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**CRIMINAL AND CRIMINOLOGICAL ASPECTS OF  
INSURANCE FRAUD**

**Summary of the Doctoral Thesis (Author's Paper)**

**for Obtaining a Doctorate Degree in Legal Science**

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**RIGA 2011**

Doctoral Thesis created: Riga, Latvian Republic

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\_\_\_\_\_.2012. Riga Stradins \_\_\_\_\_ Promotion  
Council in open session in Riga, Dzirciema 16, \_\_\_\_\_ auditorium.

Doctoral Thesis can be found on the RSU and the RSU Library website:

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# 1. DESCRIPTION OF THE DOCTORAL THESIS

## 1.1. Topicality of the Subject

Topicality of the subject of the Thesis is based on the unprecedented prevalence of insurance fraud affected by the financial and economic crisis. There are almost no scientific studies in Latvia on this phenomenon.

## 1.2. The Purpose and Objectives of the Doctoral Thesis

**The purpose of the Doctoral Thesis** is to investigate the nature of insurance fraud as a criminological phenomenon, to identify the essence and distribution of insurance fraud, to evaluate adverse impacts of it and to develop proposals for combating and preventing insurance fraud.

### **Research objectives:**

1. To examine the insurance legal relationships, including the historical context as preconditions for insurance fraud, particularly in the application of the Latvian situation;
2. To carry out theoretical and practical analysis of public views on insurance relationships and insurance fraud;
3. To analyse the insurance fraud's legal framework and its interpretation applying the grammatical, systemic, teleological and historical law interpretation methods;
4. To clarify the prevalence of insurance fraud in Latvia and other countries;
5. To analyse legal provisions related to insurance fraud and their application;
6. To investigate the nature and mechanism of insurance fraud cases;
7. To determine the key factors that contribute to insurance fraud;
8. To recommend methods of combating and preventing insurance fraud;
9. To develop proposals *de lege ferenda*.

**Research object:** insurance fraud and related interconnections in society.

**Research subject:** insurance fraud's examination as a criminological phenomenon in the context of insurance customers' bad faith, definition of causes and reasons for insurance fraud, as well as theoretical and practical problems arising from the legal framework of insurance relationships and behavioural motivation of the parties.

### **1.3. Literature and Legal Sources Used in the Study**

The bibliography consists of 169 literature sources and 56 other information resources in Latvian, Russian and English. The paper contains references to articles on insurance fraud and related matters published in specialised magazines, scientific studies on moral risks, adverse selection and information asymmetry in insurance relationships, as well as social and legal aspects of insurance fraud.

The legal basis of the study is the Law on Insurance Contracts, the Law on Insurance Companies and Supervision Thereof, the Law on Compulsory Civil Liability Insurance of Owners of Motor Vehicles, the Civil Law, the Criminal Law, as well as other laws and regulations.

The empirical basis of the study is court judgements, unpublished materials of "BTA Insurance company" SE (previous name Insurance Joint Stock Company BTA), cases of fraud described in scientific publications, statistical data and interview questionnaires.

### **1.4. Description of Research Methods**

There are used common scientific, as well as specific legal researching methods in this research. The study is based on analysis of a variety of documents, knowledge, opinion, legislation and modelling of the situation,

finding out what specific administrative and legal measures may affect the prevalence of insurance fraud, as well as any improvements on Latvian legislation are necessary. Research work`s methods are analysis and synthesis, scientific induction and deduction, comparative method, as well as historical and sociological methods.

Analysis and synthesis methods were used to explore the elements of the problem, synthesize the interconnections and formulate the coherences, researching the law and jurisprudence, as well as other legal sources and other sources of information, researching insurance fraud in its unity of social content and legal form. Analysis and synthesis are in the base of the conclusions and proposals.

