of the signals or red flags which

suggest that an insurance fraud has occurred.

On the other hand, community groups and the media have incentives for exposing selected frauds. In that sense they are moral entrepreneurs exposing frauds which express the moral outrage of interested parties. The resources and vantage points afforded to the media and community groups provide access into fraudulent transactions which is often unavailable to traditional claim processors and often not of interest to law enforcement. Informants are a tremendous resource in fraud detection, but they remain a relatively unpredictable source of fraud information.

Thus, the different structural locations and actors provide different lenses through which to view fraudulent activity. Although standing alone each agent sees only a piece of the fraud picture, combined the discovery agents could be an effective collective discovery mechanism. Nevertheless, there appeared to be relatively few instances of collective action beyond the establishment of small fraud units.

The analysis suggests that improvements in fraud detection will rely on changing the vantage points of some claim evaluators and changing the incentive structures of those already well-positioned to notice conditions suggesting fraud. The development of claim information indices (for example those developed by the Florida Division of Insurance Fraud) have exponentially increased the amount of information available. By increasing the organizational memory of the industry as a whole,

claim indices increase the potential to recognize patterns of behavior that might indicate fraud. However, as will be discussed in the section which follows, this strategy is only one of many available for fraud discovery and is limited in terms of the type of offences and offenders that can be exposed.

5.3 THE TECHNIQUES OF FRAUD DISCOVERY

The following section examines different techniques for detecting insurance fraud. Discovery mechanisms can be grouped under the following categories: audits, tests, strategic data searches, development of informant networks and accidents. In addition to describing the different discovery mechanisms available to discovery agents, I consider how the insurance process and the nature of fraud impinge on the effectiveness of these strategies and contrast different methods in terms of their incidence and effectiveness.

5.3.1 AUDITS

The discovery strategy most often discussed by claim personnel was some form of audit. Audits are designed to expose discrepancies or peculiarities in the arrangement of claim details or presentation of claim settlements. Auditors typically uncover single instances of fraud or repeated attempts at fraudulent behavior by a single fraud offender. Two forms of audit are common: (1) the financial and (2) the operational.

Financial audits assess the fairness of companies' financial presentations, while operational audits determine whether organizational goals are being achieved effectively—i.e. economically and efficiently (Elliott and Willingham, 1980). Of the two audit forms, the operational is most relevant to this discussion.

5.3.1.1 Post Claim Audits -

Supervisors typically review a portion of an adjuster's caseload. Swift (1975) notes that over fifty percent of "desk adjustments" are reviewed by independent adjusters or appraisers, while another twenty-five percent are "spot-checked" by supervisory personnel.

Although, in many cases, audits are performed as a measure of managerial control over employees, supervisory audits also may disclose incidents of fraud. Successful fraud offenders deceive insurance personnel into believing that their claims represent compensable losses. As adjusters become part of the offender's manipulation of events, their actions require review. Since file construction is a key element in the claiming process and all adjuster actions are well documented, file reviews may uncover past mistakes and instances of fraud.

Supervisory auditors may also detect instances when insurance employees are involved wittingly in the deception. Having noticed that a large number of auto physical damage claims adjusted by a particular claim representative were repaired at a particular body shop, investigators might check to see if there were any non-professional associations between the adjuster and the body shop to indicate that bribes or payoffs were offered and accepted (interview no. 24).

Internal auditors verify claim settlements through this use of "audit letters" sent to claimants after settlement drafts have been issued to them. The claimants are instructed to verify that — they received settlements issued by the insurance companies and that the amounts received were equal to the amounts settled. Although not helpful when claimants are part of the fraudulent schemes, audit letters are useful when claimants are unaware of frauds on their behalves. Discrepancies between what claimants say they received and what the company records show as paid have uncovered irregularities on the part of attorneys, doctors and other third parties who profit from claimants' losses by skimming off part of the settlements. (US Department of Commerce, 1977)

5.3.1.2 Pre-settlement Fraud Audits -

In Massachusetts where auto theft fraud is estimated to account for one quarter of the theft claims submitted to the state's insurers, the large insurance companies have established

special auto theft fraud units. Similar units have been established in areas where auto theft and auto theft fraud incidence are high (for example, the New York metropolitan area, Los Angeles and Chicago as well as other large cities). A small group of "fraud specialists" focus exclusively on the investigation of suspicious auto theft claims. The units differ with respect to number and type of personnel involved and to the unit's location in the claiming process (see appendix).

Associated with special investigative units for auto theft fraud is an auditing system for auto theft claims. Profiles of auto theft fraud have been developed to assist claim adjusters in discovering fraud attempts and passing on their suspicions to special fraud investigators. These profiles outline sets of factors which tend to accompany different fraud scenarios [9]. Companies differ with respect to exactly how these profiles are used. Some companies simply list the factors as red flags to sensitize adjusters to the possibilities of fraud as they pursue normal claims adjustment. Other companies have developed a formal point system to analyze the import of any suspicious items.

Interestingly, insurers now take items which were once asked only for suspicious claims and ask them routinely for all auto theft claims. The new auto theft claim system assumes that a large portion of claims will be fraudulent and, thus, claimants

9. The auto theft profiles developed by the SIU staff were identical in each company visited during this research.

are asked, at the outset, to supply adjusters with information that would have been asked previously only if the claims required further investigation. New claim forms and procedures enabling adjusters to capture all information necessary for fraud assessments at their initial contacts with claimants have been developed. As additional data items are identified, they are incorporated into the system. For example, when it became clear that claimants submitting phoney auto theft claims had no way to account for how they got home after their cars were allegedly stolen, companies incorporated the question "how did you get home?" into their claim procedures. If claimants say with a friend or by cab, that information can be easily verified. Thus, the fraud audits are designed to evaluate current claims by collecting all data which past experience suggests will be relevant to insurance personnel. Using the profiles as guides, adjusters make inferences about fraud [10]. Although the current claim may be compared to previous claims, it is the eventual disposition of the current claim which is of primary concern to those using the fraud audit system.

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10. One problem with the audit system is that it might "over-sensitize" adjusters so that they look for fraud in every claim. Fraud investigators note that "a little education can be a bad thing" when adjusters overstep their bounds and play amateur detective. Although, formally, the adjuster's role is to detect fraud and leave the investigation to specialists, adjusters may over-react and try to prove the case of fraud themselves, often with disastrous results-e,g, when fraud investigation was not warranted and the claimants instituted bad faith actions against the insurer.

5.3.1.2.1 Example: The Fraud Audit System For Auto Theft -

Since the fraud audit system is most developed for auto theft claims, it will be used to illustrate the system. Red flags indicating the possibility of fraud are clustered around five categories: the claim, the claimant, the loss, the risk insured, and the conditions of vehicle and insurance purchase. These red flags are designed to sensitize claim evaluators to possible discrepancies in claim details. Although it is rarely possible to deny a claim on the basis of any one red flag, the existence of several red flags outlines the set of circumstances from which fraud can be inferred (i.e. the circumstantial case).

The forty red flags are assigned weights ranging from one to five. If any of these items are present in a claim, the associated score for the items is tabulated. A total claim score of three or more indicates the possibility of fraud and suggests further investigation by the adjuster or referral to the fraud specialist. According to the audit system, items weighted three, four and five (thirty-three out of the forty items) are red flags in and of themselves and suggest more investigation. Examples of the types of indicators used to assess fraud are listed below. The list is not identical to that used by insurance personnel. It is illustrative, not exhaustive.

TABLE 5-3 ILLUSTRATIVE LIST OF FRAUD INDICATORS

1. Inconsistencies— e.g. signatures that don't match, dates which do not jibe, missing details—are examples of red flags associated with the claim document. Adjusters compare claim documents to other documents, for example, police reports, to determine whether the story remains the same each time it is told.
2. If insurance coverage was obtained or increased immediately before a loss, the profile suggests that the claim bears further scrutiny.
3. If claimants avoid contact with insurance personnel by giving incorrect home addresses, being unavailable or in other ways not cooperative with insurance claims representatives, the profiles suggest there may be intent to commit fraud.
4. Actions which suggest that the claimant is nervous about claim settlement, e.g. pressuring for a quick settlement or avoiding the US mails when claim filing (avoiding possible mail fraud charges), are other indicators that suggest the claim may be fraudulent.
5. A claimant's income, debts, or other signs of financial distress could suggest a motive for fraud. Claims representatives try to assess whether a claimant's income could support the claim that was filed.
6. The timing and location of losses may suggest fraud. Losses which occur late at night in secluded spots shortly after insurance was purchased require further investigation.
7. Cars recovered totally burned are immediately suspect as are cars recovered with ignitions intact and no sign of the keys. *
8. Car features which make the vehicle a likely candidate for a fraudulent claim (e.g. gas guzzlers) or items which could be used to inflate the value of a claim (e.g. expensively customized vans) are also red flags.
9. Cars that are allegedly rebuilt, previously stolen and recovered, or recently involved in a collision are

suspect. If the claimant has comprehensive (theft) coverage, but no collision, claims personnel are instructed to investigate further.**

10. Actions which might indicate that fraud offenders are hiding the prior condition of the car, the amount paid for the car or actual ownership are also red flags. Cash payments, duplicate or unavailable titles submitted as proof of ownership, out of state purchase, insurance purchased immediately before a loss or purchased from an agent far away from the claimant's home or business also raise questions about a claimant's intent.

* Cars don't burn totally unless the fire has been set. Unless the car was started with a key, auto thieves have to "pop" the ignition to move cars from point A to point B.

** This flag suggests that claimants may not have had collision coverages for the accident and are now inventing stories of theft in order to collect money for the damages under theft policies.

Clearly, red flags do not provide absolute proof of fraudulent intent. In fact, nearly all of the circumstances which are red flags for fraud can be explained in legitimate terms. Economic and property conditions do change, while policyholders innocently forget to keep their insurance carriers informed. Thus, while red flags sensitize claims personnel to possible frauds, they have limited value in actually proving fraud, since most red flag items can be justified by offenders wise to the system. The discrepancies in claim facts which the red flags highlight can be used as ammunition in negotiating claim settlements. Inconsistencies and discrepancies in claiming behavior can be employed as a threatening device to force claimants to settle early and for less.

5.3.1.2.2 Requirements For A Successful Audit System -

Although some companies have established profiles for other auto frauds (e.g. bodily injury, collision, etc.) a similar system did not appear to be in place for other property frauds nor for casualty related frauds. Some companies did indicate that a system was being developed for homeowner burglary claims. Interestingly, claims personnel had limited confidence in the success of the burglary system because (1) unlike cars which are often recovered, items stolen in home burglaries are rarely recovered and (2) unlike cars which have title systems to document ownership, personal property is hard to trace. The difficulties in establishing an audit system for homeowner

burglary claims points to some essential requirements for audit systems and suggests reasons why an audit would lead to discovery in one context and not another.

Discovery through an audit system relies on the ability to predict and standardize losses so that deviance from the norm is easy to recognize. In order for routinized procedures to be effective, the data elements which are collected need to be standard, clearly defined and easily verified so that they can be quickly evaluated. Thus, only certain types of losses, those with a limited and easily identified set of causes and effects are amenable to a fraud audit system.

Because claims personnel know enough about cars to easily assess damages, claims involving autos are more likely candidates for a fraud audit system than claims involving damages which are harder to assess (e.g. bodily injury). Since cars don't burn from front to back unless an accelerant is used to ignite the fire, cars recovered totally burned are suspicious. One 1978 Cheverolet looks very much like another. A solid understanding of the mechanics is possible so that an appraiser can isolate damage and offer judgment, based on a limited set of possibilities, as to what caused the loss. An appraiser can tell whether a car was driven with a key or without, whether damage was new or old or what equipment had been on the car at the time of the loss (interview no.16) [11]. The great variety of items stolen in home burglaries and the significant differences in home

design, defy adjusters' attempts to become similarly acquainted with all the possible problems and defects that would allow for easy evaluation and verification of home burglary claims.

The ability to quickly assess losses through physical review or easily accessed documentary evidence is also important to routinized audit procedures. Although many frauds are confirmed only after lengthy document searches (the paper chase), most discovery appears to rely on the "quick hit." Cars, unlike home furnishings, have relatively public existences which can be researched. Cars are registered and inspected by the state and serviced at local gas stations. No similar history, beyond a simple receipt, documents the existence of home furnishings.

5.3.1.2.3 Neutralizing The Audit System -

Routinizing the audit/discovery mechanism, unfortunately for insurance companies, provides fraud offenders with information on how to beat the system. By asking for specific data, claims representatives provide potential offenders with the necessary requirements for building legitimate claims. Several years ago insurance companies began requiring receipts for car accessories and items stolen in home burglaries. Now everyone submits receipts, legitimate or otherwise, in support of their claims. Because everyone submits receipts, they are far less useful as a

11. One Florida Division of Insurance Fraud case was initially discovered when an appraiser noted that a specialized winch claimed by the policyholder could not have fit on the car in the first place.

screening device for detecting potential offenders nor as useful for verifications of ownership.

The fraud audit system provides the structural outline for the manipulation of loss images. Claimants are able to provide claims adjusters with all the correct (i.e. legitimate) claim responses. Individuals aware of the claims process know what items tend to be disallowed and why. Many claimants know that they are not covered for items stolen out of a vehicle unless there are clear indications that the car was entered by force (broken windows, broken locks). If claimants wish to submit that type of claim, they may create the breaks themselves. Several claimants interviewed in this research noted that on their second claims they knew when receipts were needed and when not and they manipulated their claims accordingly. Labelling a piece of jewelery as a family heirloom, for example, can negate the need for a receipt.

A company's system of control can be subverted by claimants when they use the system to add credibility to their claims. Insurance companies often accept photographs as documentation that items now claimed as stolen were actually in the claimant's possession at the time of loss. One fraud offender borrowed property (a television set, stereo, silver), planted it in his own home, took a picture and returned the property to his friend. Shortly thereafter he reported that he had been robbed and that his television set, stereo and silver were taken. The claimant

used the photos to document that he had possession of the items at the time of the burglary (interview no.7).

Some insurance companies have started sending verification letters to prior owners of cars now claimed as stolen and unrecovered. These letters are used to document the existence and prior condition of the vehicles. By providing a check on part of a claimant's story insurance personnel hope these letters will deter claimants from inflating the value of their cars and catch instances where cars never existed in the first place [12]. According to one fraud investigator, as soon as that procedure became routinized, professional fraud offenders developed a system to neutralize it. By selling the cars to each other for nominal consideration (similar to the approach taken to inflate the value of property in arson for profit schemes), fraud offenders can build a title history for the vehicle. Since one ring member sells to another, all prior owners listed on the vehicle's certificate of title are part of the ring. Thus, prior owner letters are sent to members of the fraud ring who will always substantiate the value and condition of the car and, thus, the claim. The intent of the prior owner letter is subverted when fraud offenders use the system to add credibility to their fraudulent claims.

A similar scenario may accompany the institution of

12. One claims manager who used the prior letter form on all theft cases noted that compliance was high. He estimated that 80-90% of all letters sent elicited responses. (interview no.13)

gift/donor letters. Because many claims include "gifts" for which no verifying receipts are available, insurance companies are considering asking claimants to provide the names of donors who can verify that the items were actually given as presents. Although company officials believe that engaging a third party (the donor) into the fraud will deter some claimants from committing fraud, others note that some fraud offenders will use the gift/ donor letter to add additional credibility for their false claims.

5.3.1.2.4 Efficacy Of Fraud Audits As A Detection Technique -

By formalizing the audit system fraud investigators have limited their effectiveness in discovering certain types of fraud committed by certain offenders, primarily professionals. Amateur fraud offenders, often the one time defrauder, are most likely to be discovered through the routinized audit system simply because they are unaware of the claims procedures. Professionals who are aware of the system have a greater chance of beating it.

Methods designed to deter potential fraud offenders, in particular strategies to engage innocent third parties into the deceit, may actually work to build credibility for the offender. Claimants' fraudulent statements about property ownership, and condition are verified by third parties who willingly aid the claimants in defrauding insurance carriers. Third parties may participate because they are part of a larger fraud operation or

simply because they see no moral wrong in helping a friend get a "little extra" from the insurance system.

Fraud audit systems also are limited because their effectiveness depends on recognizing deviance in otherwise predictable sets of events. Only certain types of losses are associated with that degree of predictability—losses involving standard, easily identifiable property. Losses which involve unique sets of risks (individuals) for which cause and consequences are uncertain are less amenable to the fraud audit system.

The use of an audit system, therefore, implies a choice in the type of offence and offender detected and deterred. The implicit choice is to detect a greater number of marginal offenders at a relatively low cost per detection and hope that a smaller number of larger fraud offenders will be detected through other means.

5.3.2 TESTING

Insurance frauds may be discovered through tests similar to those given by employers to test the honesty of their employees or law enforcement and consumer groups to expose bad business practices. (See, Jesilow and O'Brien (1980) for a study of testing as a system for deterring auto repair fraud.) Tests are used most often to detect rule breaking in decisions to grant publicly mandated benefit programs (pensions, state disability

systems, medicaid and welfare) and to test the quality and quantity of service provided by third parties (particularly doctors and hospitals in medicaid claims). New York City's pension medical board was tested by the city's Department of Investigation when an undercover detective filed a fraudulent disability claim using x-rays from another person's back injury. The Department of Investigation provided the board with films that showed the claimant playing sports and lifting heavy boxes while he was allegedly disabled. Despite the evidence, the board awarded a disability pension for over \$20,000 a year. Interestingly, the pension board doctors were not cited for wrongdoing. An overburdened case load was cited as the reason for what was described as insufficient attention placed on each claim request (Boston Globe April 15, 1982;21.)

In the property-casualty fraud arena the testing strategy was discussed in reference to testing the credibility of body shops. An accidental case of testing eventually led to criminal investigation when an insurance agent uncovered a fraud ring while trying to get his legitimate car damage repaired. Personnel at the body shop, probably unaware of his occupation, "propositioned" the agent to engage in a bodily injury fraud scheme (ICPI Reports March/April 1979;8). In this case the agent reported the solicitation.

5.3.3 STRATEGIC DATA SEARCHES

Another form of discovery—strategic searches of data bases—has been enhanced by computer technology. Searches are conducted on data bases which include information on all claims, legitimate or otherwise, filed with certain companies, in certain geographical areas or for certain types of losses. Typically strategic data searches are used to compare two or more events in order to find out additional information about a particular person/event.

Centralized data bases increase the organizational memory of the industry as a whole and, thus, increase the potential to recognize patterns of fraud. Without such centralized data bases, fraud offenders could disperse their frauds among a number of companies and no one company, or particular branch office necessarily would have the fraud experience to recognize the claim or claimant as part of a fraud scheme. The combined experience of a centralized data base increases, exponentially, the information available for comparative claim analysis.

5.3.3.1 Computer Indices -

In Florida, the Division of Insurance Fraud maintains a computer index of all bodily injury and stolen property claims. When current claims are input into the index, information on previous claims is output. Similarities are noted and relayed to the appropriate insurance personnel.

Florida investigators also use their indices to ferret out violations that cut across many seemingly dissimilar claims. Investigators might examine their data base to see if a doctor-lawyer combination appearing on one claim systematically appears on many other claims. If so, investigators may detect a pattern indicating the operation of a fake accident ring. Since the computer search generates a list of claims involving the targetted combination, the search also provides a list of potential complainants, both insurance companies and policyholders who may be unaware of the extent of the claims filed on their behalves [13].

The Property Claims Service of the American Insurance Association, an umbrella organization for property-casualty insurance companies, has developed a computerized registry of property, mainly fire, claims. Four hundred and ninety-one companies subscribe to this service which went "on line" in January, 1980 [14]. Adjusters are required to submit receipts of all fire losses exceeding \$500 to the Property Insurance Loss Registry (PILR). Claim information is maintained for five years.

13. This is a form of third-party exploitation of losses. A policyholder may know only that the claim payment was sent to the attorney and that the thousand dollar payment, covering the policyholder's legitimate costs, was, in fact, received. What the policyholder might not know is that the doctor and lawyer padded the claim to the tune of ten thousand dollars. When the payment was received by the attorney, one thousand dollars was sent to the policyholder. The attorney and doctor then split a handsome nine thousand dollar profit.

14. The service began collecting information, however, in December, 1979.

The Property Insurance Loss Registry is used to inform subscribers of other recorded claims which bear similarities to recent claims. Four computerized searches are conducted routinely for fire claims submitted to the index. These searches provide information regarding: undisclosed insurance (attempts to claim the same loss from different companies); previous claims involving the insured; previous claims emanating from current loss locations; claims reported from policyholders' previous addresses; and other claims which include any combination of names involved in the current loss (e.g. named insured on current loss appearing as a mortgagee or contractor on a subsequent report). If any of the searches bears fruit, a report is issued listing previous losses with characteristics similar to the current loss.

PILR information is provided only to the officers of the subscribing companies as there is some concern that the information may be abused.

"It is expected that the recipient of the Register's information will be in supervisory level and will retain the file, only passing along to subordinates pertinent data therefrom with instructions for its use. Since the Register staff has no means of verifying [the] accuracy of data submitted by adjusters, and the purpose of the Register reports is to alert subscribers to the need for further investigation and [to] commence building a civil defense, circumstantial evidence file, it will be necessary for subscribers to use their initiative in verifying and building upon the information sent to them." (W.D.Swift, VP Claims-American Insurance Association-, January 15-16, 1980.)

Although many claims personnel interviewed here suggested that

the PIR system could provide assistance in detecting fraud, there was little indication that the system was used very often. Limited use may be explained by the fact that the system had only recently started operating when this research was conducted, however, and, thus, may not reflect a negative evaluation of PIR's efficacy in detecting fraud.

The National Auto Theft Bureau (NATB) is a clearing house for information on vehicle theft and salvage. Many states have adopted legislation requiring law enforcement officials and/or insurance personnel to submit auto theft reports to the National Auto Theft Bureau (NATB). The agency maintains records of all vehicles reported stolen and all vehicles reported "totalled" and sold as salvage. (According to insurance definition a car is totalled when the cost of repair exceeds the book value of the car.) These records can be used to detect "paper car schemes." Fraud offenders who employ this scheme purchase the certificate of title for a salvaged vehicle, use the title to insure the non-existent car and then report the car stolen. Since the cars never existed, they can never be recovered. When a new auto theft report is entered into the NATB system, a routine search is conducted of the existing data base to determine whether the Vehicle Identification Number of the car now reported stolen had been previously entered as a total loss. A match, suggests that the new claim involves a paper car. As an indication of the insurance community's growing awareness of the auto theft fraud problem and acceptance of the use of computerized indices to

detect their own victimization, member companies increased their use of the salvage information data base by one hundred percent from 1978 to 1979 (NATB Annual Report, 1979;6).

Operationally, the use of computer indices raises some serious questions, particularly with respect to what gets detected and the reliability of the information provided. We know, for example, that if fraud is attempted at the first opportunity (i.e. the first claim), it will not be detected since the index system relies on comparison to previous claims. Because indices are supported by "member companies" one also wonders whether data from non-member companies is excluded and, if so, the importance of that exclusion. Are non-member companies without the financial incentives and/or resources to support the index system defrauded more often or are they less able to discover frauds? Are other fraud situations similarly ignored? If so, over-reliance on a computer index may result in categories of fraud which are systematically ignored.

Similarly questions can be raised about compliance. One claims manager noted that claims personnel are unlikely to fill out the necessary index forms unless they can be certain that, should they need the index information, it can be obtained in a useful and timely fashion. He noted that few entries are sent to the burglary index (a manual system) because no useful information is derived from that index (interview no. 14). Are data about certain types of claims and/or claimants

systematically missing from these data bases? One must review the quality of the data as well. What are the error rates? Are these rates serious enough to cause one to question the reliability of computer "hits?"