The method of scientific induction is applied to formulate general conclusions on the basis of separate facts and establish connections. The method of deduction is used for a logical and systematic theoretical explanation of empirical research results. They make it possible to investigate insurance fraud in the context of the Latvian and international law, taking into account connection of the phenomena`s content with the conception prevailing in public opinion and subject to civil and criminal liability for such offenses, ensuring fairness and reciprocal respect.

The comparative method provides useful information from other nations` practice for helping to improve the efficiency of the law, comparing the regulatory framework and other related aspects of insurance fraud in Latvia and other countries.

The historical method was used to understand the aspects of insurance`s appearance and development, creating the basis for insurance fraud, as well as the understanding of existing trends in the law.

Law analysis techniques - the grammatical, systemic, teleological and historical law interpretation methods were used for interpreting the legal

definitions for determining the meaning of a law, application characteristics and formulate proposals for improving the regulatory framework.

The research is also based on special legal scientific method - a sociological method for studying and evaluating the legal framework and law structure in the context of society, scientific and cultural aspects.

Well-established set of methodologies is used to cover a wide range of problems in accordance with the objectives of the research. Secondary sources of the research are used to provide market and social backgrounds, perspectives and trends, together with the quantitative and qualitative nature of the research.

During the research, obtaining empirical information, the methods of case studies were used: using specially designed programs, the analysis of court decisions was provided; using specially prepared interview`s programs, opinion polls, focus group interviews, semi-structured interviews of experts were provided; statistical surveys were analysed; points of views of the various organizations and scientists were collected; content analysis through periodicals, bibliographic publications, documents of scientific conferences and Internet resources is provided. In addition, the author uses the practical observations of daily practice, as well as the modelling of the situation to determine how to provide adequate protection to the rights and the public interests.

There is a lot of descriptive material in the research; besides, the author interprets the law, expressed as a practically applicable legal advice to practised lawyers.

Data processing is carried out quantitatively, using the SPSS program (Statistical Package for the Social Science), as well as qualitatively, by performing content analysis of the data obtained through interviews.

### **1.5. Theoretical and Practical Aspects of the Novelties of the Thesis**

A complex study on insurance fraud phenomenon has been carried out for the first time in this Thesis, offering a solution to the main theoretical and practical problems related thereto.

While carrying out surveys of Latvian residents during a four-year period, a transformation of opinions has been established relating to fraudulent activities in the field of insurance. Studies carried out abroad on the public's perception of insurance relationships are not directly applicable to the situation in Latvia. Consequently, not only can the Thesis can be viewed as a contribution to the development of scientific research of the social perceptions of the Latvian population, but its results can also be directly used for practical social processes and improvement of legislation.

Such a study on the social perceptions in Latvia has been done for the first time, and it is a reference point for future research on insurance relationships.

The study is a contribution to juridical science, as the work contains detailed analysis of the reasons for insurance fraud as a social phenomenon and its prevalence in Latvia. The information gathered will allow practitioners and legal researchers to better target improvement and interpretation of the existing legislation.

In terms of consumption of insurance services, Latvia is still significantly behind the developed European countries. As the insurance industry develops, the number of consumers of these services will grow and so will the volume of the services used. Timely dealing with insurance fraud issues will control and prevent potential damage.

The knowledge collected during this study can be used in the process of studies and legal education of the society, as well as in drawing up textbooks and study tools, and in scientific and practical work of students.

## 1.6. Approbation of the Results of the Thesis

The findings established during the preparation of the Thesis have been published in conference speeches and scientific articles.

The research results have been discussed and approbated in scientific conferences.

Year	Title, Location, Topic of the Paper, Volume
2007	RSU International Interdisciplinary Scientific Conference “Society, Health, Welfare”, 8-9 November 2007 – lecture “Public Attitude toward Insurance Fraud”
2007	RSU International Scientific Conference “Social, Legal and Medical Aspects of the Society’s and Individuals’ Safety During Globalisation” – lecture “ Insurance Contract – a Contract of Utmost Good Faith ( <i>Uberrimae Fidei</i> )”;
2007	RTU International Scientific Conference “Towards a Knowledge-based Economy” & “Enterprise Management: Diagnostics, Strategy, Effectiveness” – lecture in collaboration with Vladimirs Gonca, Prof., Dr.sc.ing. “Vehicle Insurance Fraud”
2007	XI Annual International Conference “Insurance and Reinsurance in the Baltics 2007” – lecture “Insurance Fraud in Latvia: Key Problems”
2008	RSU Scientific Conference – “Society of Current Social, Economic, Political, Legal and Medical Problems” – lecture “The Social Nature of Insurance Fraud”
2009	RSU Scientific Conference together with Latvian Academy of Sciences, Baltic Centre for Strategic Research, Swedish Institute for Security and Development Policy, Mykolas Romero’s University and Estonian University Nord, “Strengthening Security During Crisis” – lecture “Problems with Latvian Regulatory Framework and the Influence of Economic Crisis as Contributing Factors to a Person’s Illegal Behaviour.”
2010	RSU Scientific Conference together with the Latvian Academy of Sciences, Baltic Centre for Strategic Research, Swedish Institute for Security and Development Policy, Mykolas Romeris University and Estonian University Nord, “Strengthening Security During Crisis” – lecture “Evaluation Possibilities of Insurance Fraud Prevalence”
2011	International Scientific and Practical Conference “Society. Individual. Safety. 2011” Baltic International Academy (BSA), Society for Baltic Security (SBS) – lecture “Topicality of Insurance Fraud Problems”

Study results included in scientific publications:

Year	Title	Edition	Page
2007	Insurance Contract – a Contract of Utmost Good Faith ( <i>Uberrimae Fidei</i> )	RSU Collection of Scientific Papers	14
2008	The Social Nature of Insurance Fraud	RSU Collection of Scientific Papers	9
2009	Possibilities to Combat and Prevent Insurance Fraud	SPapers/RSU	9
2010	Legal Consciousness of People in Insurance Relationships and the Effects of Economic Downturn Thereon	RSU Collection of Scientific Papers	10
2011	The Criminal Aspect of Insurance Fraud (co-author O. Joksts)	Administrative and Criminal Justice	7
2011	Insurance fraud in the current issue of the basis of an analysis of the surveyed experts views	Administrative and Criminal Justice	4

### 1.7. Structure and Size of the Thesis

The total length of the Thesis is 211 pages.

The paper consists of an introduction, four chapters divided into several sections and subsections, conclusions and proposals, references and appendices. Results of the theoretical and practical knowledge analysis are presented in 17 figures and 8 tables.

The introduction reviews the topicality of the study subject and states the study purpose, objectives, object and subject, as well as the scientific methods and methodology used.

The first chapter of the paper is a review of insurance relationships, clarification of their nature and analysis of the related legislation and scientific literature in Latvia and other countries.

The second chapter of the paper goes into the definition of insurance fraud, its nature, types, prevalence and consequences, and the impact of the economic processes thereon.

The third chapter describes the surveys of Latvian residents, expert interviews, including interviews with Latvian judges on insurance fraud issues as well as preconditions for insurance fraud are analysed.

The fourth chapter offers techniques to prevent and combat insurance fraud.

Sections of the paper's empirical part describe the study design and basis for selection, research methodology, research processes, results and psychological interpretation. Conclusions and proposals are made based on theoretical analysis and empirical results obtained during the study.

## **2. SUMMARY OF THE THESIS**

### **2.1. Introduction**

In the introduction it is stated that insurance buyers often do not perceive insurance services as actually received, so the role of insurance may be underestimated.

The civil and criminal regulatory framework of insurance relationships performs important social functions.

It has been observed that insurers, upon receiving the insurance fee, often do not explain to their clients, or even mislead them, about the insurance contract terms, but upon receiving a loss application, are looking for reasons to not pay the compensation.