Access to these data bases typically depends on one or more predetermined variables (e.g. claimant's name, claim number, etc.). Computer access requirements may limit the usefulness of such searches if access variables can be easily manipulated. For example, indices which focus on name searches may be neutralized by the use of multiple names. If cars are registered under different family members' names, corporate names or even aliases, it is unlikely that the computer index will recognize the link between individuals. An example of an index system gone awry is the Massachusetts Merit Rating Board. The system was designed to add surcharges to insurance premiums of policyholders or car operators who were involved in accidents. People are changing names, getting phoney licenses, all in order to beat the surcharge system. Over-reliance on computer systems for fraud detection may permit some offender types to systematically beat the system.

Despite the level of use or problems associated with computerized searches, the mere existence of computerized mechanisms for indexing claim reports may have significant deterrent effects which are hard to measure but which cannot be ignored. The deterrent factor may be more symbolic than real as

people tend to ascribe to computer systems fantastic powers of deduction and detection which may or may not be technically realizable. However, the symbolic threat of "computer surveillance" may be significant enough to overcome the practical problems cited above and to deter the marginal offender.

5.3.3.2 Personal Information Networks -

Strategic data-base searches are not limited to the computerized systems described above. In one large metropolitan area, special auto theft fraud investigators meet on a monthly basis to discuss fraud cases involving stolen vehicles. These meetings can perform the same informational function as computerized data search systems. The meetings are used as a forum to discuss suspicious cases and, through open discussion, to discover cases in which the same claim is submitted to several companies or cases in which the same car is used for a number of different claims. Investigators might report on all claims submitted for thefts of Lincolns, Mercedes and Corvettes, car types commonly used in auto theft frauds. Investigators might also report on individual claimants of whom they are suspicious and ask their fellow investigators for any additional information about these individuals (interview no. 23) [15].

Virtually every special investigator interviewed credited

15. Recently the Massachusetts state legislature passed an immunity statute for the exchange of information among insurance companies investigating auto theft fraud.

this type of information exchange with helping their efforts to recover auto theft fraud. On the other hand, consumers might have some cause for concern over the free exchange of sometimes confidential material. It is not known what criteria prompts investigators to release the names of claimants or if names are released on an ad hoc basis. One investigator commented that it would be "troublesome if the public knew what was going on in these meetings" (interview no. 23).

5.3.3.3 Efficacy Of Strategic Data Searches -

Strategic searches appear to work best in detecting sophisticated fraud operations involving many participants over a relatively long period of time. More often than not, strategic searches are conducted outside of the normal adjustment process either by insurance personnel designated specifically as fraud specialists or by outside agencies. The method used to select likely fraud offenders varies from routine spot checks of computerized indices to information generated by other fraud investigators or law enforcement agencies or informants.

Although data to address questions of efficacy are not available currently, future research should consider the following. Under what conditions are computer searches employed—e.g. when a fraud specialist's case load is low?, for political reasons? What criteria are used to select targets? Are some offender types systematically included or excluded?

What are the expected outcomes of these searches? Is the information generated to be used in the claim process, for claim denials, or for criminal prosecution? How successful are these forms of discovery—i.e, how often do they achieve their expected outcomes?

5.3.4 CULLING INFORMANTS

As exposing fraud rings often requires the testimony of those who have knowledge of ring activities (see Chapter 4, Section 2.3), the development of informant systems can be a useful strategy for fraud exposure. Informants can be coerced into providing information with threats of arrest on other matters (see section 1.8 above). Investigators have used the threat of subpoena to "convince" investigation subjects that they should "willingly" provide information (interview no. 65). The establishment of secret grand juries can also be used as an investigative device for discovering information on fraud and other business-related crimes. (See Marx, 1980 for more on the development of informant networks to discover hidden and dirty data.)

Insurance companies have begun to formalize the public informant system through the development of TIP Arson Award Programs. In Michigan \$1,000 is offered for information leading to the arrest and conviction of persons responsible for particular fires. According to Arson News (January, 1981), since

its inception in July, 1975, twenty-six payments have been made by the Michigan program. Insurance companies may also take advantage of existing informant networks for the recovery of stolen property to discover possible frauds. Klockars (1974) and Lipson (1975) recognize the existence of organized informant systems by insurance investigators.

5.3.5 ACCIDENTAL DISCOVERY

According to a majority of the fraud investigators interviewed here, a large percentage of frauds are discovered by accident. Unfortunately, accidental discovery is hard to typify because it is a chance, usually one-time event. Typically the discoverer is not looking for fraud, but stumbles on to it. Accidental discovery can occur within the insurance claims process, for example, when a filing clerk notices a discrepancy on the claim form. Several claim managers related stories about frauds discovered in casual conversations among adjusters. In one case an adjuster was having a problem with a claim and mentioned the name of the claimant when describing his problem to a fellow adjuster. The second adjuster recognized the name from other claims he had worked on while employed at another company. The two compared notes and the fraud was exposed. In another case fraud was exposed when two adjusters from different companies covering the same risk arrived simultaneously at the same loss scene (interview no. 10). This double dipping might have gone undetected except for the chance meeting of the two

adjusters. Frauds by a company adjuster were discovered when a report by the adjuster was found in an unmatched claim file with the file jacket missing. While searching for the correct jacket, other adjusters exposed discrepancies and similarities in other claims adjusted by this individual which implicated him for his part in defrauding the company (156-255).

In Cleveland, a local news station reported on the bizarre circumstances of a recent robbery. Two individuals had been robbed while parked in their car. The thieves allegedly handcuffed the pair to the steering wheel before taking off with their spoils. One of the victims had an unusual name which was recognized by an adjuster listening to a news broadcast covering the bizarre incident. The adjuster located the insurance carrier involved with the loss, compared notes and discovered that the claimants had fabricated that same robbery story on several occasions and had submitted claims with several insurers (ICPI Reports Jan/Feb/ March 1980;6).

Many frauds perpetrated by third parties on behalf of policyholders who have no knowledge of the claims are discovered when policyholders actually have occasion to submit claims. Then, much to the surprise of the innocent policyholders, adjusters question them about their previous claims.

Frauds may also be exposed in the course of other investigations. In Los Angeles, an insurance fraud ring was exposed when an undercover agent involved in obtaining illegal prescriptions was solicited by a doctor to participate in an auto accident scheme. (ICPI Reports July/August 1980;1.) In Florida, a phoney boat theft operation was discovered after a boat operator was picked up on Fish and Game charges. Detectives noticed that the boats serial numbers had been filed off. Checking the stolen property index they learned that the boat had been reported stolen and a claim paid for it several years earlier (R79-152).

5.4 THE EFFECT OF TECHNIQUE ON DETECTION OPPORTUNITIES

The implementation of one or another discovery strategy suggests an implicit choice in the kinds of offenders/offences that may be exposed. Discovery strategies are not universally effective, nor as was shown in the first section of this chapter, universally accessible. Discovery strategies also differ according to the types of information that may be disclosed and the relative certainty that the information is a good indicator of a claimant's intent to deceive. Finally, discovery strategies differ in terms of their departure from normal claims process and their easy implementation into routine claims procedures.

Audits do not depart significantly from the tradition of claim verification. The questions asked may be different, the orientation to the claim may change, but the tradition of questioning claim facts remains within the boundaries of routine claims processing as claimants expect to be asked to elaborate claim details. Opportunities to discover frauds through an audit system can be built directly into the insurance system. Audits are limited however, because they depend on the standardization of losses and loss consequences which is not typical of the uncertain and contingent conditions for which insurance is usually obtained. Additionally, routinization of the audit system provides the seeds for its neutralization. Clients learn how to use the system and how to beat it.

Strategic data searches rely on predicted or expected behavior patterns as well. Computerized systems are programmed to match specific data items. Over-reliance on computer technology to detect victimization may cause frauds which do not fit the expected pattern to go undetected. Thus, there is an inherent limit to the types of fraud that may be detected through computer searches. Questions regarding claimants' rights to privacy and unrestrained and unregulated information exchange may be raised as well.

Testing for fraud was not a strategy that appears to be used very often in cases of insurance fraud. One can speculate that it is limited in terms of volume of cases discovered since it

often is employed for specific offenders over short periods of time. The development of informant networks also appears as a detection strategy when specific offenders and sets of events have been identified previously as somewhat suspicious.

Accidental discovery was discussed quite often by investigators participating in this research, however it is hard to typify and to predict. Although one can structure some activities to increase the chances of accidental discovery (e.g. encouraging more informal discussions among adjusters), for the most part, accidental discovery cannot be planned.

This discussion raises question for further policy analysis. To what extent are choices made among types of offences/offenders exposed, who makes the choice and how are these decisions reached? Discovery decisions may focus on which frauds do the most damage or which are the easiest to catch. We would expect variation to depend on the discoverers' goals in exposing deceit: apprehension of fraud suspects, deterrence of future frauds, or simply generation of information useful to claims process. Future research should assess whether insurance company goals are different and perhaps in conflict with their clients' goals or with more general enforcement goals.

The next chapter examines the enforcement options available to social control agents once fraud is detected. The options social control agents choose often depend on the quantity and quality of information provided through the discovery process.

CHAPTER 6

UNRAVELLING DECEPTION

Individuals who suspect fraud react to their suspicions in different ways. Some ignore fraud and, in so doing, implicitly discount their own suspicions. If frauds are ignored, they remain hidden from all but the initial detectors. Others who suspect fraud disclose their suspicions and investigate in order to prove their suspicions right or wrong. In this chapter I examine what mechanisms are available for unravelling deception [1]. In the following chapter I outline the enforcement options and indicate how insurance process, fraudulent behavior and available investigatory techniques influence enforcement decisions.

Individuals responsible for investigating suspected

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1. Investigating claim facts to determine fraud is a different order phenomenon than examining claims for technical violations. Adjusters routinely are responsible for ascertaining whether a claimant complied with the claiming procedures and, if not, the claim is denied. Negating a claim because of a technical violation is not the same as proving misrepresentation or fraud. Investigators have suggested that on occasion, suspected frauds will be denied on the basis of a technical violation, if no other means for claim denial is available.

insurance fraud are connected to one of six organizations types: (1) claims representatives who, in the course of conventional claims adjustment, unravel frauds; (2) salaried employees of insurance companies (typically part of special investigative units); (3) private investigators working under contract to insurance companies; (4) investigators employed by one of a number of profit or not-for-profit insurance service organizations (e.g. the not-for-profit Insurance Crime Prevention Institute); (5) employees of one of five state fraud bureau or (6) public safety officials—local police, fire marshalls, state or federal law enforcement. Organizations specializing in fraud investigation are described in greater detail in the Appendix.

The first section of this chapter examines questions raised by the three types of fraud defined in Chapter One. The second section looks at the general strategies for unravelling deceit. Factors influencing the choice of a particular strategy are considered in section three.

6.1 QUESTIONS RAISED BY FALSE CLAIMS

Insurance claims are accounts of victimization eligible for compensation from insurance carriers. A fraudulent claim is one in which loss details and circumstances have been manipulated so that an ineligible or non-existent loss appears to be one that is eligible for insurance compensation.

Claims can be divided into concrete, verifiable facts and story-lines or threads which tie the facts together. An example of a set of facts would be the following. My car is worth \$5,000. On October 1st my car was parked on the corner of Maple and Cedar. My car is missing. A "thread" or "story-line" might relate these facts to each other in the following way. My car, worth \$5,000 was stolen from the corner of Maple and Cedar where it was parked. Although investigators can verify that facts, as stated, are or are not correct, story-lines or threads are often non-verifiable. Thus, while one can establish that the car is not there, it is harder to prove that it is not there because it was stolen.

Fraud investigators try to discount claimants' stories or images by presenting others. If a claimant states that she visited a clinic on five separate occasions, investigators verify those visits and, if they cannot, they try to show that the claimant was actually somewhere else when she says she was at the clinic. If claimants say that they are sick, investigators may try to prove that they are healthy. If claimants say that their businesses were thriving and the fires totally destroyed them, investigators might try to establish that, in fact, the businesses were failing even before the fires.

The three fraud types—exploiting losses, inventing stories and creating losses—point to slightly different questions that need to be addressed in fraud investigation. If investigators

suspect that losses are exploited, they will try to determine whether specific claim details "match" loss details obtained from other sources. Claim facts are at issue. If offenders invent stories of losses that never happened, investigators will try to determine that the loss-events did not or could not have occurred by suggesting alternative stories of loss. At issue is the explanation of events (e.g. this jewelry is not here because there was a burglary). For the third type of fraud, created losses, the issue is one of responsibility. Investigators try to determine whether the losses were induced and whether the claimants are responsible [2]. These questions are not mutually exclusive. Questions raised by a lower-order frauds, (e.g. exploiting losses), are addressed in investigations of higher order frauds, (e.g. created losses), when investigators fail to answer the more complicated questions.

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2. Arson investigations typify those designed to prove that losses were created. Investigators examining fraud fires refer to the process of investigation as the "arson triangle." Corpus delicti (establishing that the fire was set) is the point of the triangle. The bases of the triangle are the subject's motive and exclusive opportunity to set the fire (Karp, 1978).

6.2 STRATEGIES

The strategies employed to address questions raised by false claiming activity fall into one of the following categories:

documenting facts

creating counter images

setting up new opportunities or inducements

Strategy refers to a pattern of investigatory conduct which may encompass a number of individual techniques (e.g. interviewing and/or document research).

The three strategies reflect different temporal orientations to unravelling deception. Again, these distinctions are analytic. The investigation can include past, current or future behavior. Documenting claim facts tends to involve the investigation of past behavior (Was the car parked here?). Creating counter images may include investigation of current or past behavior (Were you financially healthy? Are you now in financial ruin?). Setting up new opportunities for fraud anticipates future behavior (Given the opportunity, will you commit fraud?).

The three strategies also differ in terms of the primary focus of the investigation. Investigations into rule breaking behavior can focus on the offence (what rules are broken), the offender (who broke the rules) or some combination of both. For

the most part, fraud investigations, unlike conventional law enforcement activities, focus on the offence—what happened—rather than the offender. According to an officer of the California Highway Patrol,

"An insurance fraud case is different from other criminal cases. In a standard criminal case, you have a crime which has occurred and your problem is to figure out who did it. In an insurance fraud case, you know who did it and your problem is to prove that a crime occurred." (Los Angeles Times August 7, 1980.)

Documenting claim facts and creating counter images tend to be oriented to the offence, while setting up new opportunities for fraud are strategies typically aimed at offenders.

Table 6-1
Investigatory Strategies
by Temporal Dimensions and Focus

<u>Temporal Dimension</u>	Offence	Offender
past	document claim facts	
current		creating counter images
future		set up new opportunities

6.2.1 DOCUMENTING CLAIM FACTS

Insurance claim facts can be related to any one of three categories: the insurance policy (what's covered? for how much?); the loss-event (who, what, where when and how?); and the damages sustained. A fraud investigation may focus on any one or all three of these categories.

6.2.1.1 Facts Surrounding Insurance Purchase -

Investigators examine the details of insurance purchase in order to verify inconsistencies between what is being claimed and what was allegedly insured. Inconsistencies in claim facts often involve the value or the existence of the risk insured, ownership, or the timing between policy inception and loss. At issue are events and behavior which are related to insurance purchase (e.g. determining property value, or ownership) not specific policy items.

In a Florida case involving an alleged auto theft fraud, investigators checked into the legitimacy of a policyholder's proof of sale used to establish vehicle ownership and to purchase insurance. Investigators believed that the car never existed. Using NATB records, they determined that a car with the vehicle identification number stated on the "proof" of purchase was never manufactured (case no. 32). In another Florida case a woman claimed that her engagement ring worth \$1,000 was stolen. Insurance company personnel were suspicious of the claim.

Investigators interviewed her estranged husband who provided documentation that the ring was worth far less than the \$1,000 claimed.

A discrepancy in property value was discovered accidentally when fraud investigators interviewed a claimant's insurance agent for policies covering property other than the \$25,000 customized van now claimed as stolen. (Insurance agents are standard witnesses to a claimant's financial status, and other claim experiences). Investigators learned that the claimant originally tried to insure the vehicle in question for \$9,000 but was refused coverage because the agent did not represent companies willing to accept such risks. When the claimant actually purchased the \$25,000 worth of insurance from a different agent, he submitted a receipt for van customizing which, if legitimate, would have increased the van's value. Investigators interviewed personnel from the van customizing company and discovered that the so-called receipt had actually been a quote—the work had never been completed. The two facts— that the claimant had originally tried to insure the van for \$9,000 and that the customizing work was never completed— built a solid case of fraudulent statements against the claimant (case no. 64).

6.2.1.2 The Loss Event -

Investigators will check into all details of the loss as claimed by the insured. As a first step investigators often interview public safety officials (police, or fire officials) to determine if the facts as stated by the claimants are consistent with the officials' versions of events. Witnesses to the loss events will be interviewed for their stories of what happened. Discrepancies are noted and further research confirms or denies witnesses statements.

In several cases of alleged hit and run accidents, Florida Division of Insurance Fraud investigators checked the license number of cars the claimants stated hit them and found that the plates were never issued. Since claimants may develop any one of a number of justifications for why the numbers they provided were incorrect —e.g. It was dark, maybe I really didn't see it clearly—, false numbers may not be sufficient proof of fraud. Nevertheless, they suggest that further inquiry is required.

In cases of "past posting" investigators may focus on the date of loss—did the loss happen when the claimant said it did. A Florida claimant stated that two gold rings were stolen from his vehicle when he was moving out of his girlfriend's house. Investigators interviewed the girlfriend and learned not only did he move out on a date different than the one claimed, but his car had been repossessed prior to the date of the loss. Bank records confirmed the date of repossession (case no. 15).

A woman claimed that her car had been stolen from a restaurant parking lot where it had been parked overnight. She stated that she left the car there because she seemed to have some engine trouble. The restaurant owner verified that the car had been parked there. The date he recalled, however, was significantly different than the one claimed. Further investigation located the car in a garage on the night it was allegedly stolen (case no. 17).

An anonymous tip to fraud investigators provided information leading investigators to conclude that a reported auto theft was actually a case of insurance fraud. The informant provided investigators with the location of an allegedly stolen vehicle. Investigators identified the vehicle as the one claimed as stolen, interviewed the current owners and obtained a copy of the check the current owner used to pay the claimant for the car (case no. 41). In another case, investigators located items allegedly stolen in the possession of a divorced spouse (case no. 22) [3].

6.2.1.3 Facts About Damages -

Policyholders typically document their loss damage with receipts, doctors' reports of injury, medical bills, letters of

3.. This case has prompted investigators to routinely interview divorced spouses for information on the whereabouts and value of property allegedly stolen.

lost wages, pictures, etc. If investigators suspect that a claim is fraudulent, supporting documents, whose authenticity can be verified, are convenient starting points for fraud investigations.

In a case reported by the Insurance Crime Prevention Institute, investigators researched receipts for surgical equipment submitted in what they suspected was a phoney bodily injury claim. Personnel at the surgical equipment store noted that such equipment was receipted routinely on forms quite different than those submitted by the claimant (ICPI Reports-August/September 1979;3). Fraud investigators in Florida discovered a case of phoney receipting by interviewing store owners who could document that the prices stated on the claimant's receipt were not correct and that the items were not in stock until after the date of the receipt (case no. 35). In one case investigators checked store receipts and discovered an instance where a claimant had photocopied a legitimate receipt and then substituted her own name. In still other cases investigators have learned that what claimants submitted as receipts were actually estimates, work orders or "lay away" slips.

Lost wages can be verified with company personnel officers. On rare occasions, public investigators have used the IRS wage reporting system to determine that an individual claiming lost wages from one company was actually being paid full-time wages

from another (O'Neal).

Neighbors and individuals who service property can be used to verify the existence of property now claimed as stolen. In one Florida case neighbors testified that they never saw the specialized auto part now claimed as stolen. In other cases attendants employed at gas stations where cars are routinely serviced have provided information about the car's prior condition.

In another case neighbors reported that a moving van was parked in front of a claimant's house several weeks before an alleged break-in. Investigators interviewed the juveniles charged with breaking and entering into the claimant's home. While admitting to stealing some of the items, they denied even seeing some of the others. Officials from the moving company confirmed that many of the items allegedly stolen were actually stored in a nearby warehouse.

6.2.2 CREATING COUNTER IMAGES

Because it is often difficult to prove that a loss did not happen (e.g. that a theft did not occur) or that the facts of a loss are not related in the way they are claimed, investigators must rely on their abilities to create alternative scenarios of events. Counter images are means to undermine or question the veracity of a claimant's account by portraying claimants and/or their losses as something other than what they appear to be.

Counter images rarely provide proof beyond a reasonable doubt that claimants engaged in fraud but they can provide circumstantial evidence, or add to a preponderance of evidence, from which guilt may be inferred.

Counter images are sometimes related to loss-events or consequences of losses. For example, investigators might try to establish that a bodily injury claimant is not really injured. They may show movies of the claimant playing football or lifting a heavy box at the time he or she is claiming total incapacitation. Investigators may try to show that merchandise now claimed as stolen simply could not have been because it never existed or because it couldn't have been transported. Counter images also may be character related and only indirectly associated with the claim. Typically these images center on a claimant's financial status before and after the loss. Investigators might try to establish that a claimant who says he is a pillar of society is, in fact, associated with known criminals. Investigators might try to establish that a claimant is not financially healthy but is, in fact, in some financial distress.

Counter images may reflect current or past behavior. Compare these two situations. A claimant says she was healthy, but as a result of her loss she is now sick. Investigators typically will try to prove that she is not now sick. The dispute is not whether she was healthy in the past, but whether

she is now sick. In another situation a claimant may state that he was financially healthy, but the loss financially ruined him. Investigators may try to prove that he was destroyed before the loss. In this case the dispute is not whether he is now financially ruined, but whether he was solvent before the loss occurred.

6.2.2.1 Loss-related, Past Images -

These images are drawn to show that loss facts, as related by the claimant, cannot "hang together" as claimed. They are used to undermine the claimant's version of the story of loss—to raise doubts.

Florida Division of Insurance Fraud investigators undermined a claimant's story by establishing that the merchandise reported stolen from a truck could never have fit in the truck in the first place. In this case the merchandise was all purchased from one mail-order business. Investigators obtained copies of the receipts describing the material, including the serial numbers. They then checked the store's catalogue and found the exact dimensions of the items stolen. After measuring the cab of the truck they were allegedly stolen from, the investigators determined that the cab's cubic feet was significantly smaller than the total cubic feet of the merchandise. By establishing that the merchandise could not have fit into the truck in the first place, they undermined the claimant's story of loss (case

no. 35).

In a different Florida case investigators were checking into the circumstances of an alleged auto theft. The claimant stated that on one day she travelled from point A to point B. Her car was stolen at point B. Investigators measured the distance between point A and B and determined that even if the car was in perfect working order, it could not have been driven from Point A to point B in the time allotted (case no. 17).

In some instances theft and fire claimants will argue that "vandals" are responsible for stealing their items or lighting their, obviously, incendiary fires. Investigators may try to prove otherwise. For example, in an arson case investigated by a private firm, investigators were able to undermine a claimant's version of events by showing that the building was locked prior to the fire, that the claimants were the only ones with keys and, thus, they had exclusive opportunity to set the fire. They determined that all the doors and windows were secure when firefighters arrived at the scene, that there was no evidence of forced entry, and that the alarm was in working order and did not go off until after the fire had started and firefighters entered. If the fire was incendiary, who set it? From the evidence they collected, investigators established that vandals could not have set the fire, and, by inference, that the claimant was responsible (case no. 74).