On the other hand, the courts tend to unreasonably defend the weaker contractual party. Employees of law enforcement authorities believe that criminal procedures related to insurance fraud are too difficult and that

insurers themselves can solve their problems. Investigators may subjectively choose to stand on the side of the fraudsters, identifying with insurance holders.

Problem-solving is necessary due to the Latvian economic processes related to the worsening of criminality and increase of crime.

The existing criminal law framework for economic crimes lags behind the current economic situation. There is also a lack of professionals among law enforcement workers and there are no specialised structural units to combat such crimes. The cooperation between insurers and law enforcement agencies is very weak; while the population's legal awareness level is low. All these factors contribute to the spread and latency of such crimes.

While insurance fraud in Latvia is quite widespread and the public generally supports it, the existing criminal legislation does not permit full assessment of fraudulent activities in the field of insurance, in order to punish perpetrators of fraud, and thus ensure protection of the public interests. The incomplete development of theoretical viewpoints and the weak development of judicature contribute to errors in the classification of fraud.

This problem is magnified, as the state, acting in the public interests, has established some insurance types as mandatory, without the public fully comprehending the objectives of such an action.

Based on the above considerations, the following main reasons for fraud have been specified:

- 1) Gaps in legal framework;
- 2) Negative public perception of insurers;
- 3) It is a relatively simple way to get money;

- 4) Bias and corruption of law enforcement bodies;
- 5) Law enforcement bodies are not sufficiently specialised;
- 6) Underestimation of the seriousness of the problem and unfamiliarity with the specifics of fraud on the insurers' side.

## **2.2. Characteristics of Insurance Relationships**

### **2.2.1. Insurance definition and essence interpretation, the insurance legal framework and related problems**

The first chapter discusses the questions of the nature of insurance, insurance relationships and their regulation.

Insurance is a social process that affects essential interests of individuals by providing safety and stability. There is a mutual interaction between social processes and the behaviour of insurance participants.

Insurance is a type of legal transaction, whereby a transfer of risk takes place in return for a consideration. Its economic substance is a form of risk management to guard against the negative consequences of risk occurrence and receiving loss compensation from a special fund held by the insurer. The insurance premium is determined in return for a transfer of certain types of risk, and damages are paid only if the harmful event complies with the contractual description of risks.

To better understand the nature of insurance, an analysis of insurance history was carried out. Originally, property owners started to notice the random nature of extreme events and the non-uniformity of injuries. Joint loss-sharing was created among interested farms, reducing the negative consequences of natural disasters and other accidents. That is how insurance began, based on the concept of closed joint loss compensation.

The insurance relationship as a financial relationship is specific, as it is based on a probabilistic nature. The insurance premium is calculated by collecting insurance premiums from several clients in an insurance fund.

The history of insurance in Latvia began with the establishment of the first mutual insurance company.

In Soviet times, as we know, a market economy did not exist at all.

When the insurance market in Latvia was renewed in the early 90s of the 20th century, work began with insurance legislation. However, the basic principles of insurance in the legislation were not properly described. In 1998, while developing the Law on Insurance Contracts within the European Union's PHARE program, with a participation of a recognised European insurance expert, a proper foundation was laid, however, the grammatical expression of the legal provisions was not clear enough. Later, these provisions were repeatedly amended and the need for improvement still exists.

Insurance is neither mentioned in the Civil Law, nor the Commercial Law. Insurance transactions are currently regulated by the Law on Insurance Contracts developed in isolation from general business legislation. Consequently, insurance transactions are not subject to general legal provisions regarding contractual relationships, such as provisions on business components. Also, rules of deception, deceit and duress in civil transactions are not directly attributable to insurance transactions. In 2009, provisions on insurance transactions were included in the Law on Insurance Companies and Supervision Thereof, which is trying to regulate insurance as a type of business in Latvia.

Problems arise when Latvian insurers attempt to carry out cross-border activities. The author proposes to take over the "legal principles of European insurance" created to harmonise divergent insurance regulations of the EU member states.

The nature of insurance is often misinterpreted by the public, as the immediate result is not visible upon purchasing insurance services. Sometimes insurance is expected to perform atypical tasks, such as solving social problems. The myth of social problem-solving with the help of insurance is maintained by public relations campaigns organised by the insurers themselves.

Private insurance is different from national social security – it has different goals, objectives and organisation. However, private insurance may supplement insurance in the public-sector, dealing with demographic problems and other social problems. The definition of objectives and development of a system is up to the state social policy.

An explanation is provided as according to high level of moral hazard Latvian insurers cannot afford individual health insurance.

Insurance events must be clearly defined in the insurance contract, and they should be incidental.

A precondition for insurance is the prior ability to calculate insured losses. It is mandatory for two factors to be measurable: the probability of loss and the amount of loss caused by its occurrence.

Insurance premiums must be real, so that insurance buyers would be able to afford them.

Risks that are not described in the insurance contract are not insured. This causes disagreements between insurers and clients, and the information included in insurance contracts may be difficult to understand or is not provided in full.

The injurious events must be accidental or at least outside the conscious control of the insured. Losses must be clear consequences of such events, that is, they must be caused by an insurance event.

The development of insurance legal framework in Latvia is described as a law creation before a picture of the nature of the insurance relationship has

created. Consequently, the legislation has many shortcomings. The current public perception of insurance is false; the application of law often does not correlate with the insurance nature of the relationship. It quotes examples.

### **2.2.2. Presumption of Good Faith**

The insurance contract is not just an issue of the usual good faith in business, but it is an issue of utmost good faith. An analysis is performed on the *uberrimae fidei* doctrine of good faith in relation to insurance relationships.

Good faith is expected both from the client and the insurer.

This principle is violated if the insurer is reluctant to accept a decision on the payment of insurance indemnity under the pretext of the need for an investigation of the circumstances, or is refusing to pay insurance indemnity based on the grounds arising from the insurance contract that have remained unnoticed by the client upon entering into the contract.

In case of insurance contracts, the balance between the parties is not as stable as in other contracts. The insurer as a professional is more responsible for the contract terms and their fulfilment. However, each party of the insurance contract, upon entering into the insurance relationship, has a fundamental obligation to disclose all material facts and known conditions which may affect the other party's decision to enter into a contractual relationship on the terms necessary to it. Consequences of the non-fulfilment of the contract are a declaration of all or some of its provisions null and void.

However, the relationship between the insured and the insurer is not completely reliable, because it is based on a contract between opposite parties. The principle of *uberrimae fides* does not modify the antagonistic nature of this relationship, but only raises more serious requirements than most other types of contracts. This principle is also included in Latvian legislation.

Contract terms are drawn up by insurers in advance and the potential client has minimal opportunity to affect them.

Observation of the *uberrimae fidei* principle by the insurer means that it should provide all necessary explanations to the client as to the fact that the insurance does not cover absolutely all risks, regardless of the positioning of insurance in advertising, paying equal attention to both the cases in which compensation will be paid and the cases in which compensation will not be paid, as well as the contract advantages.

When assessing the conduct of the insurer from the good faith point of view, the insurer must prove that his conduct was reasonable and that he did not intentionally prevent or delay the insurance indemnity claimed.

There is a similar provision included in the Latvian Law on the Prohibition of Unfair Commercial Practices, but with limited application. The author explains that it is important to ensure that, in case of an abuse of the insurer's rights; the insured should be entitled to require coverage of indirect losses and lost profit of the claimant not included in the insurance indemnity amount.

The insurer would often scrupulously examine the circumstances of the accident, assuming that the client is acting in bad faith. It is the insurer's obligation to examine the circumstances of an insurance event, but unreasonable and excessive activity on the part of the insurer is not to be permitted and is objectionable.