In a case involving an alleged theft, investigators tried to counter the defendant's story that the merchandise was stolen by showing that it was impossible for anyone to have broken in via the only apparent route. According the claimant, the thieves had entered through a hole in the wall, which in summer housed an air conditioner, but othertimes was covered by wood boards. Investigators examined the area closely and found undisturbed cobwebs covering the entire space. If the thieves had used this as their route of access (and it seemed the only likely candidate), how did they manage to enter without disturbing the webs (case no. 72)?

Investigators tell stories of claimants who smash their own windows and then claim they have been robbed. Often these claimants stand inside their homes when they break their windows and all the glass falls outside. Investigators looking at that particular loss scene can quickly establish a different loss scenario.

In a case cited earlier a man filed a claim against his parents' homeowners policy for a slip and fall in their home. The adjuster assigned to the case was suspicious because of what appeared to be a recently damaged vehicle parked in the claimant's front yard for which no claim had been filed. The case was turned over to an investigator who examined the circumstances of the auto accident. Interestingly, investigators did not focus on what was claimed—i.e. whether or not the

claimant fell in the bathtub—since that would be nearly impossible to prove. Instead, they tried to build an alternative story of loss. They reviewed local police department and towing records and learned that the car in question had been in an accident several days earlier and that the claimant was the driver. The doctor who treated the claimant verified the treatments, but stated that he understood the injuries were sustained in an auto accident. Further, the doctor claimed the date of treatment was not the date the claimant said he fell, but, rather, the date of the auto accident. As a result of this investigation, the claimant was arrested on insurance fraud charges.

6.2.2.2 Character-related Past -

In general, character-related past images show that the loss could not have been responsible for the claimant's current condition because the condition was evident before the loss occurred. Although financial health is not the only characteristic that is subject to investigation, it is most typical since there is often more accessible documentation of one's financial character than documentation of other personal characteristics.

Claimants try to hide their previous financial statuses by destroying records or creating their own images of solvency. To counteract these pictures, investigators often wade through

records of business incorporation, tax statements, credit records, or civil court records of suits brought against the claimants for non-payment. If the claimant owns a business, statements are taken from employees or contractors who might provide information on moneys owed. Neighbors are interviewed for their impressions of business operations—e.g. how many hours per day the business operated, or number of customers).

Standard procedure for investigators involved in arson cases is building an account of the claimant's financial status prior to the loss. Successful arson investigations depend on establishing (1) that the fire was incendiary (2) the claimant's motive and (3) the claimant's exclusive opportunity to cause the fire. Since financial distress is considered a strong motive for arson fires, it is critical for investigators to determine a claimant's financial health before the fire occurred.

Investigators may also look for past associations which could link two, allegedly, unrelated actors. A standard arson scenario is the sale of property for a nominal cash downpayment. The original owner holds a substantial, and inflated, mortgage. Several subsequent "transactions" inflate the property value and the mortgage. Eventually the building burns. In Massachusetts and in many other states, the mortgage holder is entitled to recover the mortgage amount regardless of whether the fire was set and the property owner implicated in the arson [4].

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4. Without such protection, it has been claimed, banks and other investors would not be likely to extend credit.

Those who hold the mortgage are protected unless a link between the fire, property owner and mortgagor can be established. In several of the arson indictments in Suffolk County, Massachusetts (1978) investigators examined volumes of financial documents to draw the links between property owners, mortgagors and arsonists. Indications of previous associations were used to weave a case of arson conspiracy against the indicted individuals.

In Clifford Karchmer's Arson Enforcement Manual (1981;354) the author suggests that one should examine the disposition of an insurance settlement to help build a picture of a claimant's guilt or innocence as it often provides a picture of a claimant's intent in filing the claim in the first place. Karchmer notes that evidence that funds have been "laundered"--i.e. passed through multiple bank accounts--, could provide circumstantial evidence of a policyholder's guilt.

6.2.2.3 Current, Loss-related -

These images are often used to provide an alternate account of loss consequences. Typically current loss-related images are concerned with personal injury and are generated as a result of surveillance. Images may be used to document that a condition is not what it appears to be and/or to suggest avenues for further investigation. For example, in Florida, investigators watched claimants, allegedly incapacitated, as they went to and from their new jobs. The investigators approached the employer and

obtained records verifying that their disabled claimants were, in fact, working. Occasionally, moving pictures are taken to document the free movement of supposedly disabled claimants. Movies are expensive as they require minute by minute annotation if they are to be used in court. As a result, movies are not used very often, if at all.

Unobtrusive surveillance is not the only means to create counter images. Investigators will conduct what they call "activity checks" on their physically injured claimants. They arrive at a claimant's home, unannounced, for a spot check on the claimant. If a totally disabled claimant is found gardening, investigators inquire further. As part of their routine activity checks investigators might also canvass the neighborhood asking neighbors if they are aware of the claimant's movements. Although a standard insurance task, neighborhood canvassing is more useful for developing investigatory leads than for creating counter images directly.

Sometimes the counter image is derived by accident. The Insurance Crime Prevention Institute reports that an insurance fraud was exposed when a private investigator happened to be passing by a park and noticed two bodily injury claimants he was supposed to be investigating tossing a football around. (ICPI Reports. April/May 1980;5)

6.2.2.4 Current, Character-related -

Investigators may also try to create counter images which show claimants to be different than their own images suggest. For example, investigators may try to create a counter image of a fire claimant as a "shady" character connected to the "underworld" at the same time that the claimant tries to establish himself as an upstanding citizen "victimized" by crime/arson.

Investigators might also try to prove associations between two alleged adversaries in a claim situation. The Insurance Crime Prevention Institute reports that investigators followed an individual suspected of being part of a staged accident ring. The man was followed to a hotel room where investigators learned that he and the man he was supposedly responsible for hitting were actually living together. Further investigation uncovered the entire staged accident operation. (ICPI Reports, March/April 1979;7)

6.2.2.5 Questionable Practices Associated With Counter Images. -

One can raise some legitimate questions about how far investigators should go in establishing counter images. Activity checks, neighborhood canvassing and surveillance all intrude on individuals' privacy. Although claimants are required, under the insurance contract, to "assist" investigators who are examining their losses, it is unclear in what situations, if any, that

assistance extends to being subject to surveillance.

According to one former claims adjuster, investigators may provide temptations for allegedly injured claimants in order to induce them to act in a way that is inconsistent with their injuries. For example, investigators may drop money in the path of a claimant who says he can't bend down and wait to see if the claimant picks it up. Chernik (1969) suggests that investigators have offered free skiing weekends, and weekends at dude ranches, to "encourage" claimants to throw away their pretense of disability. What if claimants were truly injured and still enticed to try out exotic weekends? Serious injuries could result. Chernik (1969) tells a story of a very sick, old lady who actually won a free trip to Las Vegas. As part of her winnings she was given a bagful of coins to gamble in the slot machine. Investigators saw an opportunity to prove, once and for all, that she was not truly injured. They took movies of their claimant pulling the slot machine levers with vigor. Then the woman collapsed. According to Chernik, she almost died. This story suggests that money is a powerful lure that at times can induce people to do things they ought not do. Used as a strategy to create counter images of disabled claimants such inducements pose serious ethical and practical questions.

6.2.3 SETTING UP NEW OPPORTUNITIES OR INDUCEMENTS FOR FRAUD

It is not clear how often opportunities are created to catch insurance fraud offenders. The relatively few instances in which this strategy was used in the sample of cases reviewed here suggests that such undercover activities are limited.

Investigatory strategies setting up new opportunities for fraud can be analytically separated into those which target claimants and those which target the supporting fraud organization (lawyers, doctors, auto body shop owners, etc). When claimants are the foci of the investigatory activity the "sting" strategy is employed. Investigators help set-up the supporting fraud organization. Control agents provide the trappings and wait to see if someone falls into the net. In cases where the fraud organization is the foci of investigation, investigators infiltrate the existing fraud organization by posing as "innocent" loss victims who may be swayed into participating in the fraudulent schemes.

Strategies to set up opportunities for deception also can be distinguished by the degree of target specificity. In the first example presented below the sting is aimed at a fairly specific target. Agents are trying to catch an identified individual committing a specific crime. In the second example investigators reach out to net a subset of what is assumed to be a pool of unknown offenders.

The Insurance Crime Prevention Institute reports that after a businessman reported that he was approached by a fire broker, investigators set up a building as a likely candidate for arson. An undercover agent from the United States Treasury Department, equipped with a concealed recording device, contacted the fire broker who promised to arrange for the fire. Subsequently, investigators videotaped the arsonist saturating the building with an accelerant. The "torch" and broker were arrested before the fire actually did any damage (ICPI Reports, May/June/July 1979).

In a Worcester, Massachusetts investigation, nicknamed "operation humanity" state police set up a "civilian operative" in a job at a hospital where suspects in an auto theft fraud operation were employed. The job enabled the operative to make contact with persons involved in the crime ring. Eventually he became a ring member. His job was to act as a receiver or middleman for allegedly stolen vehicles. Car owners contacted the undercover agent to have their cars "stolen" or torched. In return, the car owners received nominal sums and the opportunities to file auto theft claims with their insurers. Ring members kept the cars for resale, and export. In April 1980 state police arrested ninety-nine individual car owners who had participated in the fraud operation. (ICPI Reports April/May 1980;8). A similar sting operation in Buffalo net over 100 individuals (ICPI Reports, August/September 1979;5). Both investigations led to the arrest of a large number of "otherwise

honest" policyholders who participated in insurance fraud. Whether these policyholders would have engaged in fraud without the opportunity presented to them is unclear.

Property stings initially designed for other purposes could uncover instances of insurance fraud as well. A "set-up" fencing operation might net individuals who try to sell their property at the same time they report it stolen.

Most examples of undercover infiltration into organized fraud operations are related to the investigation of doctor-lawyer schemes. In such cases loss victims are solicited into fraud rings by unscrupulous lawyers who refer the victims, some of whom are not even hurt, to particular doctors. The doctors inflate the amount of treatment necessary for the specific injuries involved. Inflated bills for the often unnecessary treatments are submitted to the victim's insurer, sometimes even without the claimants knowledge.

One strategy for infiltrating this type of operation is to have an undercover agent pose as an accident victim. Through the use of concealed microphones, cameras, and other devices, the agents can document the processes leading to fraud. In Minnesota, a Deputy Sheriff posed as a welfare recipient involved in a traffic accident. He approached a particular doctor for treatment, admitting to the doctor that he wasn't really hurt. The doctor asked him how bad he wanted to be hurt. The doctor then referred him to a lawyer who arranged the insurance

settlement. The case ended after the doctor pled guilty to charges of attempted theft by swindle and medical assistance fraud and the lawyer was found guilty of attempted theft by swindle (ICPI Reports October/November/December, 1979;1).

6.3 CHOOSING AN INVESTIGATORY STRATEGY

Investigatory strategies can be compared along several dimensions: resource requirements, intrusiveness and scope of net cast. Dimensions can be thought of as evaluative criteria used in decisions to investigate suspicious claims.

Although exact figures are unavailable, we can rank investigatory strategies by the costs they might impose. Documenting claim facts is assumed to be least costly while setting up inducements incurs the greatest costs. At the very least, documenting claim facts will require fewer personnel than, for example, setting up an elaborate sting operation [5].

Documenting claim facts also requires less specialized knowledge than either of the other two strategies. While inducements and counter images often necessitate the use of sophisticated surveillance technologies, documenting claim facts typically involves less specialized document research and interviewing. (Note that some financial detecting requires specialization in business accounting. Accounting skills would appear to be more readily available to financial institutions such as insurance

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5. Compare the cost of a sting to the cost of putting X number of detectives in the field to track down information.

companies, than some other more sophisticated investigatory techniques.)

The three strategies address different questions raised by the three types of fraud outlined in Chapter One. When investigators document claim facts they directly confront the possibilities that loss details have been distorted (exploited losses). When claimants invent stories of loss, investigators try to build a counter image or alternative explanation of loss events. Finally, when claimants create losses themselves investigators may offer inducements to see if the deviant pattern will emerge again. Thus, the three investigatory strategies cast very different nets. Documenting a claim fact typically involves a relatively small and narrow net. Investigators search for specific pieces of information to answer specific claim questions. For example investigators might look for information to document the date of an automobile accident. Police records or towing service records might be researched by investigators. When creating counter images investigators are typically searching for a preponderance of evidence from which something can be inferred. Although focused on particular individuals or sets of events, the scope of information collected is relatively vast. Investigators are engaged in "fishing expeditions." Inducements, on the other hand, are often offered to net a large number of offenders on specific items (e.g. sale of a car to an undercover agent).

Investigatory strategies also differ according to the inherent intrusiveness of techniques and their integration into routine claims process. Whereas verifying loss details is consistent with the routine of claim settlement procedures, unobtrusive surveillance extends beyond what claimants are likely to expect as part of the claiming process. Setting up inducements for fraud are clearly activities divorced from any given claim context. The relative separation from what is routinely expected as part of claims process is, in some measure, an indicator of the intrusiveness of the strategy employed.

In decisions to choose one strategy over another investigators appear to be influenced by their auspice and by the expected outcomes of their investigations. Investigators will evaluate strategies along the dimensions cited above and choose a strategy or group of strategies to reflect their organizational interests. Private investigation is conducted to ascertain whether a claimant is entitled to compensation for a given loss and the company's defence of a claim denied. Public investigation is oriented towards the arrest and conviction of insurance fraud offenders in efforts to deter future fraudulent behavior.

If the expected outcome of an investigation is claim denial or defence of a civil suit brought by the claimant, investigators may choose to focus either on documenting claim facts or creating counter images or both. These two strategies tend to be the

least costly and the most focused on particular offences or claims. Since claims handling is a case by case affair, it is unlikely that private resources will be expended to deal with the prevention of future frauds or to frauds whose effects the private company does not feel directly [6].

Claimants' roles as insurance company clients may also influence the decision to employ a particular strategy. While checking into claim details may be viewed as an appropriate insurance function, creating counter images or setting up inducements might be seen as directly offensive to insurance clients. Interests in claimants future premium dollars could restrict claim investigators to documenting claim facts and leave the other strategies for non-insurance personnel.

Law enforcement personnel tend not to get involved in insurance fraud investigations unless they can expect a criminal conviction [7]. Documenting a claim discrepancy is rarely sufficient proof of criminal fraud. Investigators must be able to prove that the offenders intended to deceive when they

6. This may help explain why some frauds are tolerated. If the effect of fraud is dispersed among policyholders--or even other insurance companies--no one company will necessarily face a concrete dispute. The idea that companies do not investigate claims because claim costs are shared among the companies has been suggested in the Massachusetts Governor's Task Force on Auto theft (1980) as well as other task force reports examining the insurance fraud problem.

7. The low probability of criminal convictions was the primary reason cited by both law enforcement and insurance personnel for public sector avoidance of insurance fraud investigations.

"misfiled" claim details. Thus, criminal investigations often require implementation of strategies to assess an offender's motive and opportunity for the fraudulent behavior. Thus, law enforcement concerns may lead them to choose strategies which are more clearly concerned with controlling offenders rather than offences. They may choose strategies to net multiple event frauds rather than single event fraud and strategies to net organized rings rather than isolated individuals. As a result, we can expect to see law enforcement relying more directly on strategies designed to "set-up" new inducements for fraud or attempts to create counter images so that suspected offenders can be "caught in the act."

As one might expect, public and private distinctions are often blurred in the real world. The investigation and control of fraudulent claims reflects the blurring of public and private legal mechanisms. This is seen most clearly when insurance fraud cases involve a crime in addition to filing a false claim. The following chapter examines the range of enforcement options available to social control agents once they suspect that claims are indeed fraudulent.

CHAPTER 7

DEALING WITH THE DECEIVERS

This chapter examines the enforcement options individuals and organizations face when confronted with what appears to be fraudulent behavior. Two questions related to fraud enforcement are explored. First, what enforcement options are available to control specific incidents of fraudulent behavior? Second, to what extent are these options influenced by the insurance context and the nature of deceptive activity?

Enforcement in the insurance context differs from conventional law enforcement in terms of both the number of enforcement options available and the variety of enforcement agents who may respond. Unlike decisions to arrest or not arrest, enforcement in the insurance context can take one of four forms: (1) ignoring fraud--non-enforcement, (2) mitigating a suspected fraud by adjusting the dollar amount of a claim to a lower amount, (3) denying the claim or (4) prosecuting the alleged offender.

Each enforcement option redefines the problem in a slightly different fashion. Ignoring fraud (i.e. not acting upon discovery) redefines the potential criminal violation as no problem at all. Adjusting what appears to be a false claim in order to reduce company liability defines the situation, not as fraud, but as a difference of opinion to be mitigated through normal claims process. By denying suspected false claims, an insurance company asserts that it has been a fraud target. Fraud is defined as a civil wrong instead of, or in addition to, a criminal violation.

The enforcement options available to social control agents reflect both private and public interest. As a form of theft, insurance fraud is a public wrong to be handled in criminal court. As a breach of contract, insurance fraud is a civil matter to be mitigated by the private parties directly involved. The differences in public and private interest are best expressed in the operations and style of associated legal mechanisms. In his discussion of fraud and consumer complaints, Eric Steele (1975; 1108-1109) distinguishes law enforcement (public interest) from mediation (private interest). Law enforcement agents identify offenders whose future actions can be controlled. They serve the public interest in so far as they protect the interests of the public any of whom could be a victim some time in the future. In contrast, one can respond in a manner that deals with private interest. Mediators focus on the resolution of disputes concerning known and identified interested parties.

The mediative stance focuses not on the deviant, but on the concrete dispute. Here, the emphasis is on the offence—what happened and how it can be corrected.

The ambiguity inherent in white collar offences (Aubert, 1968), defies easy categorization of the behavior as either civil abuse or criminal violation (Edelhertz, 1970). As a result, enforcement activities may be carried out simultaneously in the two spheres. A multi-enforcement network may be tapped for any one set of fraudulent transactions. Law enforcement agents may be investigating a charge of arson, while private investigators are looking for evidence to deny a fire claim. Multi-level enforcement efforts may result in some frauds falling through the cracks, if each enforcement agency believes that the other has jurisdiction, or if the efforts of one agency undercut the efforts of another.

Insurance fraud investigators may change options during the course of their investigations. An investigation which is aimed initially at claim negotiation may ultimately end as a claim denial. Investigations aimed at claim denials may be downgraded to claim negotiation or upgraded to criminal processing. In some instances criminal matters are down-graded to civil matters [1].

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1. This may reflect a more general trend in the enforcement of business-related crimes. The introduction of civil RICO and enforcement of "technical violations" may be important as well.

Whether an investigation is upgraded or downgraded depends, in part on the available evidence, and auspice of the investigators. If private investigators cannot make a case for claim denial, they will work to limit a company's liability to pay by excluding some portion of the claim. If public officials cannot make a criminal case against the suspected offenders, they may try to pursue a civil option [2].

Civil outcomes may affect criminal ones. A civil settlement surrounding behavior generally recognized as a type of white collar crime may negatively affect successful criminal prosecutions.

" . . .the victim will no longer be a whole-hearted witness for the prosecution,. . .any defense counsel worth his salt will find some way to make the jury aware that the case was mooted by civil settlement. . ."
." (Edelhertz, 1970;30)

In some cases, however, criminal charges are brought only after civil settlements have been reached. In 1971, a fire destroyed a vending machine warehouse. The FAIR Plan extending insurance coverage for the property argued that the warehouse owner was responsible for the fire and refused to pay the claim. The

2. There may be something else here. People's ideas of where justice can be served may have changed. Crime victims, for example, may use a civil court mechanism to achieve their notion of justice. The privately funded Crime Victims Advocacy Institute counsels victims who wish to file civil suits against their assailants. It is not just the offender who is subject to suits. Municipal and state governments have been sued for failure to provide adequate protection and supervision. For example, a widow sued the state of Washington after her husband was killed by a state prison inmate while participating in a "Take a Lifer to Dinner" program. The widow was awarded a substantial settlement Parade Magazine March 16, 1980.)

claimant sued the company for claim recovery. In 1974 a jury found in favor of the plaintiff and the FAIR Plan was ordered to pay the claim. After the payment was received and cleared through the banks, the property owner was indicted and convicted on federal fraud charges. If the claim had not been paid, it is unclear that federal fraud charges could have been brought against the offender. The issue was no longer whether the FAIR Plan should or should not pay the claim, but whether the claimant was guilty of using the mail to defraud an insurer. As a result of the criminal convictions, the FAIR Plan was able to void the original civil decision and the property owner was ordered to pay back the monies awarded to him.

The sanctions associated with each response differ in kind and severity. Ignoring fraud imposes no sanction. The only sanction associated with claim adjustment is a reduction in claim value; even so, claim reductions may be perceived as legitimate claim procedure rather than as a form of punishment. When claims are denied, the entire claims, not just portions of them, are invalidated. In such cases offenders stand to lose all the time and expense that was put into creating the false claim in the first place. The most severe sanctions—fines and/or prison sentences are associated with criminal action [3].

Data are not available to make inferences about the distribution of enforcement options. Those interviewed during the course of this research had trouble even estimating. The

difficulties stem, in part, from the fact that most actors do not see the enforcement process in its entirety. Once a claims adjuster suspects fraud and the decision is made to investigate further, that case may be taken out of his or her hands and the ultimate disposition may never be known. Nevertheless, I can use data from the interviews to make inferences about how often each enforcement option is employed.

There is no easy way to estimate how often frauds are ignored. Ignoring fraud is a private decision. No one but the initial detector need suspect that something is amiss. In fact, decisions to ignore fraud may not be conscious ones, as adjusters may simply choose to avoid looking for problems. It seems likely, given interview data collected, that small frauds are processed in this way.

As insurance companies become more aware of fraud and the effects of fraudulent behavior we may see an increase in the number of fraudulent claims which are denied, rather than simply adjusted. The growth of special investigators almost assures an absolute increase in denied claims as more personnel are engaged in activities aimed at claim denial. Nevertheless, the

3. The severity ranking established here is consistent with court decisions regarding double jeopardy.

"In a civil action by a government agency following a criminal conviction, the conviction is generally conclusive as to issues established against the defendant because of the government's higher burden of proof in the criminal proceedings. An acquitted defendant, however, must fully relitigate all issues because the same governmental proof may meet the civil proceeding's lower burden." (Fiske, 1980;191)

proportion of denied claims to total claims remains small. Estimates from one of the larger insurance companies were as follows for 1981: 31,000 auto claims were handled by the local office; 346 cases were assigned to the Special Investigative Unit as potential frauds; 206 (60% of the cases they reviewed, but less than one percent of all auto claims) were ultimately denied (interview no.16).

It appears that criminal prosecution of fraud offenders is an unusual or rare event. Most claims managers admitted great reluctance to turn a case over for criminal prosecution. Even in Florida where the state has established a special bureau to handle fraud cases, criminal prosecution is a relatively rare event. The Florida Division of Insurance Fraud reviewed hundreds of cases in fiscal year 1979-80. Only 58 cases were presented for prosecution and only 45 were ultimately prosecuted. Note that these numbers include all types of fraud, not just policyholder frauds against companies. A small percentage of the Division's case load included frauds by insurance agencies and brokers.

What accounts for the enforcement decisions? Other studies of discretionary enforcement inform my analysis, but are limited because they are empirically grounded in behavior and situations that are inapplicable to the insurance fraud context [4]. Previous models of selective enforcement consider conventional crimes which have the following characteristics not found to be

true of insurance fraud: (1) the offence is apparent (i.e. "a smoking gun"); (2) the offence is a discrete event; (3) the lines separating victim, offender and social control agent are clear; and (4) social control agents have effective power over offenders. By contrast the following conditions apply to insurance fraud. (1) Deviant transactions appear no different than conventional ones, and, thus, they are hard to recognize. (2) Fraudulent claims are processes which take place over time. (3) The lines separating victims and offenders are not clear as offenders mediate their crimes through the intended targets of deception. (4) Victimization is often diffuse. (5) Complainants and enforcers may be one and the same and, as a result, the stigma of being a fraud target impinges on the enforcement role. (6) Finally, fraud offenders exert some power over social control agents.

Although a defendant's power and legal resources to fight criminal action is central to arguments of selective or non-effective enforcement of crimes committed by corporations (Braithwaite and Geis, 1982; Clinard and Yaeger, 1980; Stone, 1975), explanations for controlling such crimes are not easily

4. Studies of policing focus on social control agents' discretion to evoke criminal process (Goldstein, 1963; Pilivan and Briar, 1968; Black and Reiss, 1970; Bittner, 1970; Reiss, 1971, Lundman et. al., 1978, Smith and Visher, 1981 as well as others.) These studies tend to cite: the characteristics and demeanor of suspects (Pilavin and Briar, 1964; Black and Reiss, 1970; Sykes and Clark, 1975; and Lundman, et. al, 1978); complainant characteristics (Black, 1970; Lundman, et. al. 1978) or the specific enforcement context of police-citizen encounters (Smith and Visher, 1981; Manning, 1977 as well as many others.)

applied to the insurance fraud context. Insurance fraud is not corporate crime as it has been studied conventionally, since the corporation is not the direct offender. Instead, the offence is mediated through the corporate entity. Insurance fraud offenders' powers to avoid enforcement rest, not in their individual attributes, but in their client status or in their participation in ongoing business activity.

My analysis is consistent with those studies which argue, implicitly or explicitly, that enforcement is limited because both rule breaking and control are located in conventional business activities which often neutralize enforcement efforts. Katz (1979), for example, notes that when crimes occur within legitimate organizations, the legitimate enterprises often diffuse and cover-up criminal intent. He suggests ways in which the forms of deviant transactions thwarts enforcement. Braithwaite and Geis (1982) and Ogren (1973) as well as others, note that the complexity of white collar offences (typically complicated economic transactions) renders conventional criminal enforcement more difficult and other enforcement responses necessary. Finally, some studies of white collar crime recognize that enforcement decisions are not based in discrete events, but in ongoing, legitimate transactions. (See, for example, Walsh, 1980.) The effects of enforcement on business relationships and on innocent third parties must be considered [5].

I argue that the business of insurance limits the incentives to control fraudulent behavior. Cost factors and other organizational goals discourage potential social control agents from exerting control even when they suspect that fraud is involved and enforcement would be appropriate. Difficulties in attributing fraudulent intent to a specific set of claiming behaviors further limits enforcement. In the following sections I will examine the enforcement options and suggest how each is influenced by the insurance process and by the nature of fraudulent behavior.

7.1 IGNORING FRAUD

Non-enforcement is typical when the costs of enforcing insurance rules exceed benefits in a particular case. Some claims, fraudulent or otherwise, are too small to invest time or money into further inquiry and they are paid [6]. Paying claims rather than investigating, even when fraud is strongly suspected, is considered sound business practice when the expected outcome of the investigation is negligible (i.e. a small reduction in an already small claim). Note that this decision strategy reflects only cost to the company and does not reflect indirect or less tangible costs (e.g. the loss of a building to community vitality, individual suffering accompanying intentional injuries, lost homes, etc.) or benefits (long-term deterrence). If investigatory costs differ by fraud type (the analysis developed in Chapter Six suggests that they do) then we can expect to see

different thresholds for ignoring fraud depending on fraud type.

One can imagine situations where many small frauds are perpetrated by an organized fraud ring. Each claim, individually, may be too small to warrant further investigation, but taken together the company may be defrauded of a large sum. Unless the ring is discovered by someone outside the system (typically after the claim has been paid), the small dollars associated with the individual claims may permit the ring to continue its operations undetected.

Other, larger, non-routine claims are treated as if they were small and routine because of adjusters' workload constraints prohibiting more in-depth investigation. Adjusters overburdened with cases may choose to pay some claims just to relieve their workloads. If Ross' (1970, revised 1980) assessment of

5. The enforcement of some white collar crime has broader implications which impinge on the livelihoods of innocent third parties. Non-enforcement of health safety regulations, for example, could result in injuries to innocent workers. Enforcement has its costs as well. Walsh (1980) poses the dilemma for some enforcement officials.

"Those put in the position express great discomfort and concern at being asked to be economic policymakers. . . should I as an enforcement official be empowered to decide that 8,000 people will be put out of work."
(p. 51)

6. This figure will vary by company and claim department as well as by type of claim. One can imagine that the large companies can afford higher limits on small, routine claims simply because their underwriting base is higher. On the other hand, economies of scale in the large companies may lower the cost of investigating claims and, thus, companies can afford to investigate lower dollar claims.

incentives facing adjusters is correct, we can assume that some adjusters, pressured to close cases quickly, will close them at the expense of more careful investigation. (See Chapter Three for more detail.)

7.2 RECOGNIZING FRAUD BUT ADJUSTING THE CLAIM NONETHELESS

Once fraud is detected, claims personnel look for ways to limit their companies' obligations to pay the claims. Companies can limit their obligation by negotiating with the claimant and arriving at a lower claim figure [7]. A description of the claim process can be found in Chapter Three.

If adjusters suspect fraud, but don't believe they have the resources (time, money, or even evidence) to prove so, they may try to disallow certain claim items they believe are illegitimate. A study of arson incidence confirms the use of negotiation as one option when fraud is suspected. Researchers for the All Industry Research Advisory Council included as "arson claims" those in which

"A compromise settlement was made based on facts within the claim investigator sufficient to indicate incendiary origin, but insufficient for criminal indictment." (All Industry Research Advisory Council 1982;2)

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7. Most property-liability claims can be limited by negotiating a lower dollar value for the loss. Workers' Compensation claims, however, are more or less value fixed. Claims are limited by shortening the length of injury time-i.e. proving that a claimant is no longer injured.

Some claims suspected to be fraudulent are negotiated because the insurer is obligated to pay a significant sum to third parties, regardless of the claimants' actions. For example, in the case of some fire insurance fraud the insurance company is obligated to pay the mortgage holders, regardless of the claimant's involvement in the loss. If fire totally damages a building insured for \$100,000 and the bank holds an eighty thousand dollar mortgage, the insurer is obligated to pay the \$80,000 no matter what caused the fire, unless a link between the mortgagee, the claimant and the fire can be established. Since they are obligated to pay the \$80,000, the costs of a lengthy investigation to prove fraud might outweigh the \$20,000 expected savings [8].

Consumer legislation, in particular Unfair Claims Practices legislation establishing time limits for claim settlement, are cited as important factors in determining whether to investigate. Several claims managers noted that their abilities to investigate suspicious claims are often thwarted by legislation which demands that claims be settled quickly. However, it appears that in practice, companies are not as limited as they would like us to believe. Although required to inform claimants of claim status, companies need only tell them that their cases are under

8. Of course if the courts upheld claim denial, the insurer could sue the claimant for the amount they paid the mortgagee. Although on paper this seems like a fairly nice option, in practice these suits are rarely instituted since there is little possibility of collecting.

investigation and refer claimants to the state regulatory agency if they wish to file a complaint. In most instances, the state Departments of Insurance will stand behind a company's claim handling procedures. According to one claims manager, "If you can't handle an over-aggressive insurance department, then you have bigger problems." Thus, while many claim managers cited consumer legislation as a constraint on their ability to take action against potential fraud offenders, they could provide few instances when they have been sanctioned for investigating claims [9].

Some suspected frauds are negotiated or adjusted because the costs of claimants' reactions to denials and costs associated with wrongfully denying claims are outside company control and potentially great. The uncertainties in claims processing lead to two types of errors: false negative errors (denying legitimate claims) or false positive ones (paying illegitimate claims). Since false negative errors are potentially quite costly, claims personnel, faced with uncertainty, will make every effort to avoid them. In their efforts to avoid denying legitimate claims, processors may actually increase their

9. One option insurance companies have is to refer a case to the Insurance Crime Prevention Institute. Three hundred companies support this agency designed to bridge the gap between the insurance community and law enforcement. ICPI is mandated to evaluate fraud cases in terms of their likely criminal prosecution. They do not provide investigatory services for routine claims handling. According to several claims managers, they are reluctant to refer cases to ICPI precisely because ICPI investigators cannot and will not supply them with information useful for claim settlement (i.e. in a timely fashion).

acceptance of illegitimate ones.

False negative errors can impose significant costs if a claim is denied and the claimant sues for recovery. Although civil suits are relatively rare (only a fraction of all claim denials end up in civil court— approximately five percent of all denied claims according to one claims investigator), the threat of a civil suit greatly influences adjusters' claims handling decisions. The civil court outcomes could exceed the original claim amount if juries find that the original settlement was too low. If the claim is eventually found to be legitimate, the additional investigatory expense will prove unwarranted. Suits for punitive damages when a claimant has been wrongfully accused could result in payments up to three times the amount of the original claim [10]. Although it is not clear that punitive damages have been awarded very often, if at all, processors note that the mere threat of the treble damage award is enough to make them think twice before pursuing claim denials (interview no. 14.)

Processors also might be pressured to avoid false negative errors because the costs of such errors are not as easily recovered through rate relief as are the costs of false positive ones. False positive errors simply increase the loss experience

10. For example the Massachusetts' Consumer Protection Legislation—General Law 93A states that "If the court finds for the petitioner, recovery shall be in the amount of actual damages; or up to three, but not less than two, times such amount if the court find that . . .the act [e.g. claim denial] was a wilful or knowing violation."

upon which rates are based. The claims are paid as if the losses were legitimate. False negative errors, on the other hand, increase operational costs which may or may not be included in rate calculations (interview no. 44).

Incorrectly labelling a legitimate claim as fraudulent also may have damaging reputational consequences. Companies which pride themselves on fair claims service may be reluctant to accuse "otherwise honest" clients' of fraud unless they are certain that they can prove fraudulent intent. As noted in Chapter Four, proof of intended wrongdoing is often difficult in cases of deception. Many methods used to construct deceptive claims may be justified as legitimate mistakes. In situations of uncertainty, therefore, insurance personnel may avoid the risks of false accusations and pay claims which they suspect are fraudulent.

Finally, even if claim denials could be successfully defended in civil court, the cost of court may pressure insurance companies to settle out of court. Recognizing that claim denials may ultimately end up as negotiated settlements anyway, processors may opt for a negotiation strategy in the first place.

The interviews with claims managers do suggest that personal style influences individuals' choices to "play out their hunches." While some claims managers take a conservative approach (i.e. negotiating a claim when they are uncertain of their abilities to prove fraud), others will take small risks. As one

claims managers commented, it is often hard to make a fraud case on a few inconsistencies, but "you can bluff it out sometimes."
(interview 9)

Company size may be a factor as well. The larger companies may be more likely to take steps to fight suspected fraudulent claims simply because they have more resources to do so. Smaller companies, however, may choose the expensive course of action just to prove that resources do not affect their claim procedures. In the words of one claims manager for a small, local property insurance company

"From an insurance standpoint, it is very important for small companies like ourselves to take a strong stand for no other reason than to get the reputation as a company that fights back." (interview no.9)

Thus, the data suggest a number of organizational reasons why suspected frauds are mitigated through normal claims adjustment rather than denied outright or criminally processed.

- (1) Proof of fraud may be difficult and costly to obtain. Adjusters may lack the resources (time or money) to engage in the necessary investigation to support claim denial. The evidence, primarily that confirming conclusions about a claimant's motive and intent to defraud, is often privately held and intractable. Without specialized expertise, these data are hard to access.
- (2) Conflicting processing goals to minimize costs and, yet, service policyholder/clients may lead processors to compromise, even when they think the claimant is lying. Negotiation provides

a means to fulfill two goals at the same time. Adjusters can limit their companies' obligations to pay claims while, at the same time, they can provide a sense of servicing their clients.

(3) Claim managers suggest that consumer legislation enacted to protect claimants opens up avenues for consumer abuse if it impinges on the careful evaluation of claim facts. They indicated that legislation limiting claim settlement periods did not provide sufficient time to investigate claims they suspect are fraudulent. Rather than run afoul of consumer legislation, adjusters compromise.

Overall, a conservative strategy for meeting profit oriented goals prevails. Individual claims personnel and departments pursue the safest way to reduce claim costs even when alternative, more risky, strategies could save more company dollars. Given the uncertainties involved, processors focus on those activities over which they can exert some control—e.g. decisions to allow or disallow claim items. Because the costs associated with claim denial are uncertain, that strategy is often avoided even though a successful denial is the most effective way to limit company liability. Negotiating a settlement is more certain than civil or criminal process, as the company will surely pay something less than the original amount claimed. A degree of certainty is exchanged for absolute dollar savings.

7.3 DENYING CLAIMS

Denying a claim is a direct challenge to claim legitimacy. Unlike adjustments or negotiations involving claim value (how much a particular claim is worth), denials are direct implications that the claims are illegitimate, if not fraudulent. Claims are denied because the contract has been violated, because the company "denies" liability for the damages or because the company can document the claimant's fraudulent intent. The standard of proof is a civil standard. Only a preponderance of evidence is needed to develop a case for claim denial.

Citing a policy violation or denying liability may be a "quicker route" to claim denial than proving fraudulent intent. Consider the following. A man saw an advertisement in an out-of-town newspaper for a Mercedes selling below market price. He bought the car and paid for it in cash. The car was delivered to him. The next day it was stolen. Insurance personnel examining the claim discovered that the certificate of title was a fake. They don't know whether the claimant ever had the car, whether he was duped and simply "ripped off" or whether he is part of a larger fraud operation. They are suspicious, however, and are trying to deny the claim based solely on the fake title. The company argues that since the title was fake, the claimant has no "insurable interest" in the loss. If successful, the company can deny the claim without having to ascertain or prove any fraudulent intent on the part of the claimant.

In some cases claims are withdrawn before a formal denial is issued. A reporter from an insurance industry trade journal surveyed lawyers who defend insurance companies' claim denials in civil courts. He reports the outcome of his survey.

"Of the cases assigned to lawyers and after the preliminaries with the insured, 40% of the insureds withdrew the claim, meaning no payment. Twenty percent of the files [sic] went to trial. Of the cases that went to trial, the insurance company won 75%" (Coppock, 1981;22)

This study suggests that companies fare better in civil court than one would have guessed given interviews with claims personnel. What we see, however, may be the product of the insurance companies' conservative approaches to claim denials. If insurance companies select for civil court only those cases which they feel relatively certain of winning, we should interpret the seventy-five percent success rate in a more negative light [11].

Because claim denials require more intensive investigation than is typically undertaken in the normal claims process, special investigators are often employed to examine these claims. Several insurance companies have established special investigative units to investigate suspicious auto claims. Private investigators are often hired as well.

11. Other research suggests that when civil court cases involve individuals versus organization, organizations tend to have more favorable outcomes (Galanter, 1974). Wanner (1974,1975) conducted a study of 7900 cases and found that corporate plaintiffs win more, settle less and generally lose less than individual plaintiffs.

Typically, when companies consider claim denial the investigation is turned over to an outside attorney. The attorney directs the investigation making sure that investigators comply with rules of evidence and rules against unfair claims practices. (Should a company be found to have engaged in unfair claims practices, punitive damages could be awarded to the complainant.) By turning its investigation over to an attorney, the insurance company protects its investigation as a "work product" covered under attorney-client privilege. Although not an absolute barrier to discovery should claimants consider civil action, the work product privilege is an additional obstacle to claimants' attempts to recover. The work product privilege also protects an investigation by limiting the information available to claimants and, therefore, preventing them from creating data to support a position that counters that developed by fraud investigators.

If benefits accrue over time, companies may pursue civil or criminal options even when the cost of doing so exceeds direct savings. For example, it may be politically expedient to pursue criminal prosecution of certain claimants if such prosecutions build a company's reputation, attract new legitimate clients and/or deter fraud offenders from filing claims with the company in the future. Public statements about insurance industry activity against fraud offenders recognize such long range benefits to stringent claims handling. However, with the possible exception of established special investigators for auto

theft, it does not appear that the long range benefits are part of an individual's calculus for determining how claims are processed.

Future research should address what appears to be a mismatch in corporate and individual goals around the issue of fraud. From the corporate standpoint illegitimate claims should not be paid. In practice, however, individuals pay illegitimate claims because their success is measured in terms of their abilities to limit company liability and they choose the safest path for doing so [12].

7.4 CRIMINAL PROCESSING

Insurance fraud can be prosecuted in a number of different ways depending, in part, on who discovers fraud and the jurisdiction within which the frauds occurred. Although only a minority of states have penal sanctions against filing false insurance claims, insurance fraud may be prosecuted under a number of general fraud, larceny or theft statutes where appropriate. Insurance fraud offenders in Massachusetts have been prosecuted for crimes ranging from larceny or arson to

12. Part of the issue is that companies project data on aggregate company performance and do not focus on individual decision-making. If a company says it is "getting tough on claims" that may simply mean that they have assigned one person to investigate fraud. That one person may cover a territory that averages many thousands of claims yearly. Nevertheless the company projects the image that it is policing its own backyard and doing something about fraud.

defraud an insurer to simply filing a false insurance claim. A sample of indictments generated by the US District Court in Massachusetts shows that although the type of activity differed, all cases were presented for prosecution as violations of Title 18, US Code, Sections 1341 and 1342, the mail fraud statutes.

Interestingly, the Florida Division of Insurance Fraud which has an insurance fraud statute at its disposal, has found that the grand theft statutes, often used in conjunction with the insurance fraud statute, have been most successful in the prosecution of insurance fraud. According to Division investigators, prosecutors are more familiar with the nuances of the theft statutes and are more likely to accept insurance fraud cases if they can be easily understood as theft. Furthermore, since theft statutes emphasize that insurance fraud is a form of stealing, investigators believe they are easier for juries to understand and convictions involving some form of punishment are more likely [13].

The federal RICO (Racketeer Influenced and Corrupt Organization) Acts and the state legislation modeled after it have also been used against insurance fraud offenders. RICO makes it unlawful for an "enterprise" (defined in the legislation as an individual, partnership, corporation, association or other legal entity) to conduct its affairs through patterns of racketeering activity. A recent Supreme Court decision that RICO

13. The small sample of Florida cases reviewed did not permit comparison of sentencing by charge type.

was not limited to criminal organizations which take over and infiltrate legitimate businesses upheld the Justice Department's broad interpretation of RICO to cover many types of organized criminal activity. (The New York Times, June 18, 1981). In addition to criminal penalties, the RICO statutes have associated civil "remedies" as well. For example, Florida's state attorney general's office filed civil charges under the Florida RICO statute against the Florida No-Fault Insurance Agency. Florida No-Fault had been criminally charged with "schemes to defraud," a third degree felony, for "sliding" additional coverages on the auto policies of its customers and hiding the cost of those coverages in the premium. If convicted on the civil RICO charges, fines up to three times the total dollar amount charged as having been derived from illegal activities can be imposed against the company.

Whether the great number of options for the prosecution of insurance fraud helps or hinders prosecutors' efforts is unclear. Generally, however, the task forces that have looked at insurance-related crimes conclude that jurisdictional problems and lack of specificity in statutes have made prosecutions more difficult. One study of the states' efforts to combat white collar crime indicates that despite state legislation against deceptive trade practices and/or specific legislation against fraudulent practices, state activity has been piecemeal in reaction to specific schemes rather than comprehensive in an overall effort to combat fraud. The study authors conclude that

the lack of a specific plan to combat fraud has resulted in inefficient use of law enforcement resources. (Hanna, Swerin and Amos, 1977)

Insurance companies, as complainants to the fraudulent action, can take their cases directly to law enforcement officials. Claims managers interviewed here indicated their reluctance to do so, although all would cooperate with an investigation if asked to by law enforcement officials. Although they favor criminal prosecution of fraud offenders, claims personnel seemed unprepared to stand as complainants in criminal matters against their policyholders. As one claims supervisor said, "This is insurance. You don't go booking people." Companies' refusals to sign complaints reduces their chances of getting a case prosecuted (interview no.16) [14].

In Florida, investigators from the Division of Insurance Fraud can act as sworn complainants relieving companies from publicly accusing their clients. However, investigators in New York's fraud bureau will not serve that function. The director of the newly formed Insurance Frauds Bureau advocates for policies which force insurance companies to sign complaints as he

14. Interestingly, the one exception to the company's refusal to sign complaints was a large auto fraud case involving a number of the state's larger car insurers. This suggests that while the company may be reluctant to damage its reputation by pursuing criminal prosecution, it is willing to cooperate with a group effort toward that end in which no one company is singled out as being particularly tough on claims.

believes that "insurance companies have a moral obligation to face facts [about their own victimization.]"

Company preferences for handling fraud privately rather than publicly (in criminal court) may be part of a more general trend in business-related crimes. Business reluctance to participate in criminal action against offenders has been discussed most frequently in reference to employee thefts (Robin, 1970, Ditton, 1977). Studies indicate that criminal prosecutions are avoided because they incur additional costs with no clear return on investment [15]. Public prosecution is also avoided to escape the publicity that might result, or to avoid public disclosure of company practices. Finally, company reluctance to avoid public recognition of their victimization may also be related to the company's or public's perception that the target may have, in some way, facilitated the crime [16].

According to some claims managers and fraud investigators, even when they want criminal action, cooperation from local prosecutors is not always forthcoming. Investigators, in

15. Robin's (1970) analysis of company reluctance to prosecute employees who steal argues that companies prosecute only when they recognize the advantages of doing so. Robin argues that an employer

"...may be more concerned with simply eliminating the cause of profit loss than with revenge, especially if the defalcation is small and/or if further investment of time, money and effort involved in prosecution is not economically justified." (Robin, 1970;124)

16.. For a discussion of how the "rape model" fits to some white collar crime situation see Walsh and Schram (1980).

particular, felt that personal influence was necessary to convince prosecutors that criminal charges were warranted. Even in Florida where a law enforcement agency was established to investigate insurance fraud exclusively, investigators still found themselves convincing prosecutors to handle their cases.

Public authorities cite the length of time it takes to investigate insurance related cases compared to the expected outcome as one reason they avoid insurance fraud investigations altogether. Given standard criminal justice performance measures and scarce resources, it is unlikely that a local law enforcement agency will spend six months to a year investigating two or three individuals on insurance fraud charges when they can use that time on several, shorter investigations which net more arrests and convictions. Of course, in some situations, for example, when performance is measured by variables other than arrests, the longer investigation may be politically expedient.

Organizational priorities also help define the types of cases investigated by special fraud units established by public authority. Since these bureaus are evaluated in terms of successful arrests and convictions, one can imagine that case acceptance is influenced by some measure of potential for prosecution. In addition to criminal justice performance measures, fraud bureaus must rely on organizational reputation to maintain funding. They must convince the relevant funding authorities that they are acting in the funders' interests and

are "successful" in their operations. Cases will be selected, in part, in terms of their abilities to meet that criteria. When the Director of New York's recently established Insurance Fraud Bureau began operating, he was advised to begin operations with a big fraud, preferably an insurance broker fraud because both insurance companies and the public are victimized and outraged. This piece of advice points to the important relationship between organizational reputation and type of case investigated.