### **2.2.3. Insurers Bad Faith**

The term "insurance bad faith" denotes a situation where the insurer acts in bad faith towards his client. If the insurer acts in bad faith, an additional claim may be brought against the insurer for illegal activities including contractual penalties, late fees, etc. As a result, if the insurer has committed

serious deviations from normal behaviour, the claimant may receive more than the agreed insurance amount stated in the insurance policy. In addition, loss recovery from the insurer in case of bad faith also fulfils the role of preventive penalty. Analyses of the practice in other states are provided when this practice is not implemented in Latvia.

The author criticises the practices of the Consumer Rights Protection Centre (CRPC) by expressing consumer complaints and the administrative case law of CRPC decisions.

CRPC, with the engagement of administrative courts, acknowledges the contract terms as “unequal”, “unjust” and “not discussed”, hence null and void, ignoring the fundamental principles and objectives of the European Community Council Directive 93/13/EEC. Proceedings regarding the validity, legality and interpretation of contractual terms in administrative courts are contrary to the purpose of the creation of these courts, as well as significantly prolongs the period of dispute.

Based on the above, it is proposed that alternative forms of civil dispute resolution be developed and that the regulatory framework be improved.

#### **2.2.4. Behavioural Motivation of Parties in Insurance Relationships**

Insurance clients' behaviour is based on the idea of obligations of closed insurance contract and insurance essence in general.

All insured parties are responsible for the size of the insurance premium, as the insurance premium varies depending on the insurance indemnities paid. Consequently, the unduly paid insurance indemnities leave a negative impact on honest insurance clients. However, it remains unnoticed from society's point of view.

Insurers are not aware of the insured risks and the insurance object before receiving this information from the client. Thus, the contractual parties

have asymmetrical information upon entering into and performing the insurance contract. With the development of the Internet, information asymmetry is likely to decrease.

Attributing the economic theory of information asymmetry and adverse selection to insurance legal relationships, it can be assumed that asymmetry of information is a factor that affects the behaviour of the insurance relationship parties (George Akerlof in relation to the used car market, Michael Spence in relation to his signalling idea, Joseph Stiglitz in relation to the monitoring theory and Kenneth Arrow in relation to health insurance).

Adverse selection in insurance, when the insurer does not have the required information about the risks, can manifest as follows:

- 1) Persons with increased risks will purchase more insurance for a standard price;
- 2) After concluding the insurance contract, a person's behaviour may become more careless, without an appropriate reaction of the insurer.

From the public policy point of view, some manifestations of this phenomenon may even prove beneficial, transferring a part of the budget expenses to the insurers.

Insurers require their clients to provide information before signing the contract for risks' evaluations and defining contract obligations. In Latvia it is provided for by the law, except for one of the most common types of insurance –third party motor liability insurance.

According to the theory of moral hazard, the following cases exist where the insured contributes to the occurrence of the insured risk:

- 1) The risk is increased without intentional or malicious conduct on the part of the insured (moral hazard);
- 2) The risk occurs as a result of malicious activities of the insured;

3) After the occurrence of the risk, the insured requires the insurer to pay a larger sum of money than the actual incurred loss.

The subjective side of the clients' actions may be different, as evidenced by the illustrative material provided in the paper.

Moral hazard can be reduced by introducing co-payments of the insured – deductibles, franchises, etc. When moral hazard is so excessive, the insurer must refrain from offers.

The author opposes the view that the insurer must check the condition of the insurance object before signing the insurance contract. Cost of the insurer in carrying out the insurance contract signature procedure will significantly increase the clients' insurance premiums. Information should be provided based on the *uberrimae fidei* principle (A.K. Dixit, M. Rothschild and J. Stiglitz, also P. Pickard).