Funding for criminal investigation may depend on the private sector's willingness to pick up at least part of the cost of investigations. According to the Assistant Attorney General in charge of Suffolk County, Massachusetts' largest arson conspiracy trial, prosecutorial success could not have been achieved without private sector funding. The Massachusetts FAIR Plan provided the money and manpower (in the form of private investigators) to supplement state police investigation. Private monies covered the cost of keeping the prime witness in protective custody for eighteen months as well as all overtime costs accrued during the course of the investigation (interview no. 39). Unfortunately, we cannot estimate how often private funds are used to finance public investigations, although we can speculate that in times of fiscal austerity, public investigations into insurance fraud will rely heavily on private sector funding if they are to occur at all [17].

Overall, criminal prosecutions of fraud offenders seem to be rare events. Prosecutions are most likely in situations where insurance companies can join together as complainants or when specialized agencies advocate for prosecution of fraud offenders. Otherwise, false claims tend to remain private matters handled by the parties directly involved. The Florida Division of Insurance Fraud and the Insurance Crime Prevention Institute are examples of agencies which perform that latter function. In general, law enforcement personnel seem reluctant to get involved in fraud cases other than arson (note: the fire is a crime in itself), unless the frauds involve large conspiracies and significant sums or if they involve other criminal matters.

7.5 FACTORS INFLUENCING ENFORCEMENT

The fraud enforcement option pursued often depends on one of four factors: the certainty that what one believes is fraudulent is actually fraudulent; current workloads of fraud investigators and other enforcement personnel; the consequences of wrongfully accusing a claimant of fraud and the cost/benefit ratio of enforcement. It appears that the most severe sanctions will be placed on fraud offenders only when social control agents are

17. Whether private companies will support criminal investigation is unclear. Early impressions suggest that companies do not feel it is "their place" to undertake that type of financing. Interestingly, the insurance industry was prepared to lobby for the continuation of ATF when that agency's demise appeared imminent. The reason was simply that ATF, a public organization, conducted fire scene investigations useful to the insurance industry (interview no. 4).

certain of the claimants' fraudulent intent, and the consequences of an incorrect (or overruled) accusation of fraud are assumed to be trivial. However, certainty that a crime/fraud has occurred is undermined by the ambiguity of the crime itself. Both the methods used to construct fraudulent claims and the organization of fraudulent activity hinder efforts to determine that a fraud has occurred and to assign culpability for the fraudulent action.

Since claims processors are both fraud targets and enforcers, they are constrained in their abilities to take action. As targets they are often structurally disadvantaged in terms of their abilities to acquire information that would enable them to recognize their victimization and to assign guilt. Individual claim processors, for example, may not have enough information about claims filed with other companies to enable them to identify the current claim activity as part of a pattern of fraud. Processors have limited information on how losses occur which then limits their abilities to determine that the claimant's story could not be true.

Although insurance personnel could identify few instances when insurance companies have been fined for incorrectly labelling a claim as fraudulent, the threat of potential consequences, both direct dollar costs (treble damages) and anticipated costs (damage to ongoing business relationships) appears to be sufficient to create situations of enforcement avoidance. Rather than risk incurring costs greater than the

initial claim, processors will either negotiate a lower dollar figure or pay the claim at face value.

Finally, insurance companies are profit-oriented enterprises and they will not enforce rules against fraud unless there are clear benefits to doing so. My analysis suggests that the benefits of fraud control to individual companies may not be enough to outweigh the costs since fraud effects are diffused through the system. Because fraud costs are often shared among companies, no one company has the incentive to protect itself against losses. The moral hazard argument which has been introduced to explain why insurance subsidies cause policyholders to reduce self-protection and to incur greater losses, may explain company laxity in fraud enforcement.

Again, through their actions, or non-actions, insurance actors make implicit choices about how and when fraud should be controlled. Those directly affected by fraud (e.g. insurance consumers and community residents) need to critically assess enforcement incentives and performance in combatting fraud.

CHAPTER 8
CONCLUSIONS

This thesis takes a broad view of the processes involved in the manufacture and control of fraudulent insurance claims. I have argued that insurance fraud, the manipulation of loss circumstances and reports to obtain benefits unlawfully, can be usefully conceptualized as rule breaking or crime committed through or mediated by organizational structures and activities. Consequently, the study of such behavior is appropriately focused on the interaction between rule breaking, rule enforcing and conventional business transactions. Sets of transactions, rather than individuals or organizations, provide the empirical context for studying the interaction between insurance process, fraudulent behavior and attempts at fraud control.

The processes used to construct, detect and investigate false claims have been described in light of two questions. First, since insurance fraud offenders use the insurance process to obtain benefits unlawfully, to what extent do insurance organizations and activities influence the construction of false claims? Second, to what extent do the processes of image

manipulation and the relationship between deceiver and insurance organization influence the incentives and abilities to detect and control fraudulent behavior?

Opportunities for rule breaking in the claims-making context are analyzed in terms of (1) opportunities to deceive, (2) opportunities to conceal offences and (3) limits on fraud recognition and control. These factors are apparent in the structures and activities of insurance process and the nature of deception.

My argument for "criminogenesis" in the insurance claims process rests not simply in structural explanations. Offenders are not passive agents as they often act to manipulate insurance structures to their advantages. Thus, my research is, in some sense, a synthesis of the structural and interactive perspectives in deviance and social control.

The model of fraud and fraud control developed in this study argues that fraudulent behavior persists because of features of insurance process and deceptive behavior which (1) permit the manipulation of loss images and reports and/or (2) dissuade potential social control agents from exerting control. Insurance fraud can not be explained simply in terms of the rational pursuit of expected gains, as the economic theory of moral hazard would assume. Fraudulent behavior is a consequence of the contradictory character of insurance activities and relationships. Furthermore, the analysis suggests that limits on

fraud enforcement are not due simply to lax control or poor risk selection and screening. Limited enforcement can be viewed as a mismatch between the fluid processes of image manipulation and fixed structures of enforcement. Insurance goal conflicts as well as diffused fraud effects further limit incentives and opportunities for control.

8.1 OPPORTUNITIES TO DECEIVE

Insurance fraud offenders manipulate facts so that it appears as if they are eligible for insurance compensation when, if the true facts were known, compensation would not be forthcoming. Since the key factor in the deception is the manufacture of an insurable loss, insurance frauds are distinguished by the ways in which offenders construct their fraudulent loss scenarios. Three fraud types are identified—exploiting losses that already happen, inventing stories of losses that never happened, and physically creating losses.

Overall, the opportunities to distort loss events and reports are present in the activities of insurance claims service and can be understood in terms of paths and incentives for deception. Insurance provides paths for deception by creating latitude or encouragement for deceit and by providing the data or activities to divert attention away from possible claim discrepancies (e.g. by providing the mechanisms for enhancing

claim credibility). The insurance business increases the incentive for fraud in so far as it provides the profit motive for deceptive activity and when, by their actions, insurance personnel permit violators to feel justified in assuming their rule breaking behavior.

8.1.1 INCENTIVES FOR DECEPTION

Chapter One introduces the notion of a moral threshold for fraud. I suggest that claimants' participation in the insurance process or, in some instances, knowledge of others interaction with claims processors, increases the acceptance of deception as a legitimate interactional strategy. Insurance companies provide moral opportunities for their own victimization, not simply because they are big, impersonal financial institutions, but because of the nature of claims activity itself. The bargaining and negotiation which is part of conventional claim activities, sets up a framework for the use of deception. Fraud is perceived as the only way to "get even," given insurance practices of depreciating property and negotiating lower settlements.

Insurance companies may be responsible for their images as legitimate fraud targets to the extent that they fail to provide the "protection" that their advertising suggests they will deliver. Conflicts over what constitutes acceptable "protection" or even "compensation" in the event of losses may provide incentives for rule breaking by "otherwise honest" policyholders.

The insurance business also creates fraud incentives when it inadvertently provides the profit motive for fraud. One profits from fraud when insurance compensation exceeds loss values. Insurance companies are directly involved in maximizing profits when they knowingly create conditions where the value of insurance is greater than the risk insured. The lure of investment profits may create situations where underwriters are less careful in their risk selection and implicitly agree to accept "fraud prone" risks just for the premium generated. Investment income may offset future claim payments. (Nevertheless, the loss still occurs.) The pursuit of agency commissions has led historically to the overinsuring of properties when agents receive some percentage of the total premium collected. Since the insurance coverage is worth more than property value, overinsurance is cited as one motive for fraud. Thus, segmentation in insurance tasks may create conditions encouraging some actors to overinsure or provide insurance when it should not be provided and, in so doing, to contradict the concerns of other insurance actors trying to minimize losses and loss consequences.

8.1.2 PATHS TO DECEIT

Insurance is a trade in the perception of risk and protection. Since commodity sales often depend on intangible perceptions, there is significant latitude in defining what is bought and sold. Just as insurance industry officials can shape

the meaning of the services they provide through advertising, policyholders may shape the perceptions of their need. The uncertainty in the commodity— what is bought and sold—provides some margin for those wishing to undermine the process.

Opportunities to manipulate loss events and reports can be associated with the contingencies of loss events and with uncertainties in claims-making as well. Since claim service takes shape only after losses occur, fraud offenders are able to mold loss events and reports to their advantages. Because losses are contingent events, evaluators must be prepared to accept a range of possible loss outcomes. Although insurance officials can predict that one building out of a hundred will burn, they cannot predict, with any degree of certainty, that a particular building will burn nor exactly what shape the associated loss will take. Since claim evaluators lack certainty about what shapes losses should take, deceptions are hard to recognize.

One way companies have tried to compensate for the complexity of loss events and claims is to routinize the claim process. Routinization has an inherent irony. It permits client learning. Knowledgeable fraud offenders learn exactly what should or should not be included in the claim of loss and work their manipulation within the framework of acceptable behavior. For example, in a case cited earlier, fraud offenders knew just how long to fabricate a hospital stay in order to keep it within the boundaries of acceptable treatments for the injuries they

allegedly sustained. Again, because of the contingencies of losses, claim evaluators must be prepared to accept a range of responses to their requests for claim details. Although claim evaluators may insist on receipts to document property, they cannot determine what form those receipts should take. Thus, claimants are at an advantage in creating documentation for their losses as it is difficult to exclude documentary evidence without extensive investigation.

The activities of service delivery—the claim process—also set up opportunities to manipulate loss images and reports. Claim evaluations can be understood as a series of negotiated decisions based on the social reconstruction of loss events. Each party to the process seeks to reconstruct events in ways to further their position. Since neither side oversees the other's documentary processes, there is a certain latitude for deception. Negotiation processes also provide offenders with the boundaries of tolerated outcomes. By providing a range of acceptable behavior, negotiations implicitly "teach" violators just how far they can manipulate the system without tipping the balance against themselves.

The structure of claim service as a form of street-level bureaucracy opens up possibilities for fraud and abuse. The discretion afforded to street-level workers may be subverted by powerful claimants whose influence over adjusters' decisions may be greater than that exerted by the insurance organization. The

bureaucrat's strategies for coping with conflicting goals in a complex working environment may limit their incentives for fraud recognition, and, thus, provide offenders with a relatively risk-free environment for deception.

The association between reducing claim costs and the sale of salvage material is illustrative of ways in which insurance goal conflicts provide opportunities for fraud. In Chapter Three we learned that claim departments attempt to recoup some claim costs through the sale of salvage. This has led to some instances where insurance officials accept the highest bid for salvage even when they suspect that the salvage material will be used to construct a fraudulent claim sometime in the future.

Finally, insurance company fraud enforcement decisions may actually contribute to the success of false claims. Claim evaluators, faced with uncertainty can make two types of errors: false positive errors (paying illegitimate claims) or false negative errors (denying legitimate claims). I have argued that processors tend to avoid false negative errors because of the negative consequences of unwarranted denials. In their efforts to avoid denying legitimate claims, processors increase their acceptance of illegitimate ones.

8.2 OPPORTUNITIES TO CONCEAL FRAUDS

Unlike conventional crimes where the offence is apparent and the task is to discover who committed the crime, fraudulent activity is often concealed. Investigators may know who committed the violation, their job is to figure out how it was done and why. The abilities to ascertain whether claims are legitimate, given the rules of the insurance contract, are limited because of the contingencies and uncertainties of losses in the first place, the inherent nature of deception which makes it hard to recognize and the features of insurance process which limit data available to claims processors for informed evaluation of events and reports of events. Finally, the organization of fraudulent activity as it is mediated through conventional insurance organizations and actors, shields fraud offenders from their targets and potential enforcers.

The ambiguities and uncertainties associated with loss events opens up many possibilities for fraud offenders to manipulate the meanings of their actions in a given situation and to neutralize control. Knowledge gaps or uncertainties about the relationships between cause and event thwart efforts to determine fraudulent intent. It is difficult to prove that damages or injuries sustained were not caused as claimed by policyholders if no alternative theory of causation can be developed with greater certainty. Claim evaluators rarely have sufficient information to develop alternative theories of loss.

Certain methods used to deceive are hard to distinguish from legitimate interactions and, thus, fraudulent intent is nearly impossible to prove. Proving intent to defraud on the basis of omitted data, for example, may be extremely difficult since the claimant can almost always cite a legitimate or credible reason for the omission—e.g. "I made a mistake." Insurance companies, keenly aware of their negative reputations, are not likely to want to perpetuate or extend that image by swearing out complaints against their clients who claim they made simple mistakes when filling out complicated claim forms. The acceptance of deception as a legitimate negotiating strategy may also act to cover-up fraudulent intent. Deceptions with the intent to defraud are hard to distinguish from those that are "expected." Overall, the ambiguity surrounding insurance fraud as a criminal or even moral wrong gives the benefit of the doubt to the claimant. If a claimant's story seems plausible, it will, often be believed.

Mediators pass along and legitimate images of victimization and, thus, substantiate, add credibility to claims, and often conceal fraudulent transactions. Mediators can be part of the fraudulent organization or they can be unwitting accomplices to the deceit. By reporting a burglary to the police or an injury to a doctor, claimants build credibility for their claims. While many insurance adjusters may be comfortable in doubting an individual policyholder's story, they are less willing to question the public record or a doctor's assessment of loss.

Several insurance investigators interviewed in this study noted that it would be difficult and often uncomfortable to doubt a professional's judgment.

Interestingly, some of the methods to deter potential fraud offenders, in particular those strategies designed to engage third parties into claim verification, may actually enhance the mediator's position in fraudulent schemes. The prior owner letters sent to the previous owners of cars now reported stolen and not recovered, and the gift-donor letters described in Chapter Five may actually build credibility for false claims. Fraudulent statements about property ownership, for example, can be verified by third parties who willingly aid claimants in defrauding insurance companies.

The strength of ties between fraud organization members will influence abilities to conceal fraud. The bonding mechanisms holding fraud organizations together reflect different types of relationships between members. Since detecting and unravelling frauds often require the breaking apart of intricate fraud organizations, the strength of these ties will influence the opportunities to conceal or expose the fraud.

Fraud offenders also conceal their participation in rule breaking by distancing themselves from fraudulent activities or by disassociating themselves from loss events. Placing distance between themselves and their targets shields them from social control efforts. Some property owners involved in arson insulate

themselves from fraud by establishing "straws" or "fronts" for their property ownership. Others hire "torches" to set the fires for them. Policyholders who conveniently leave their automobiles where they know they will be stolen also insulate themselves from the loss event.

Insurance fraud activities can also be concealed within larger business operations both legitimate and illegitimate. These operations can themselves provide opportunities to insulate and cover the fraud offenders and to buffer social control. Legitimate business, organized crime and even law enforcement have acted in this capacity.

The insurance process helps conceal frauds by limiting the vantage points of potential discovery agents and their incentives to look for fraud. Discovery agents are differentially located throughout the claiming process. Since one's vantage point determines, in part, what frauds can be seen, discovery agents are limited in terms of the frauds they expose merely by the fact of their positions vis-a-vis the claims process and the claimant. Discovery agents also differ in terms of their incentives to discover frauds. For example, the media and community groups have incentives to look for selected frauds that reflect their particular interests. Claim processors' incentives for exposing fraud are embedded in larger insurance goals that often conflict with fraud exposure.

Some frauds are concealed because detection strategies are not well designed to capture the fluid processes of image manipulation. The processes of deception afford to those who deceive certain opportunities to change imagery during the course of a claim and, in so doing, to neutralize discovery mechanisms. I have suggested that attempts to make the discovery process more predictable through standardized audits and standardized computer matching programs have an inherent weakness. Knowledgeable offenders learn the system and use that knowledge to manipulate their images of loss and conceal their frauds.

8.3 LIMITS ON ENFORCEMENT

Even if one could identify fraud, it is not clear that under all circumstances, insurance claims personnel or law enforcement wish to control fraudulent behavior. My analysis suggests several reasons why some frauds may be tolerated: (1) fraud effects are diffuse, (2) the costs of fraud enforcement may exceed any direct benefits to enforcers, (3) pressures to handle the matter internally and/or (4) fraud control might negatively affect other aspects of the insurance business.

8.3.1 DIFFUSED EFFECTS

Insurance companies can share the risk of paying excessive, and even fraudulent, claims through joint associations and reinsurance mechanisms which allow companies to share the cost of

fraud and other high risk business with other companies (see Chapter 2 for more discussion on these mechanisms). No one company need feel the burden of fraud, since the cost of such activity is spread among participating companies. Thus, there may be little incentives to investigate. In fact, in criticizing the Massachusetts Reinsurance Facility for auto insurance, the Massachusetts Governor's Task Force on Auto Theft notes that

"Sharing losses reduces the incentive for individual companies to design special and innovative approaches to theft claims control." (Massachusetts Governor's Task Force on Auto Theft, 1980;27)

Fraud effects are diffused in yet another way. Fraud targets may recoup some of their losses through rate relief—passing the costs back to the consumers. Just as store owners capture the cost of shoplifting in the price of their goods, insurance companies capture some fraud costs in the price of their commodity. Premium rates are calculated, in part, on the basis of loss experience, a measure of claim frequency and severity. Since successful fraudulent claims increase loss experience they indirectly increase future premium rates as well. While the increase in individual premiums may be so small that individual consumers do not feel the effect directly, the aggregate effect may be substantial (estimates range in the millions of dollars).

8.3.2 ENFORCEMENT COSTS

Small claims are often paid with little or no investigation since if the claim is small enough, it is likely that the cost of investigating will exceed the claimed amount. The exact cut-off figure for a more-or-less automatic payment is not known. However, one might expect that the figure will vary across companies, since economies of scale may reduce investigation costs for some companies and not others.

Although denying small claims may not produce benefits directly, it may produce a deterrent effect which can benefit the individual company and/or industry in the long run. It appears, however, that corporate long-term strategies for tough claims handling are not necessarily transmitted to the street-level bureaucrats who must contend with heavy workload and other organizational pressures to limit costs for specific claims.

Proof of fraud may be difficult to obtain. When evidence confirming an offender's motive for fraud is privately held and difficult to extract, specialists are often needed. Since outside investigatory assistance is expensive, companies may prefer to limit some of their claim liability through routine claim process rather than expend the extra resources denying the claim and possibly facing a civil suit by the claimant.

Job pressures may force adjusters and other social control agents to ignore some frauds or to conduct only limited investigation into claim legitimacy. Texts on insurance note that suspected claims require more careful scrutiny and, thus, more work for adjusters (Webb et. al., 1981; Swift, 1975). Since most adjusters are juggling many claims at the same time, they may be reluctant to take on extra work unless they can be sure of a payoff.

Interestingly, the development of special investigative units for auto claims has taken some of the pressures off adjusters since now when fraud is suspected, the claim file is sent to those newly created units for further investigation. However, the mere volume of claims that would require more intensive investigation relative to the manpower available to investigate, assures that only a handful of cases will be investigated. An individual special investigator for auto theft fraud, for example, can handle between seven and twelve cases a month. The larger special investigative units only had four or five investigators. Thus, one unit can handle only some fraction of suspected frauds. The rest are handled through the normal claims process.

Claims managers suggest that legislation designed to protect consumers from unfair practices by insurance companies actually limit their abilities to combat fraud. They argue that legislation limiting claim settlement periods does not provide

adequate time for investigating suspicious claims. Unfortunately, data were not available to confirm or refute this argument.

Cost and expected outcome will also influence public agencies' willingness to take on insurance related cases. Public agencies are not likely to expend scarce resources unless the payoff (measured in number of arrests for large scale frauds) is substantial. In addition, many law enforcement officials suggest that insurance fraud is a private matter and that companies should be responsible for policing their own backyards [1].

8.3.3 HANDLING THE MATTER INTERNALLY

Company preferences for handling fraud privately rather than publicly (i.e. in criminal courts) may influence the choice of a particular enforcement option. Criminal processing is avoided as indicated by company reluctance to sign criminal complaints.

8.3.4 HURTING OTHER ASPECTS OF INSURANCE BUSINESS

The intense competition for insurance business may be associated with limited fraud enforcement if it leads insurance companies to "turn the other cheek" when certain clients submit

1. I suspect that this attitude changes depending on who commits fraud. While public authorities may not be inclined to prosecute one-time amateur fraud offenders, they may be extremely interested in large doctor-lawyer frauds or systematic arsonists whose activities extend well into the public arena.

suspicious claims. Insurance choices are often based on claim processing reputations. I have indicated in Chapter Two that competition for clients historically has led to liberalized claim settlements. Although the association between liberal claim settlement and fraud can only be inferred, my analysis suggests that insurance companies may want to maintain clients with whom they conduct substantial amounts of business so that small digressions from legitimate practices may be ignored.

Maintaining good relations with clients may place limits on the use of investigatory strategies. The suspect's role as insurance client may permit the questioning of claim facts, whereas other tactics, e.g. setting up inducements for fraud, are perceived as inappropriate to the insurance service context. If as suggested in Chapter 6, more aggressive investigatory tactics are necessary to document that losses are fictitious or physically created, they may not be employed in deference to the claimant's client role and, thus, the fraud will not be exposed.

8.4 GENERAL THEMES AND FUTURE RESEARCH

My analysis of insurance fraud as an example of crime mediated by or through corporate entities suggests that such behavior can be usefully understood by examining the ways in which organizational activities and structures both facilitate rule breaking and limit control. I have suggested certain conditions favoring the use of deception as a strategy for

unlawfully obtaining insurance benefits. These include, among others,:

1. The contingent quality of losses.
2. The lack of precision in the insurance commodity
3. The nature of claim process as a form of "street-level" work.
4. Claim negotiation tactics which encourage the use of deception and ease moral doubts about rule violation.
5. The qualities of deception which make it hard to evaluate.
6. Limits on the number and quality of vantage points for fraud recognition.
7. Diffuse fraud effects which limit control incentives.
8. Insurance goal conflicts which discourage social control efforts.
9. Mismatches between fluid processes of deception and fixed structures of conventional social control.

These themes which I have suggested are useful for understanding property-casualty insurance fraud can be applied more generally to four broader sets of inquiry.

1. Deception As A More Generalized Form of Rule Breaking
2. Client Rule Breaking in Street-Level Delivery Systems
3. Theft From Claiming Systems—Deception as a new currency of exchange
4. Creating Certainty in Complex Social Control Settings

5. Use of Computers to Detect Rule Violations

8.4.1 Deception As A More Generalized Form Of Rule Breaking

I have suggested that deceptions to claim insurance benefits unlawfully have certain characteristics that hinder conventional social control efforts. Because deceptive transactions appear no different than conventional ones, they are hard to recognize. Equally difficult are attempts to impute illegal motive on the part of those who employ deception since many deceptive actions can be justified as "innocent" misunderstandings. Future research might compare property-casualty insurance frauds to other frauds and then to other theft types. In so doing, one can determine whether the characteristics of deception identified in this research fit fraud types other than those studied here. One might compare frauds against different types of victims to draw out the effects of victim facilitation. From such an inquiry one might also develop more generalized conceptualizations of opportunity. Additionally, by comparing insurance fraud to other thefts where the dominant strategy is not deception, but rather violence or force, one might isolate those behavioral characteristics unique to deception as a strategy for crime.

8.4.2 Client Rule Breaking In Street Level Delivery Systems

This research has suggested that the complex working environment of insurance claims adjusters opens up avenues for client rule breaking. The thesis argues that environmental complexity—e.g. workload constraints, bureaucratic goal conflicts—helps provide opportunities for powerful clients to manipulate the discretion afforded to street-level bureaucrats. Previous research has focused on systems where the power advantage rests with the bureaucrat. Future research could compare different street-level settings in order to assess whether opportunities for client rule breaking suggested in this research are characteristic of street-level systems involving clients with relatively different levels of power.

8.4.3 Theft From Claiming Systems

As benefits supplement and/or replace wages and other traditional forms of property, the economy has come to rely on systems of claims-making and insurance. Future research should consider the problems of social order that accompany the shift from market-based to insurance-based economies. As social interaction organizes around claims-making, deception, in the form of insurance fraud, emerges as a significant source of social disorder. Examining other forms of insurance frauds—e.g. health insurance, welfare—one can begin to develop more generalized concepts for understanding this form of rule

breaking. Since my thesis argues, in part, that conventional social control strategies are inadequate or mismatched for fluid processes of deception, one needs to critically assess other measures of social control performance in claims-making contexts.

8.4.4 Creating Certainty In Complex Social Control Settings

In their efforts to control complex sets of transactions, social control agents have developed measures to routinize the process. My thesis has suggested that routinization has an inherent irony. It allows potential offenders to easily acquire the knowledge and means to subvert the system to their advantages. Historically, attempts to rationalize social control have focused on the agent—i.e. how to control agents' discretionary authority. As formal social control measures have expanded to include complex white-collar crime situations, new attempts to rationalize the process are being introduced which focus directly on the offence and the context of rule breaking. These new efforts appear to be aimed at creating certainty that offenders intended to commit the offences and had clear opportunities to do so. Future research might explore the variety of techniques social control agents have employed to rationalize or routinize crime control situations. Through such an inquiry one might be able to assess whether similar opportunities to subvert the system accompany efforts to create certainty in complex rule breaking settings.

8.4.5 The Use Of Computer Technology To Detect Rule Violations

As everyday transactions become computerized new means of policing those transactions are being developed. The use of computers to detect rule breaking in both private business and public programs has been heralded as one of the most innovative and cost-effective social control strategies available to government and business. However, computer policing raises new questions for conventional law enforcement and organizational control. Computer technology has increased opportunities for identifying certain types of rule breaking, but what types of violations are actually being exposed? What types of offenders? Computer policing will introduce changes in the occupational characteristics of social control agents. How will this change social control management? The expansion of computer technology into areas of social control also raises questions about individual privacy and civil rights. Future research needs to delineate types, goals, and targets of the new computer police strategies. Understanding the variation in computerized policing activities will inform public debate on the benefits and costs of applying computer technology to policing transactions.

1.0 SPECIAL INVESTIGATIVE UNITS

Many of the larger insurance companies have responded to the growing incidence of fraudulent auto insurance claims and, in some cases, fraudulent fire claims by establishing units specializing in fraud detection and investigation. These units operate out of regional or branch claims service centers in the larger metropolitan areas (Boston, New York, Chicago, Los Angeles, for example.)

During the course of this research interviews were conducted with at least one staff member in eight different special investigative units operating in one major metropolitan area. Officials from two units refused to be interviewed. Two special investigators permitted me to observe their daily routine. Observations were limited to a few days in each case.

1.1 The SIU Concept

The special investigative unit concept emerged out of an informal association of twelve insurance carriers writing a substantial part of the automobile insurance market in Massachusetts. The Massachusetts Auto Theft Committee was formed to address the growing incidence of auto theft and auto arson in the state [1].

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1. One SIU supervisor thought that then Insurance Commissioner Stone pressured the insurance community into forming the association after placing some of the responsibility for increased auto theft on the shoulders of the insurance industry.

The committee's goal was to pursue policies to decrease the incidence of auto theft and auto arson and to decrease insurance company liability associated with preventable, and sometimes fraudulent, auto claims. Their campaign was waged in the legislature (e.g. lobbying for legislation to increase penalties for auto theft and to change parts of the regulatory environment) as well as with the public (e.g. public relations campaigns encouraging insurance consumers to help prevent auto losses). The committee also discussed strategies for restructuring claim procedures to combat the increase in fraudulent claims. This discussion included the establishment of special investigative units in the larger insurance companies.

Public statements by insurers establishing SIUs tend to cite increased fraud incidence as the major justification for the specialized units. Although never documenting precisely the increase in insurance fraud incidence, "industry estimates" indicated that twenty-five percent of the auto theft claims filed with Massachusetts insurers were fraudulent and the problem was growing. Unfortunately, we have no way of knowing whether those figures are accurate.

Industry and company news releases cite increased fraud costs, ultimately borne by insurance companies, as the raison d'être of the new units. Cynics might note that the establishment of SIUs appeared to have as much to do with increased company costs as with increased consumer costs. Direct

costs to insurance companies were increasing because rate relief no longer adequately covered the increases in loss exposure [2]. Rising company costs also can be associated with the unique characteristics of fraudulent auto thefts. Auto theft frauds tend to involve a high percentage of unrecovered vehicles. When policyholders allege that their cars are stolen, but, in fact, ditch these cars into quarries, burn them or have them crushed into useless metal, the insurance companies have no salvage to sell after they pay the claim. Companies not only pay for these illegitimate claims, but, equally important, they are unable to get back some of what they paid through salvage sales. Since companies are paying illegitimate claims without any means to recoup some of their losses, they had strong incentives to start their fraud campaign with auto theft.

Coupled with rising cost was the insurers growing recognition that fraud investigation required some specialized expertise. According to one memo outlining the "need" for SIUs in a certain large insurance company.

"We have tried to surface this type of claim with our regular adjusting staff but because of demands of their other work, we have not been able to fully investigate and follow through for the best results. It is therefore, necessary to develop a Special Investigative Unit (SIU) whose sole function will be to thoroughly investigate auto thefts that give rise to suspicions."
(H-March, 1979)

One might argue that insurers only identified the need for

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2. At least the flat rating structure in Massachusetts would not allow insurance companies to charge higher rates for selected risks.

specialized expertise after they associated a reduction in fraud costs with their relative abilities to deny, rather than adjust, fraudulent claims. The orientation to suspected frauds shifted from simply reducing claim costs (adjusting) to negating liability (denying claims). In theory, the increased cost of investigation would be more than offset by savings associated with denied claims. [3]

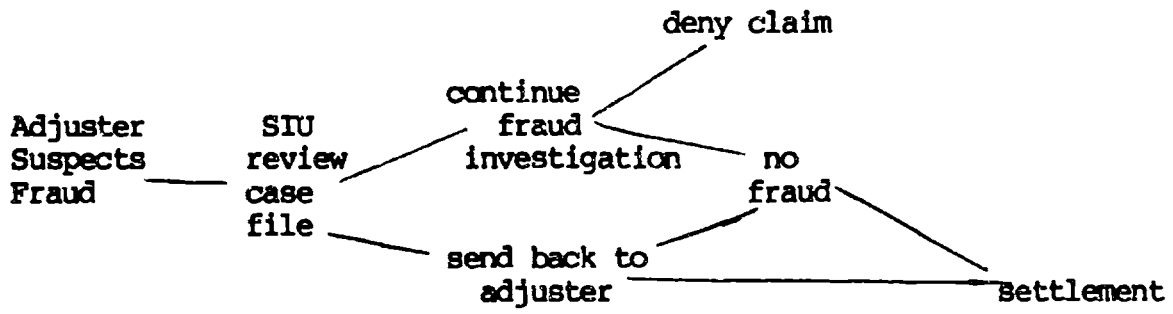
Although the SIU concept developed around the idea that the investigation of fraudulent claims required specialized expertise, companies differ in exactly how specialized investigation meshes with normal claims adjustment functions.

(1) In some companies, if a claim is suspicious, it is removed from the normal adjustment process until such time that SIU staff determine its legitimacy. SIU staff review the files. If further investigation appears to be warranted, it is pursued. If not, either because the claim seems legitimate or no clear path to proving claim legitimacy is available, the claim is returned to the original adjuster who proceeds with normal adjustment. (2)

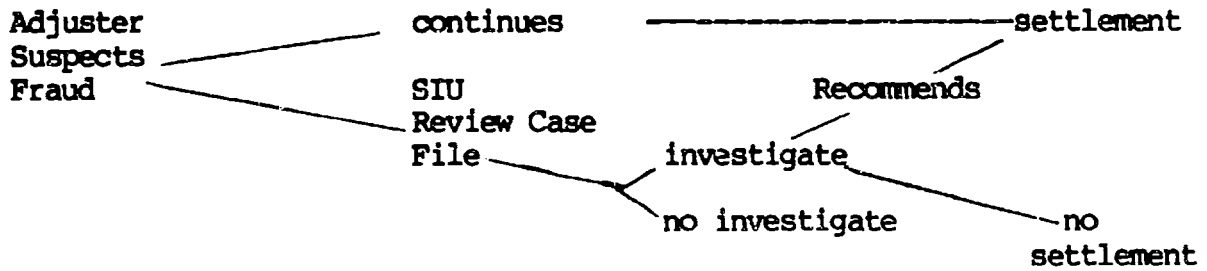
In other companies fraud investigations are conducted independently and concurrently with normal adjustment. Copies of claim documents are sent to SIU staff for further analysis. However, the adjustment process continues as if the claim is legitimate. The special investigator's evaluation of claim legitimacy is passed back to the adjuster with a recommendation

3. This is not to suggest that companies were not denying claims before SIUS were established, but that the focus or orientation to claims processing shifted.

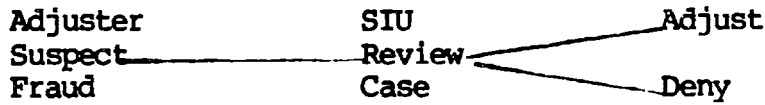
for further action (e.g. denying claims or disallowing certain claim items). (3) In at least one company the SIU staff member reviews suspicious claims and continues processing them until their conclusions/settlements. Once the SIU staff member reviews the file it "belongs" to him and does not return to the adjuster who initially referred the case. (See accompanying diagram for a map of the processes described above.)



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The organizational meshing of fraud investigations and claims adjustment reflects different orientations to the role of formal investigation in claims processing. Although, theoretically, all claims are evaluated or reviewed, there is a subtle distinction between claim verification or evaluation and investigation. Claims personnel recognize a difference between taking a second look at a claim and actually investigating a claim suspecting it to be fraudulent. The questions they ask are different and the processes used to collect information will differ as well. While adjusters focus exclusively on claim details, investigators examine loss circumstances and possible motives for fraud. Adjusters are the "front line" detecting possible fraud from the claim documents, while the SIUs investigate to ascertain whether the suspicions of fraud are, in fact, correct. Companies that remove SIU operations out of claims processing, either by physically locating SIU personnel away from the claims operations or by distinct functional task differentiation, confirm, organizationally, the distinction between adjustment and investigation.

Separating fraud investigation from adjustment allows insurance company personnel to quietly examine its suspicions without raising unnecessarily the wrath of its policyholders. In a publication produced by the Insurance Committee for Arson Control, the committee suggests that fraud investigations should be thorough, ". . . leaving no stone unturned." However, it should be discreet and confidential to avoid defaming the

insured's reputation and character." (Insurance Committee for Arson Control, 1982; 5) Companies aware of their reputation for claims servicing may prefer to maintain some distance between claims adjustment and investigation, only bringing investigatory techniques to the foreground when they are certain of their suspicions. SIU units that are part of the normal claims adjustment operation can not distance themselves in this way.

1.2 Mandate

All but one of the special investigative units were established to review exclusively suspicious auto claims, although some units take on a few non-auto claims as well. Most of the companies with special units require SIU review of all claims involving unrecovered vehicles or vehicles recovered totally burned as these conditions are often related to auto theft fraud. Other types of fraudulent auto claims are submitted to the SIUs at the discretion of field adjusters. Typically, unit investigators estimated that ninety-five percent of the cases they receive involve claims for auto physical damage or auto theft. Whether the SIU concept will expand into other areas remains to be seen.

Interestingly, the idea of special investigative units within companies has not, with a few exceptions, accompanied what is considered a serious fraud problem, arson fraud. Although frequently referred to as reaching "epidemic" proportions,

recognized fraud fires remain a relatively small proportion of the fire claims submitted through local branch offices. The exception is the FAIR Plan where there is a concentration of high risk business in the first place, and only one service office for a state or group of states. Because arson fires are relatively rare events for particular claims offices, arson experts are often called in only as needed. Some companies have fire specialists on staff, located at company headquarters, who can provide assistance to local offices. Although the effects of a single fraud fire may far exceed the effects of a single phoney auto theft claim, the relatively greater number of phoney auto theft claims submitted to a single claim office renders local fraud specialists an optimum solution for auto theft fraud and a less desirable one for arson frauds.

This research did not uncover any similar specialized units for personal injury/liability claims. A standard check into the legitimacy of a personal injury (third party) claim is routinely conducted by adjusters, examiners or private investigators. Note that, unlike first party claims (fire and auto theft, for example), these claims involve suits against the policyholder/client. Thus, the insurance company investigates claims, not simply to determine their value, but to see whether, in fact, their policyholders are liable for the losses claimed. The issue of liability requires, at the outset, more intense investigation. Claimants are visited at home and interviews with neighbors are conducted to establish that individuals are injured

as claimed. Whether these checks are conducted inhouse or by outside private investigators depends, in part, on available company personnel as well as the degree of surveillance necessary. While an adjuster might be well equipped to interview claimants and neighbors, outside consultants/investigators might be necessary for surveillance over several days or through extraordinary means, e.g. video-taping [4]. Thus, while company officials did not indicate that any specialized unit comparable to the SIU was in place for investigating fraudulent liability claims, companies may employ individuals who specialize in this area. Unfortunately, access to company employees who specialized in liability frauds was not forthcoming.

1.3 Personnel

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4. When companies suspect that claims are fraudulent they may hire investigators to take motion pictures of claimants showing the claimants engaged in activities that would negate their claims of injury. According to one claims investigator (Chernick,1969;126), a favorite film scene is the trip to the doctor. The insurance company either arranges a doctor's appointment for a certain day or finds out about a scheduled appointment. Investigators take pictures of the claimant leaving the house and going to the doctor. According to this investigator,

"Many a movie of a claimant shows him spryly walking out of the house, no limp, no pain, nothing. He climbs into his car like a teen-ager and zooms away. Next scene, the doctor's parking lot: the slow, torturous descent from the car, the suffering; walking on crutches, limping, half-dead. The same scene when returning to the car. . . Then, back at the house--no more crutches, a smooth walking gait..."

Companies may recruit individuals who specialize in this type of activity. One former police officer, now a member of an SIU, used to conduct "activity checks" for the company.

Special investigative units varied in size from one investigator to four or five. In the larger units a supervisor was responsible for case assignments and review. SIU staffs bring to the units a varied array of backgrounds and prior experiences. Some units are staffed by former claims representatives who have proved to be solid investigators. The larger units often include a combination of former claims personnel and former law enforcement agents. The ideal situation seems to be a combination of claims personnel and property appraisers who bring insurance experience to the unit and former law enforcement officials who bring investigatory training and law enforcement contacts to insurance investigations. Individuals are not recruited directly into the special investigative units unless they are recruited from the ranks of former police officers. Insurance personnel who enter the units do so only after a significant period of employment as insurance adjusters (no less than five or more years).

1.3.1 Case Referral -

Cases are referred to the special investigative unit from field or desk adjusters examining loss documents or even loss scenes. Field adjusters have been alerted to several "red flags" or signals for fraud that are suggested by their claim departments. (See chapter 5 for a detailed discussion of red flags.) Certain types of auto theft claims, cars recovered totally burned or unrecovered, are referred immediately to the

SIU.

Decisions to take a case for investigation depend on the quality and quantity of evidence. Investigators note that their cases are only as good as the initial information provided by the adjuster. However, since the SIUs have limited manpower, some cases are refused or accepted, not on their merits, but on the relative workload of the investigators. If workload constraints prohibit investigators from taking on a case, they might suggest possible paths for the adjusters to follow up on their own.

1.4 Outcomes

One of three decisions is possible. (1) SIU investigation can reveal no fraud on the part of the claimant and the claim will be paid. (2) In the course of their review, SIU personnel may discover that certain parts of the claim are, indeed, fraudulent and those pieces may be disallowed in the settlement. (3) SIU staff may suggest that the entire claim be denied. One SIU operation consisting of one person has investigated only 172 cases in its three year history. 92 claims (slightly more than fifty percent) were ultimately denied (interview no. 23). All SIUs report that their operations have led to net savings for their companies.

Whether or not a unit is considered cost effective depends on its dollar savings to the company. Savings are calculated by tabulating the claim dollars that would have been paid if not for the actions of the SIUs. Companies calculate savings by totalling the figures for claims that were denied outright plus dollar differences between claims submitted and actual claims paid. Thus, if after SIU investigation a claim was reduced from \$100 to \$50, the company would cite a \$50 savings. Commercial Union, one of the SIU leaders, noted that the first nine months of their two person operation racked up almost a quarter of million dollars in "savings." (Beacon August/September, 1978;3) The problems with this type of measurement are twofold. First, it is not clear that these savings would not have occurred without SIU intervention. Second, with respect to claims denied, it is not clear that the companies would have paid the total claim. In fact, normal adjustment might have reduced the claim by fifty percent. If so, the savings attributed to the SIU would be far less than claimed. Finally, we do not know whether the claim denials will be upheld in civil court, and, if not, if the companies will ultimately pay more than the original claim. Many of the cases have yet to come to trial and, thus, their ultimate dispositions are not known.

In a few instances SIU personnel have taken their information to local prosecutors who have initiated criminal investigations. This path is not taken often, according to SIU personnel, because prosecutors are not particularly interested in

isolated fraud cases. One investigator outlined the prosecutors preferred case type as the following, ". . .cases that will give them good press and good results [convictions]. They want 'six figure frauds' with conspiracies involving lots of people—certainly not less than a dozen."

Criminal prosecution is most likely to occur when several different companies band together and present their case. These cases usually involve fraud rings defrauding several insurers. Since no one company is singled out as the victim of fraud or as aggressively pursuing claimants, joint actions are often preferred. By joining together, no one company has to fear the stigma of being victimized nor any negative feedback for aggressive claims handling.

Investigators often mention the deterrent effect of the SIU operation. Who is being deterred? Some say the otherwise honest policyholder is deterred from making a fraudulent claim. However, that presumes that most claimants know about the SIU. I would guess that is far from true. Others say professional fraud offenders who might have reason to know of the SIU are deterred from submitting phoney claim with companies that have special units. If so, that is limited deterrence at best. If professionals are deterred from pursuing claims through certain companies, it seems reasonable to expect that we would experience displacement rather than deterrence. Professionals could submit their false claims through companies without SIUs. In fact, one

might argue that displacement could actually mean that an even greater number of frauds remain undetected. Suppose, for example, that professional fraud offenders no longer pursue claims through companies that have SIUs. If, instead, fraudulent claims are submitted to smaller companies which lack resources to undertake even the minimal investigations possible in the larger companies, we might experience more successful frauds overall [5].

Not all cases are investigated in pursuit of claim denials. Sometimes the SIU referral is used as a bargaining chip in the claim settlement process. In these situations investigators may look for ways to disallow certain claim items (interview no. 21).

All SIU personnel interviewed in this research credited the SIU concept and organization for improving the lines of communication among the various insurance claims departments and between the insurance community and law enforcement officials. The investigators provide direct points of access for inquiries about claimants' previous claims filed with other companies. The informal network has streamlined the cross-company inquiry system so that information useful to a particular fraud investigation can be received in a timely fashion. In the last year

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5. Perhaps one could find out whether there have been increases in the number of small company insolvencies since the introduction of the SIU in the larger companies. The problem is that insolvency could be related to simply higher losses (not necessarily fraudulent ones) or bad investment strategies.

Massachusetts has enacted legislation providing insurance companies with immunity from civil prosecution when they exchange information in the course of an auto theft investigation. SIU investigators believe that improved information flow has been the most important SIU development and has, more than any other fact, contributed to their efforts to combat auto theft fraud.

Information exchange between companies is not limited to individual inquiries about individual claims. SIU investigators meet regularly to discuss current cases and alert each other to problem areas. The investigators note that it was just such a meeting that led to the arrest of local residents involved in a large auto theft fraud ring. The investigators met and discussed similar looking claims, typically involving high priced automobiles, until they began to see a pattern emerge. Eventually, the investigators brought their information to the attention of a local district attorney who prosecuted the case.

The SIU network also provides a mechanism through which the insurance companies can share the cost of fraud investigations. It appears that the possibility of sharing costs is looked at favorably by insurance companies and may actually encourage them to pursue investigations which would not have been undertaken by one company alone.

Finally, STU investigators claim that the establishment of their units has increased cooperation from local law enforcement. Again, personal contact has made the difference. Before police officers were lucky to get through to a claims person at all. Now they have a name, number and a face to call should they need insurance information. Easing police access to insurance information has eased insurance access to police information.

2.0 INDUSTRY SUPPORTED ORGANIZATIONS

Industry supported organizations providing investigative services to insurers who suspect that claims are fraudulent are divided into (1) general claims services which include some components of fraud investigation and (2) organizations which deal exclusively with the fraud problem. Included in the first group is the Property Loss Research Bureau, a non-profit association of one hundred mutual insurance companies and the Property Claims Services, a subscription service of the American Insurance Association. Claims service organizations provide assistance to insurers faced with potentially fraudulent situations. In the second category are organizations which act independently of the claims process. The National Auto Theft Bureau (NATB) established in 1912 and the Insurance Crime Prevention Institute (ICPI) established in 1972 are two industry supported organizations responding directly to the fraud problem. This discussion is limited to the two organizations (ICPI and NATB) which focus primarily, if not exclusively, with the problems of insurance fraud and insurance crime.

ICPI and NATB are supported by insurance companies who pay a yearly membership fee to cover the cost of the agencies' operations. Both agencies were established to "bridge the gap" between insurance companies and law enforcement and appear more connected, philosophically and professionally, with the latter. In fact, neither agency operates to facilitate the claims process

directly. ICPI is excluded by its charter from assisting in claim settlement. In some states NATB has become so integrated into the motor vehicle registry and law enforcement systems that insurance companies are required by law to participate in NATB activities. Insurance companies must report all auto theft claims to NATB. (Massachusetts is one such state.)

2.1 Insurance Crime Prevention Institute

The Insurance Crime Prevention Institute is a nationwide organization supported by over three hundred and fifty mutual, stock and independent insurance companies. ICPI was established in 1971 to investigate fraudulent claims referred by member insurance companies and to determine whether criminal prosecution is warranted. Headquartered in Westport, Conn., ICPI has regional offices in New York, Chicago and Los Angeles.

According to its own publication, ICPI was created after increased fraud losses and associated costs prompted ICPI organizers to conclude that successful fraud investigation required full-time attention divorced from everyday claim negotiations. Companies recognized that fraud detection and control required lengthy investigations which often take longer than the typical claim settlement period allowed. Removing fraud investigations from the claims process provided greater flexibility since investigators were no longer constrained by statutory claim settlement limits.

Companies also recognized that fraud investigations were expensive, often more than one company was willing to bear alone. By pooling the cost of investigation among all member companies, the cost to any one company was reduced and became affordable.

Finally, companies recognized that fraud offenders were not bound by locale nor by company defrauded. Patterns of fraudulent activity crossed company lines as well as state lines. A nationwide organization servicing a larger number of insurers was thought to be better able to follow fraud than organizations based within single jurisdictions or companies. ICPI was established as a national fraud policing organization at a relatively low cost per company.

ICPI serves another function, although never explicitly stated. The organization stands as a symbol that the insurance industry is taking some responsible action to reduce fraudulent claims. Although fraud reduction may be more symbolic than real, the industry can use the organization to argue that they are, indeed, "policing their own backyard."

ICPI also can serve as a buffer between the insurance community and outside regulators (insurance departments or police). Information exchange may be processed through ICPI rather than directly through individual companies. Thus, ICPI can act as a screen to filter requests for information regarding insurance company operations.

ICPI was established to pursue cases towards a criminal justice outcome and is restricted from assisting claims processing. ICPI public relations material stresses the organization's role as a bridge between law enforcement and the insurance community. In fact, it would appear that ICPI is caught somewhere between a rock and a hard place. ICPI is divorced from the insurance community by charter and not officially connected to the law enforcement network. Unfortunately, this research did not systematically interview public law enforcement officials for their assessment of ICPI activities. The lore about the relationship between ICPI and traditional law enforcement, not empirically documented, is that ICPI public relations material overstates the positive relations between the two.

A cursory review of ICPI press releases reveals a disproportionate number of fraud cases prosecuted under federal mail fraud statutes as opposed to local insurance fraud statutes where they exist. One can speculate that to the extent that any relationship exists between ICPI and conventional law enforcement it exists at the federal level and primarily with postal inspectors. In fact, when asked about preferences for working with state, federal or local law enforcement officials, one ICPI official responded that federal jurisdictions were preferred. He believed that local jurisdictions were more susceptible to corruption by organized interests. The preference for federal jurisdiction may be more closely linked to the backgrounds of

ICPI agents than to any characteristic of state or local law enforcement agencies. A great many ICPI agents have had prior experiences as Postal Inspectors, FBI and even Secret Service agents. Carry overs from traditional rivalries between law enforcement jurisdictions and types of agencies may explain preferences for federal cooperation.

2.1.1 ICPI Mandate -

Although ICPI began its operations investigating only bodily injury claims, their mandate soon increased to include investigation of all types of insurance fraud except workers' compensation frauds. According to ICPI's eastern regional manager, the bulk of their work involves some facet of bodily injury claim. Doctor-attorney fraud organizations creating phoney or inflated medical bills in support of real or imaginary injuries are the most typical cases investigated. Slip and fall claims involving individuals who set up falls in public places (restaurants, supermarkets, etc.) and then claim against liability policies in force for those establishments are also typical. In the last several years ICPI has become more involved in arson-for-profit and fraudulent auto theft.

It is not surprising that the bulk of ICPI's investigations involve cases which involve a number of insurance companies defrauded by an individual or group of individuals. Because ICPI is set up as a nationwide support service for the entire

industry, it can obtain access to the files of any number of companies. This type of mandate and access is an advantage over locally based investigative agencies.

In addition to prosecuting insurance fraud offenders, ICPI is mandated to publicize these prosecutions. ICPI organizers believed that publicity will deter further frauds. To that end the Insurance Crime Prevention Institute publishes a newsletter which describes some of its most successful cases. Public relations staff disseminate information on ICPI activities to other news sources, law enforcement and the insurance industry.

ICPI staff also train adjusters to recognize fraud. Manuals, films, slide shows and helpful hints published in their newsletters are some training tools developed by ICPI. The organization also holds workshops and training sessions for fraud investigators and government officials.

2.1.2 ICPI Personnel -

ICPI investigators have all had prior experience in some other facet of law enforcement, typically service in one of the federal policing agencies—FBI, Secret Service, Postal Inspectors, etc. According to the eastern regional manager, investigators have averaged fifteen years investigative experience before joining ICPI. Although many of the ICPI agents are more senior investigators who have had previous experience in other types of investigation, ICPI is trying to lure younger

staff. They are looking for agents who might make a career out of insurance investigation rather than simply relying on individuals who come to insurance investigation only after a career in something else. Insurance adjusters (including the special fraud investigators) are not recruited or encouraged to become ICPI agents. Difficulties associated with shifting a person's orientation from routine claim settlement to criminal processing were cited as reasons for the non-involvement of former insurance personnel in ICPI activities.

Most investigative training is field training. A two to three week inhouse training session is held at company headquarters to familiarize investigators with peculiarities associated with insurance fraud. ICPI agents who enter the organization with only a minimum of investigatory experience (less than three years) work as partners with more senior agents.

2.1.3 ICPI Case Referral -

Member companies may submit suspicious claims for review by ICPI investigators. Generally the entire claim file is reviewed by a field analyst operating out of ICPI headquarters. If the analyst believes that further investigation is warranted, the file is sent to the appropriate regional office. The person I interviewed could not or would not say what criteria are used to select cases. Inquiries were made at ICPI headquarters but they were never answered. Public relations material indicates that in

fiscal year 1979-80 6,500 claim files were reviewed.

Within the regional office visited during the research, case assignment is based on workload. Occasionally a case may be assigned to an investigator because of his or her specialized expertise. Since many of the fraud cases cross state lines, sometimes even regions, more than one investigator may be assigned to a single case.

ICPI agents may also become involved in an insurance fraud case at the request of conventional law enforcement or on the basis of information provided by a private citizen/informant. Interestingly, ICPI refers to these non-insurance company initiated cases as "self-referrals" perhaps reflecting their greater identification with law enforcement than with their member companies.

2.1.4 ICPI Activities And Outcomes -

ICPI agents both conduct their own investigations, turning the results over to federal or state authorities when prosecution appears warranted, and participate in on-going law enforcement investigation providing insurance information as needed [6]. ICPI claims its activities contributed to over 1200 arrests in fiscal year 1979-80 an eleven percent increase from the previous fiscal year.

NUMBER OF ARREST TO WHICH ICPI
CONTRIBUTED *
BY TYPE OF INSURANCE CLAIM

<u>Fiscal Year</u>	<u>Liability</u>	<u>Property</u>	<u>Total</u>
1972-1973	221		221
1973-1974	443		443
1974-1975	506	36	542
1975-1976	511	171	682
1976-1977	392	269	661
1977-1978	601	489	1090
1978-1979	798	333	1131
1979-1980	739	490	1229

SOURCE: ICPI Press Packet Received

* The extent of ICPI's involvement is not known. Some cases may have been actively investigated by ICPI agents. ICPI may simply have secured insurance documents in others.

2.2 THE NATIONAL AUTO THEFT BUREAU

Established in 1912 the National Auto Theft Bureau (NATB) assists insurance and law enforcement communities in the recovery

6. Although they work closely with law enforcement, ICPI agents will not involve law enforcement officials until they are sure they have a case. Once ICPI agents officially advise law enforcement agents or ask them to become involved in a case, ICPI personnel become agents of the law enforcement organization and, thus, are bound by the same constraints as the public officials. Rather than constraining themselves unnecessarily ICPI agents will wait to officially inform public officials. We don't know how often unofficial communication circumvents these restrictions.

and identification of stolen vehicles and prevention of future auto thefts. A nationwide organization supported by nearly 500 insurance companies NATB acts as a clearinghouse for auto theft information. NATB maintains a data base of vehicle identification numbers for every car reported stolen, as well as information on salvage and stolen parts. NATB is the exclusive recipient of the "confidential" Vehicle Identification Number (VIN) used to identify vehicles when their outward appearances have been altered substantially. This information is available to law enforcement officials investigating vehicle thefts.

Although established initially as a voluntary association, NATB's constitutional charter authorized a change to not-for-profit status in 1979. NATB's change in status helped pave the way for agents more active participation in the pursuit and prosecution of auto theft offenders. In addition to their previous duties, the constitutional change authorized NATB agents to sign criminal complaints where

" . . .in the sole and independent judgment of the corporation [NATB] such action is deemed to be appropriate." (NATB Annual Report, 1979;8)

By standing as complainants NATB agents help initiate criminal prosecution in cases where heretofore it was "not practical" for individual insurance companies to act as complainants and NATB could not.

2.2.1 NATB Mandate -

NATB was established to assist in the prevention of motor vehicle thefts and related crimes and the prosecution of auto theft offenders. Five areas of concentration are outlined in NATB's information packet.

1. suppressing vehicle thefts including heavy industrial and marine equipment
2. identification of vehicles or equipment bearing altered or obliterated identification numbers
- 3 investigation of professional theft rings and frauds,
4. peace officer education in vehicle identification and theft investigative techniques,
5. maintaining a modern computerized record system designed to complement the foregoing objectives.

Several states have enacted legislation which requires insurers to report all vehicle thefts to NATB. In New York, for example, the Automobile Theft Prevention Act of 1979, requires insurers in that state to report all total vehicle theft losses (unrecovered vehicles or vehicles recovered with damages exceeding the vehicle's value—e,g, totally burned, stripped) to a central reporting agency designated by the Insurance Commissioner. NATB is the designated agency in New York state.

NATB also runs training sessions for law enforcement personnel. NATB agents have participated in local task forces formed to assist jurisdictions in combatting auto theft and auto theft fraud. Finally, NATB officials have lobbied state and federal legislatures for passage of laws the agency believes will reduce auto theft. NATB helped draft anti-vehicle theft legislation in several states (Massachusetts, New York, Illinois and Indiana, for example) and participated in US Congressional hearing on the Motor Vehicle Theft Prevention Act of 1979. NATB officials also have lobbied actively for more stringent and uniform salvage titling procedures.

2.2.2 NATB Personnel -

Data on NATB agents are extremely limited. Interviews with NATB officials indicate that a substantial number, if not all, agents come to NATB with previous law enforcement experience. The background of its agents emphasizes the law enforcement focus of NATB activities.

2.2.3 NATB Case Referral -

Inquiries into NATB's auto theft data base are made by insurance company personnel and law enforcement agents. A typical inquiry might be whether a particular vehicle identification number (VIN) has been previously reported stolen. NATB might also be asked to assist in identifying certain

vehicles or to conduct an investigation into suspected auto theft operations. Unfortunately, data on case referral are limited so that we are unable to speculate on whether the nature of these requests varies according to source (i.e. insurance or law enforcement).

NATB initiates some cases itself when, for example, NATB indices are used to uncover fraud rings. Every quarter the NATB salvage information system produces a list of all salvage valued in excess of \$250. These lists are forwarded to local NATB agents who work with state registry documents to determine whether the cars have been re-registered. According to NATB, the procedure can result in the exposure of stolen car rings using salvage as a cover for stolen vehicles. (informational memo, undated.)

2.2.4 NATB Activities And Outcomes -

Maintaining the North American Theft Information System (NATIS) is the keystone of NATB's activity. The index contains pertinent information on thefts of passenger vehicles, trucks, trailers, boats and construction vehicles. Data collected include identifying numbers, insurance information and loss details. Data on active thefts, i.e. non-recovered thefts, are stored in the system for five years. Information on theft recoveries is stored for two years. An "on-line" computer system, which by the end of 1979 held 1.5 million records,

provides immediate access to NATB information by vehicle identification number (VIN) or NATB record number. NATB agents receive inquiries from insurance company and law enforcement personnel twenty-four hours a day, seven days a week.

In their role as an information clearing house for vehicle theft, NATB maintains a stolen parts file (reports of stolen engines, transmissions, and boat engines) for five years. NATB agents can access manufacturers' production records on microfiche. Manufacturers' production records are the first chapter of vehicles biography and can be used to verify VINs at the time of manufacture, to provide information about where the vehicle was shipped after leaving the assembly plant, to trace vehicles and/or to verify a claimant's statement about where and when the vehicle was purchased. NATB also maintains, for four months, information on vehicles impounded to police custody. This information is provided to insurers to assist them in cases where claimants report losses after the vehicle has already been impounded.

NATB's most important contribution in the area of insurance fraud is as a clearing house for salvage information. Salvage reports include information on the sale of late model (less than six years old) salvage vehicles. Fraud offenders purchase certificates of title for salvaged vehicles and use them to insure non-existent vehicles. Then they report them stolen. Since the cars did not exist, they cannot be recovered. Should

the vehicle identification number of a previously salvaged vehicle appear on a subsequent theft report, NATB's North American Theft Information System will "marry" the theft report with the previous salvage report. This "marriage" prompts further investigation which might reveal an attempt at paper car fraud. As an indication of the insurance community's growing awareness of the auto theft fraud problem and the use of computerized indices to detect their own victimization, member companies increased their use of the salvage information data base by one hundred percent from 1978 to 1979 (NATB Annual Report, 1979;6).

NATB maintains limited information on vehicles that have not been stolen—in particular, vehicles wanted by law enforcement agencies and exported vehicles. Agents also have access to the NITISIS, FBI theft data base.

NATB serves the industry and law enforcement by providing both with information in a timely and concise fashion. As a central repository for information on motor vehicle thefts, NATB provides the insurance community with documentation of claimants' attempts to defraud them. By helping to recover vehicles NATB agents assist insurance companies in limiting their liabilities either by reducing claims paid (i.e. it may no longer be a total loss) or by the sale of salvage material. Importantly, NATB can usually provide this information in enough time to assist insurance companies in claim settlement.

Being able to respond quickly to vehicle theft inquiries is critical because thieves and the cars they steal are so mobile. Investigators note that a car stolen in one country can be found in another in a matter of days. Quick identification can prevent the fast exits of stolen cars. For example, in Miami, local police suspected that some of the vehicles stored in one of Miami's docks and slated for export to Haiti were actually stolen. The police called NATB to help identify the vehicles. NATB's investigators were able to identify over fifty vehicles as stolen. Some were stolen from as far away as New York and Massachusetts (NATB JOURNAL Summer 1980;9).

NATB's greatest assistance to law enforcement appears to be the identification of stolen vehicles and parts. In 1980 US customs agents called NATB agents to examine a number of automobiles awaiting exportation to Kuwait. The NATB agent discovered discrepancies in the vehicle identification characteristics which suggested that the VIN numbers had been altered. As reported in the summer of 1980, the investigation has led to the recovery of over 100 stolen vehicles (NATB JOURNAL Summer, 1980.) NATB agents worked with Connecticut state police to break a "chop shop" operation in that state. NATB agents were able to identify and trace three dismantled stolen cars.

NATB reports that in 1979 the organization assisted in the location of fifty-five (55%) percent of the 234,254 vehicles member companies reported stolen. They also report that in 1979

NATB agents participated in the investigation of 402 new theft ring cases resulting in the recovery of over four thousand vehicles. Also in that year NATB agents contributed to the prosecution of 949 individuals on charges of larceny, auto theft and fraud.

3.0 PRIVATE INVESTIGATORS

Private investigators conducting insurance fraud investigations are organized in many different ways ranging from lone operators to complex agencies where fraud investigation is one of many different functions performed by organization members. Unfortunately, this research cannot address differences among private firms. Interviews with other private investigators and caricatures of private investigators in popular journals confirmed similarities in approach and method, although some organizational differences clearly exist between the agency visited and other private agencies. Differences appear to be ones of size, personnel (background, training, competence) and style. While clearly important, further research is needed before any informed analysis of comparative types of private investigators can be drawn.

The description which follows is based on thirty days observation at the offices of one small private investigative agency and interviews conducted with the agency director before and after that period. The purpose of my visit was to review extensive case files of fraud investigations. During that time informal interviews were conducted with all agency personnel and inter-office activities were noted. As part of the research agreement, the name of the agency and personnel involved have been changed. Case details which might identify either the investigative subjects or the clients involved have also been

changed.

Ferret Inc. is a small firm conducting private investigations for a variety of clients. Insurance companies, private individuals as well as public authorities have requested Ferret's services. The firm began operating in the mid-seventies. Insurance investigations comprise a substantial part of their business. Nearly eighty-five percent of the total case load up until the time of my visit included insurance investigations, primarily arson investigations.

The firm's reputation in the field of insurance investigation is substantiated by its work with other investigative bodies and by the company's involvement in training other investigatory personnel. Agents have worked, on several occasions as consultants to federal law enforcement agencies, for example, the FBI, and ATF. The principal of the firm has organized several seminars on arson investigation for public law enforcement and has run training sessions for insurance personnel.

Because Ferret investigators work within a highly competitive market (there are many firms willing to engage in private investigation), a firm must be aware of its competitive edge, both in terms of investigation quality and cost efficiency. Trade-offs between cost and quality are often necessary.

Private investigators must also solicit business. Some private investigatory firms take steps to actively advertise their services and/or build up their reputations. For example, Pinkertons has a brochure outlining their investigative services and other, smaller, firms have produced similar materials. A large security and investigative firm operating out of Boston, Massachusetts has produced a number of manuals and training pieces outlining investigatory procedures. These materials are intended to establish that firm in the property fraud investigation arena.

While firms that provide both uniformed and, thus, highly visible guard and investigative service (for example, Pinkertons and Burns) may be comfortable advertising their services, firms which engage in more covert investigatory activity may be less inclined to advertise [7]. Firms which specialize in obtaining information discreetly may be reluctant to draw attention to themselves through advertisement. These firms depend on word-of-mouth reputation for their business.

Much of Ferret, Inc.'s business is generated by its reputation in the field. Ferret, Inc. obtains its insurance fraud cases from one of three major actors, the attorney

7. However, advertising may be a way to make covert and often illegal activities look legitimate. O'Toole (1978) discovered that Factual Service Bureau sales pitch claims that the company "specializes in securing medical records and information without patient authorization." In plainer language, according to O'Toole, the firm steals private medical records.

representing the insurance company in its defence of a claim denial, from claims personnel (either employed by the company or independents) or by a public prosecuting agency.

Looking at cases from Ferret Inc.'s perspective it is extremely difficult to determine why an insurance company refers a particular case to be investigated. The research reviewed only cases that were initiated with a minimal amount of information gathering on the part of the insurance company. Ferret's mandate was to provide a property scene examination (to determine that the fire was set) as well as investigation into the motive and opportunity for fraud.

Although most cases start at the claim settlement level and then, if appropriate, become criminal matters, there are some cases that are initiated directly by prosecutors. When public authorities initiate insurance cases there is some precedent for locating an insurance company which is willing to finance the private investigators activity. For example, the fire history of a group of owners was brought to the attention of the state prosecutor by a local community group demanding action against the suspected offenders. The prosecutor asked that investigators from Ferret, Inc. be present at the meeting with community leaders since Ferret had been involved in related investigations. Ferret's future involvement in the case, however, was predicated on an insurance company's willingness to finance the investigation.

In a celebrated Massachusetts arson case which resulted in the indictments of over thirty individuals on arson related charges, extensive private investigation was financed by the Massachusetts FAIR Plan. (Urban Educational Systems, 1980; 7) According to an assistant attorney general, the insurance industry gave what amounted to a blank check to finance the investigation. The money was used to maintain protective custody for the government's chief witness, to pay overtime for state employees and to supplement the attorney general's investigation through private efforts.

Ferret Inc. provides full investigative services for its insurance company clients. Typically, investigators provide companies with sufficient information to deny claims suspected to be fraudulent and/or to successfully defend claim denials in civil suits brought by claimants. Clients detail the extent and scope of the investigation. Some clients request fire scene investigations to determine cause and origin of the fire and nothing further. Other clients may have enough information on "cause" and want Ferret to develop the motive and opportunity for the fire. Still other clients want Ferret investigators to start with the determination of cause and continue investigating the motive and opportunity for the fire.

Without a client, someone who is willing to "foot the bill", Ferret Inc. will not continue its investigation, no matter what stage the investigation is in when the funding stops. Thus, the

nature of the investigation is determined, in part, by how much money the client is willing to spend on the investigation, an amount often negotiated before the investigation begins. As a result, some investigations are stopped far short of their stated goals of establishing fraud [8]. For example, in one Ferret Inc. case, investigators were fairly close to identifying the "torch," who they hoped would implicate the insurance claimant as having arranged for the fire, when funding stopped [9].

In some cases, however, insurance companies will authorize a minimal amount of money to conduct a partial investigation. A company might finance only a partial investigation if it simply wanted to enhance its bargaining position with the claimant (i.e. to increase its adjustment and lower the amount of claim paid.) In one case assigned to Ferret, the attorney representing the insurance company simply wanted Ferret to find out how much a potential buyer had offered for the claimant's property. The attorney calculated that if the bid was lower than the potential payment, the company could adjust the loss to the lower figure.

8. Of course this could also mean that some investigations are drawn out to fill out the negotiated amount.

9. One caveat must be noted. This case was investigated several years ago when insurance companies were apparently less inclined to pursue arson investigations. If a similar case appeared today, it is not clear that one would be telling the same story. However, discussions with Ferret investigators and other close to arson investigation and prosecution could lead one to speculate that this scenario is possible today even with all the increased media attention on arson-for-profit and insurance company promises to pursue suspected fraudulent claims to the end.

One might also speculate that companies invest in partial investigation because they believe that the true, and larger, effect is deterrence. The impression that a company is investigating is more important than any one conclusion.

Investigators do not see any systematic patterns in company decisions to follow through on any investigations. Although size of the claim makes something of a difference, other factors—principally the ongoing relationship between Ferret investigators and clients seems to play an important role as well.

Several of the arson cases involve a number of property losses and include the investigative efforts of several private companies. One attorney may represent a company in several losses and distribute the investigation of those losses to a few companies. On a few occasions these separate investigations have implicated the same group of individuals. Then the attorney might join the investigations together asking each to work in conjunction with the other. That, too, has its problems. The firms are often competitors and working relations are tense.

When a case initiated by an insurance company turns into a criminal case, the insurance company will often direct Ferret to work in conjunction with public authorities. Thus, Ferret becomes an indirect agent for the prosecuting authority. There are other cases when Ferret acts as a direct agent for the prosecuting authorities. In these instances, Ferret

investigators work as consultants to prosecutors and are paid directly by the public authority. The distinction between direct and indirect agency is based primarily on the source of payment and not on any substantive differences in activity. Every insurance case researched here was financed by the relevant insurance company.

3.1 PERSONNEL

Ferret, Inc. is a small outfit employing less than ten investigators. It is privately owned and individually managed. The firm is licensed. Individual investigators within the firm are not individually licensed.

The investigators who now work for Ferret, Inc. have little or no public law enforcement experience, although some do have military training [10]. In addition to Fred, the principal owner, and his investigative staff, the firm employs, full-time, an office manager whose responsibility appears to be to keep the office running smoothly and money coming in. Two secretaries

10. The prior experience of Ferret investigators is quite different than that of the more institutional fraud investigators. A majority of agents working for the Insurance Crime Prevention Institute and the National Auto Theft Bureau, private organizations funded by member insurance companies, have had previous experience in law enforcement either at the federal or local level. The director of Florida's Division of Insurance Fraud came to that post from the FBI. All of the Division investigators have had prior law enforcement experience. Special Investigative Units established in claims departments of many of the larger insurance companies tend to have a mixture of former claims staff and former law enforcement agents.

work hard keeping the voluminous amount of paperwork in order.

Other "consultants" (loosely defined) are brought in to a case on an "as needed" basis. For example, an accountant might be called in to go over a "subjects" books. Analysis of fire scene samples are undertaken by other private firms. Similarly, voice analysis, undertaken more often in the past than presently, are contracted out to a related firm. Other actors, whose primary assets appear to be muscle, are called in when things get rough.

The Ferret, Inc. approach to investigatory activity most resembles a team approach. A single case is divided into tasks which are assigned by Fred to his staff. Investigators are responsible for their piece of the puzzle. Sometimes an investigators "pieces" add up to the entire case, but most often, they do not.

While tasks are easily differentiated—e.g. interviewing, surveillance, document research—, the division of labor is not that precise. Although some investigators are known to be better at one thing than another, and, thus, may be asked to do that task more often, there is no clearly defined specialization within the firm.

3.2 ACTIVITIES AND OUTCOMES

Tasks are assigned, verbally or in writing, to the investigators on a daily basis. The tasks may be to uncover general information, for example, to run a "city hall check" (background check) on an individual or quite specific information, e.g. to find out whether a certain individual has ever owned a specific piece of property. General information may be bound by a specific locale, for example a city hall or civil court. To find the answer to a specific question, however, an investigator may have to search records in a number of different locations. Some tasks are performed as the situation arises. The case files were full of tidbits of information jotted down by investigators during the course of some other activity in hopes that the information will prove useful in the future. Investigators must be flexible enough to pursue any lead that arises.

Documents are researched for background information on all subjects of an investigation—both people and properties. Investigators rely on public records in the early stages of an investigation. However, at later stages, investigators often research private records, (e.g. cancelled checks, credit histories, etc.).

In some cases recorded information will not provide all the necessary data to determine or infer that there has been fraudulent activity, the opportunity for that activity or the motive. Despite the fact that frauds are never actually witnessed, observations can be essential to criminal prosecution of frauds. Observations about the loss (e.g. burn patterns) and the claimant's activities after the loss are often needed to complete a fraud scenario.

Interviews are conducted with individuals who can shed light on the policyholder/claimant and circumstances surrounding the loss claimed. Public safety officials are interviewed for their version of events surrounding the loss and for background on claimants. Insurance principals—agents, claims representatives, etc.— are interviewed for their impressions of the claimant. Neighbors, friends and witnesses are also interviewed.

An investigator needs to carefully document his/her activity in the event that the case file is subpoenaed and/or to establish appropriate client billing. Investigators take notes during all activities, even during interviews which are recorded. Information obtained from documents is taken down in note form even though, in some cases, the documents are copied. Field notes are organized into memos detailing an investigator's activities.

Reports provide the insurance company and/or its attorney with information that can be used in the company's defense of claim denials. The reports contain facts only. Conclusions are rarely developed directly in the body of the report, although occasionally investigators will include a list of discrepancies between statements and events.

Ferret investigations produce a variety of outcomes ranging from determination that claims were legitimate to criminal cases of fraudulent intent. Surprisingly, Ferret investigators were not always aware of the final dispositions of their cases. Often times the firm would produce a report for a client and never hear another word about the case [11]. In several cases Ferret investigators turned their information over to federal law enforcement authorities. The disposition of those cases was not known [12].

Attorneys might ask Ferret, Inc. to verify some points in

11. We can assume that these claims/cases were paid or that the claimants did not press their cases in civil court. If litigated, it would be highly likely that Ferret investigators would have to do some additional investigative work on the case.

12. Why wouldn't Ferret Inc try to learn about the ultimate disposition of their cases? Perhaps because they saw no benefit to doing so. They were paid. It is not clear that they would have any incentive to spend time finding out what happened with their investigations.

My curiosity about case outcome prompted me to ask Fred to call the federal law enforcement agents who was supposedly directing the case. He did and we learned that the federal agents were sitting on the case. It was clear to us that no further action was anticipated.

their initial report. Typically requests for clarification are made right before the cases are ready for trial, anywhere from six months to several years after the initial investigation began. The lag between initial investigation and trial date produces serious problems for investigators, particularly when clarification required re-interviewing witnesses, neighbors etc. Because people are so mobile, it is difficult for investigators to track down individuals a year after their original statements. Memories tend to fade and, after a time, facts become distorted. Inconsistencies in statements obtained a year apart may cause the initial statement to be disregarded [13].

Establishing and maintaining a relationship with public law enforcement is a critical component of a private firm's reputation and/or investigatory success. Fictional detective stories are replete with examples of the uneasy and suspicious, often negative, relationships between "gum shoes" and the local police lieutenant; a fiction which is apparently not too far from reality [14].

A solid reputation with public law enforcement, however makes obtaining that information far easier and, thus, boosts the

13. One can see how this could work to the advantage of the fraud offender. To the extent that successful cases against fraud offenders rely on the construction of a story that contradicts the one proposed by the claimant, time lags in investigation may work against the insurance company or the state.

14. One wonders why, if so many private investigators are former police officers, the private eyes are so mistrusted by public law enforcement.

quality of an investigation. A good relationship with public safety officials can often mean future business opportunities, especially with respect to arson investigation. Public officials can be on hand to actively promote one company or another. Some of Ferret, Inc.'s cases have been generated after fire officials advocated for Ferret's services.

Private investigators can invest in securing future, beneficial relations with public law enforcement by helping to upgrade the reputations of public officials. They can do so by providing public officials with information that could allow public officials to successfully complete an investigation. Or, public officials can be allowed to take credit for activities that were actually undertaken by private investigators.

Personal contacts with prosecutors may influence whether cases will be prosecuted. Cases that are criminally processed often, but not always, require more investigation than other cases. Thus, from the point of view of firms like Ferret, Inc. these cases are preferred. I examined what, on the surface, appeared to be two similar arson cases. One ended up in criminal court, the other did not. When I asked investigators what accounted for the difference, they told me that a large factor was Ferret's personal contacts with the local prosecutors involved.

4.0 STATE RUN FRAUD BUREAUS

Three states have granted legislative authority to a single agency to devote exclusive attention to the investigation and eventual prosecution of insurance fraud cases. Florida's Division of Insurance Fraud, created in 1977, is the model for the establishment of fraud bureaus within state insurance commissioners' offices. The California Division of Insurance Fraud began its operations in 1979. The New York Fraud Bureau began its operations in November, 1981. New Jersey has recently passed legislation calling for the establishment of a fraud bureau. Three other states, Nevada, Louisiana and Idaho have proposed bills to establish similar fraud units [15].

In June 1980 the National Association of Insurance Commissioners (NAIC) drafted model legislation for the establishment of fraud units in state departments of insurance. The purpose of these bureaus, as defined in the legislation is to investigate persons and companies suspected to be in violation of insurance fraud statutes or other provisions of the insurance

15. Massachusetts formed a fraud bureau, now defunct, in the early 1970s. Information on its operations is limited. At one time, as many as 50 individuals were employed with the agency. Interviews with insurance executives in the state revealed that the Massachusetts Fraudulent Claims Bureau (FCB) was perceived as a dumping ground for political patronage appointments, a perception which has tainted opinion on the efficacy of state run fraud bureaus in general. On several occasions questions about the efficacy of state fraud bureaus prompted replies such as "not if it's set up like the Fraud Bureau we had here in Massachusetts". The FCB was dismantled in 1975 after the introduction of no-fault insurance and the beginning of a new state administration.

code.

According to the legislation, fraud division investigators are granted authority to administer oaths, to serve subpoenas ordering the attendance of witnesses and to collect evidence. Evidence obtained through the division's investigative efforts is confidential and division investigators are not subject to subpoena in civil matters, i.e. suits filed by policyholders against insurance companies for the recovery of claims that have been denied. The model legislation grants peace officer status to division investigators and, thus, grants to them the power to make arrests and subjects them to all laws applying to peace officers in their state. In addition, the model legislation calls for insurance companies to report suspected insurance frauds to the divisions and grants civil immunity to companies and their employees who file such reports.

A key feature of the model legislation is the granting of law enforcement powers to fraud division investigators. Neither the Florida nor California Divisions began their operations with such status, however, it soon became apparent that such status was necessary for effective enforcement of statutes which made the filing of false insurance claims a prosecutable, criminal felony. It was extremely important, the NAIC reported, that division investigators be allowed to secure their own arrest and search warrants.

Although the task force report does not indicate why peace officer status is so critical to the efficacy of the fraud division's efforts, one can speculate from Florida's experience. Convincing local law enforcement officials that filing a false insurance claim is a serious crime worthy of public attention has been a large and sometimes difficult task for fraud division investigators. Asking an already overburdened local law enforcement agency to take the necessary action against insurance fraud offenders is an even greater task since resource constraints make public investigation into even the more violent crimes problematic.

Immunity legislation is a critical component stressed in the NAIC model legislation. Statutes providing limited civil and criminal immunity to insurance companies releasing information to law enforcement officials have been enacted in several states, often states without established fraud bureaus. These statutes protect insurance carriers from legal action or punitive damages regarding any information they provide, in good faith, to law enforcement agencies. The new "arson-reporting" immunity legislation is heralded by the industry as the keystone to combined efforts of the insurance and law enforcement community to combat arson as it allows for the exchange of information, potentially critical to an investigation, which would have previously been withheld for fear of a civil suit. Robert McKenna, director of Florida's Division of Insurance Fraud, reiterated the importance of immunity to fraud division success

in his assessment of the Florida Division's first year of operation. He claimed that without the immunity provision, insurance industry cooperation would not have been forthcoming. The legislation, however, tends to be specific to arson related information and, in many cases, is not generally applicable to insurance fraud. Prosecution of other forms of insurance fraud in jurisdictions which have only limited forms of immunity is, thus, more difficult.

4.1 FLORIDA'S DIVISION OF INSURANCE FRAUD

Florida's Division of Insurance Fraud is headquartered in Miami with field offices in five other Florida cities, Tampa, Orlando, Fort Myers, Tallahassee and Jacksonville. Nineteen full and part-time investigators are employed by the agency which began its operations in April 1977.

Funding for the Division of Insurance Fraud is generated from insurance companies writing business in the state. Each company writing fire and casualty insurance is assessed an identical amount to provide for the operations of the Division. In the next fiscal year (1982-83), however, the division will be funded through the state's general revenues, an indication of the state's commitment to combat insurance fraud. Independent funding has been strongly advocated by Division personnel. Detached from industry dollars, the Division can assert its independence from the insurance community. Although never an

agent of the insurance industry, the Division's dependence on insurance company assessment may have created the perception of special interest to insurance companies and limited the Division's credibility with other law enforcement agencies. Independent funding, thus, assures the Division of its place as part of the state law enforcement network. The importance of independent funding is underscored by the NAIC proposal which states that the cost for administration and operation of the fraud units should be borne by the general revenues of each state.

Efforts toward criminal prosecution of insurance fraud offenders do not impinge on the civil processes of claim settlement. The control of fraudulent and criminal behavior is not directly related to the disposition of specific claims. Division action cannot be used as a means to hold up payment or better a company's bargaining position with respect to claim settlement. If a company requests Division investigation into a suspicious claim which has not been paid, the company must be prepared to deny the claim and face a civil suit by the policyholder or pay the claim. Clearly, if the company denies the claim and the case then goes to civil court, criminal action against the claimant would make a successful defence of the civil suit far more likely. (Note that a case goes through criminal process faster than civil so that the outcome of the criminal action will most likely be known at the time the civil case is tried.) Similarly, if the claim had been paid prior to the

Divison's investigation and that investigation resulted in a criminal conviction, a company can hope that restitution to the company will be part of the sentence imposed on the offender.

4.1.1 Mandate—Florida Division Of Insurance Fraud -

The Division began its operations in 1977 with the authority to investigate only motor vehicle accident frauds. These frauds generally included staged accidents, ambulance chasing and/or doctor-lawyer frauds. The later fraud scheme utilized unsuspecting accident victims to boost and create doctor bills for injuries sustained in real accidents. Compensation went directly to the doctors or lawyers, the accident victims often knew nothing about the inflated claims made on their behalves.

Within a year the authority to investigate insurance frauds had been extended to all types of frauds. As of July 1979 the Division had set up eight categories of fraud based on type of loss claimed. Fraud categories are assigned by case supervisors at the time a case is opened for investigation. The eight fraud categories include: (1) motor vehicle accident frauds, (2) workers' compensation frauds, (3) miscellaneous medical and health frauds, (4) frauds concerning stolen or damaged property—auto, homeowner and commercial property, (5) fire insurance frauds (including, but not limited to arson), (6) life insurance frauds, (7) frauds by insurance companies or agencies against policyholders, and (8) bond and surety frauds.

Cases Presented for Prosecution
 July 1, 1979-June 30, 1980
 which have reached FINAL disposition *

FRAUD CATEGORY	N=	(%)
Motor Vehicle Accident	8	(14%)
Workmen's Compensation	5	(9%)
Miscellaneous Medical & Health	7	(12%)
Stolen & Damaged Property	25	(43%)
Fire Insurance	2	(3%)
Life Insurance	0	0
Companies/Agents	11	(19%)
Bond & Surety	0	0
	<hr/>	<hr/>
TOTAL	58	(100%)

* Because classification of fraud cases into one or the other categories is primarily a matter of judgment and is sometimes inconsistent, at least for the purposes of research, I found it useful to re-classify certain cases. For example, I included certain auto physical damage claims resulting from motor vehicle accidents in the first category "motor vehicle accidents" rather than the fourth category "stolen and damaged property." This was done in an effort to make the categories consistent within the sample. Thus, all frauds resulting from motor vehicle accidents, despite the nature of the claim (i.e. personal injury or physical damage) are included in the same category. Similarly, I considered all frauds by insurance personnel against their employers and/or policyholders under the category of "company/agent" despite the type of policy used to defraud. As a result there are some slight discrepancies between my category statistics and those available from the Division.

4.1.2 Activities-Division Of Insurance Fraud -

4.1.2.1 Case Processing: -

The major thrust of the Division's activity is the investigation of fraudulent claims. Investigation into fraudulent claims is a specialized activity within the state law enforcement network. Division investigators maintain a separate "investigative index" for their own use which is not available to insurance personnel. Standard measures of protection for information obtained through law enforcement activities applies to the Division's investigations as well. These activities are described in greater detail in the main text of the thesis.

A second, related activity, however, is the maintenance of two indices for the insurance industry, a bodily injury index and a fire and stolen property index, which provide insurance claims personnel with the prior claim histories of their claimants. Claim indices provide a mechanism through which repeated attempts at fraud can be recognized. If a claimant's name already exists in the index, copies of information from the current claim and information on all previous claims entered into the system are sent to the current insurer. Instances where claimants are attempting to obtain payment from two companies, simultaneously, can be detected. Similarly the indices can detect when policyholders try to claim items for which they had been previously paid-for example, a man claims that a watch was stolen

in March 1981 and a check into the stolen property index reveals that he claimed and was paid for that same watch in January 1980. A cover letter is attached to these "claim histories" outlining the correct referral procedures should the company formally request investigation by the Division.

Division investigators swear to the affidavit of complaint, thus relieving insurance companies from being on record as complainants in any one case. Interviews with fraud investigators, claims managers and prosecutors in a number of jurisdictions have disclosed that insurance company reluctance to sign complaints is common and when such reluctance exists the chance of getting a case prosecuted is greatly reduced. Organizations like the Fraud Division expedite (both politically and organizationally) complaint signing and, therefore, we might see a greater propensity toward criminal prosecutions where these organizations operate [16].

4.1.2.2 Information Brokering: -

Perhaps the most important Fraud Division role is as advocate for the prosecution of insurance fraud and broker of insurance fraud information between relevant parties. Division personnel believe that prosecutors must be convinced that insurance fraud is a prosecutable crime; insurance claims

16. May explain why companies will support the Division despite the fact that some of its activity is directed against insurance company employees.

personnel as well as traditional law enforcement agents must be shown how to recognize fraudulent situations, what evidence to collect and where to take that evidence once collected; prosecutors must be given cases that are understandable and are presented in a useful format; victims of insurance fraud schemes must be informed that an agency exists for their protection. Finally, in order for there to be any deterrent effect to the division's activities, investigators argue the public has to be educated that insurance fraud is a prosecutable offence for which an offender will be punished.

The Fraud Division provides a link between the insurance community (where these "crimes" occur) and prosecutors. According to the director of the Fraud Division, prior to the Division's inception, communication between the insurance industry and the prosecutors was limited at best. Insurance industry personnel concerned with what appeared to them as gross incidents of fraud were unable to distinguish what was apparently fraudulent from what could be provable fraud. Prosecutors, on the other hand, were not able to penetrate the insurance jargon and unorganized claim files which would form the basis for their cases if they accepted them. The director of California's Division of Insurance Fraud also noted the reluctance on the part of the prosecutor's to go after fraud because

"it's very difficult and time consuming. . . that's why, frankly, the new bureau was created--so we could bridge the gap between law enforcement and industry."

The Fraud Division takes a fraudulent claim story from the insurance community and translates it into a criminal scenario which is understandable to the prosecutor. Under the assumption that a prosecutor, given limited resources, is more likely to take a case that is strongly presented, the Division has developed a "prosecutor's summary" which details the division's case in a standard format and outlines the case, evidence and witnesses in a manner useful for trial preparation. This summary is presented to the state attorney who then decides whether or not an arrest should follow from the Division's investigation as it has been outlined in the report.

Division personnel believe that if law enforcement agents are more familiar with insurance fraud schemes and the activities of the Fraud Division they will be more likely to recognize possible frauds and more likely to collect information useful for Fraud Division investigation. Similarly, prosecutors, given the proper information, would be more likely to begin criminal action against suspected fraud offenders.

Since most prosecutors and law enforcement agents are not familiar with insurance fraud cases, the Division has produced the "Insurance Fraud Investigation and Prosecution Assistance Digest" designed to illustrate problems typically faced by insurance fraud investigators and prosecutors. Problems addressed include: filing a criminal information before the facts are in; witnesses changing stories during the course of an

investigation; multi-jurisdictional problems; difficulties with proving intent, etc. Similarly, the division has produced an investigators manual, a case manual developed to ". . .familiarize investigators and other law enforcement agencies with the kinds of insurance fraud being committed here in Florida."

Through the use of "Special Fraud Bulletins", the Division alerts companies to be on the lookout for alleged fraud offenders. Although obtaining information from the companies was the intended use of the Bulletins, insurance companies also receive information on who and what to watch for in their own operations.

Finally, public relations activity is an important division function believed to effect the public's willingness to report criminal activity and as a deterrent. Informing the public that insurance frauds by and against companies are criminal felonies in the state of Florida, that people are indeed prosecuted for these crimes and that offenders are sentenced to jail, can act as a deterrent to potential fraud offenders and can increase crime reporting from those who have been victimized. A standard press release form is filed after each arrest and conviction.

4.1.3 Outcomes-Florida Division Of Insurance Fraud -

During my field visit with Florida's Division of Insurance Fraud I had the opportunity to review cases that had been presented for prosecution during fiscal year July 1, 1979 through June 30, 1980. Only those cases which had reached their final disposition were subject to review. Cases presented for prosecution were those investigated by the Division, either independently or in conjunction with another law enforcement agency, and formally presented to the state attorney for prosecutorial consideration. Cases that had reached their final disposition were disposed through criminal action (either a conviction, acquittal, dismissal or pretrial intervention,) or finalized because the prosecutor did not wish to prosecute, the case was dropped by the Division or the offender remained a fugitive. Cases excluded from this small study were those for which criminal action was still pending or cases for which no decision regarding prosecution had been made by the state attorney.

Eighty-eight cases were presented for prosecution between July 1, 1979 and June 30, 1980. 58 (66%) were included in my sample. The records for two cases presented during that period were sealed by the court upon final disposition and, thus, were beyond my review. 11 (12%) cases were closed, but unavailable because the records were at another location. (Note: All 11 cases were out of the Tampa field office.) 17 (19%) cases were

still pending at the time of my review [17].

Prosecutors decided to proceed with the prosecution of 45 (78%) of the cases presented. Arrests were made on 44 cases, one alleged offender remains a fugitive. In 12 (21%) cases prosecution was declined and, thus, no arrests were made [18].

The reasons for declination were often stated in the case files. In some instances prosecutors indicated that justice would not be served by prosecution or that the case lacked criminal intent and more properly belonged in civil court. Cases were declined because victim/witnesses changed their stories or refused, after initially agreeing, to cooperate. In other cases prosecutors felt that Florida was not the proper jurisdiction in which to try the case or that the case didn't fit within the administrative guidelines of their offices. Prosecutors' declined to prosecute one case in exchange for information on other crimes. Finally, the statute of limitations had elapsed before prosecutors made a decision to proceed on another case.

17. Using the Division's statistics on the total number of cases presented, broken down by case number category, I compared my sample with the total. My sample is fairly representative in terms of fraud type, although it may underrepresent, slightly, company/agent frauds and overrepresent miscellaneous medical and health insurance frauds. Clearly, the sample is biased against cases that take a long time to get from presentation to disposition.

18. As is true with much white collar crime enforcement, (Hagan, Nagel and Albonetti, 1980) summary arrests are not the norm. Division of Insurance Fraud investigators must get the approval of a prosecuting attorney before affecting an arrest.

Several cases for which arrests were made were never "officially" prosecuted. Three (7%) cases were dropped because a victim/witness changed his/her story or because the defendant cooperated in another case. Offenders in 6 (14%) other cases were referred to pretrial intervention programs.

One study of prosecutor discretion to continue a case notes that the decision to drop the prosecution of a suspect already charged is a visible one, subject to exposure by the media and, thus, public reaction becomes a critical variable in the decision-making process. Public outrage to the visible charging of a suspect might occur when the public believes that someone has been wrongfully accused or when the public identifies with the accused. In such instances charges might be dropped [19].

Most discussion of public reactions to prosecutorial discretion ignore the fact that the persons accused need not be quiet bystanders, and, instead, may take initiatives to influence public opinion. The media can be used to manipulate their images so that prosecution appears unjust. Fraud Division investigators relate a story involving the arrest of an insurance company executive accused of adding coverages on policies and hiding the cost of those coverages in the premiums. After his arrest, the

19. With respect to employee theft, "Perhaps one of the most important reasons for infrequent prosecution of thieving employees—and one related to the effect of public tolerance of various types of criminal behavior—is that the rate of prosecution will vary inversely with the extent of psychological and social identification of the public with the offender." (Robin, 1970;124)

insurance executive made a statement to the press suggesting that he had been unfairly accused by a group of disgruntled customers. The executive noted that out of nearly 100,000 customers, the state had only eighteen complainants/witnesses, implying that eighteen unhappy customers was hardly worthy of criminal prosecution. In fact, the case was later dropped. The accused had effectively decriminalized his activities. He did not deny that his company had taken the actions for which he was accused. Rather, he conveyed the impression that one was dealing with only few customer complaints. Eighteen unhappy customers was not a bad record for a company dealing with 100,000 customers overall.

Cases Presented for Prosecution
 July 1, 1979 - June 30, 1980
 Disposition by Referral Source

Referral Source:	PROSECUTED		NOT PROSECUTED		
	guilty	guilty	declined admin. closed	dropped after charge	pretrial inter- vention
Insurance	17	0	7	2	2
Law enforcement	8	1	5	1	2
Citizens	3	0	1	0	1
TOTAL	28	1	13	3	5

missing values =8

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