Analysing the view of Jason David Strauss on the principle of *uberrimae fidei* and adverse selection in insurance, the author expresses an opinion on the assessment of the insurer's possibilities to prove the provision of false information, which in Latvia may be supplemented by the need to prove the subjective side of the client's action, taking into account the specific regulatory framework.

Compared are insurance purchasing habits in Latvia and other European countries, where the demand for insurance services is much higher. Latvian insurance buyers are not aware of the *uberrimae fidei* principle, and they have poor knowledge of the particular types of risks, instead they purchase insurance services because they are imposed by the state or a creditor and are choosing them mainly based on the pricing. Consequently, society supports the view that the insurer is obliged to pay damages under any circumstances. Underwriting of risk is based primarily on objective criteria that are known to the insurer in

advance, and not so much on the assessment of the information provided by the client, which may reduce the availability of insurance due to its high cost.

## **2.3. Criminal Aspects of Insurance Fraud**

### **2.3.1. Definition of Insurance Fraud**

Insurance fraud is an economic, legal and social issue, as well as moral or psychological problem, depending on the context. Analysis in the paper is carried out from the socio-legal perspective.

Looking at moral projections of insurance clients, one is able to distinguish between dishonest behaviour on a micro-level, mid-level and macro-level. If the goal of such behaviour is to obtain an unfair advantage from the insurance indemnity paid, it is insurance fraud.

Insufficient knowledge and cultural awareness contributes to misunderstanding fraud against insurers. Clients consider it to be normal when the amount of insurance indemnity claimed is greater than the losses incurred by the insurer, or when the circumstances of the injury are “somewhat” changed in order to receive insurance indemnity.

Definitions of insurance fraud are important in determining its causes, prevalence, social impact and other elements and also for providing the research. A common definition of insurance fraud does not exist.

Insurance fraud may be defined as any action in order to fraudulently obtain payment from the insurer. However, this definition is too broad, with no indication as to what insurance fraud is directed at.

A common reason for all financial crimes is financial gain.

The European Insurance and Reinsurance Federation, CEA has defined insurance fraud as an act or omission in respect to concluding an insurance contract or filing a loss application in order to achieve unjust enrichment of the

fraudster or another person or to cause losses to another person. Similar definitions can also be found in other practical editions.

The author views insurance fraud as any deliberate (malicious) act of a person in order to take unfair advantage of insurance, including ensuring that the insurer pays an insurance indemnity in excess of the amount due under the insurance contract and the circumstances of the accident.

### **2.3.2. Analysis of Insurance Fraud Realisation Schemes**

**Depending on the mechanism for incurring damages**, damages can occur:

- 1) When a person knowingly destroys, hides or damages any property or intentionally causes bodily injury to somebody in order to benefit from insurance indemnity;
- 2) Independently from the person, but wishing to receive compensation for damages, the person provides false information to the insurer about the circumstances leading to these damages.

The paper sets out characteristics of the cases of fraud within each group, concluding that the first group is the most dangerous.

**Persons who contribute to insurance fraud** (and thus the fraud itself) can be divided into three groups:

- 1) *The average consumer* – usually he is “forced” to commit fraud; it is more like taking advantage of the situation rather than performing carefully planned activities. This group of individuals has no specific characteristics;
- 2) *Criminally-minded persons* – carry out insurance fraud along with several other property crimes, which allow them to provide for themselves; may be either fully or partly criminalised – may even have a regular paying job;

3) *Organised crime groups* – usually these are professional criminals and part of organised criminal groups which are involved in large and complex fraud schemes against insurers (there are no such groups in Latvia).

Classification of fraud cases by the **insurance fraud mechanism** (erroneous loss applications are not fraud):

1) *Exaggeration of loss*, when the client is applying for a loss that is larger than the actual injury;

2) *Distortion of conditions of the event*, when the client is providing false information about the underlying conditions in order to qualify for compensation;

3) *Prior falsification of an insurance event*, when the client is damaging or hiding (including illegal realisation) property, or is causing bodily injury in order to obtain insurance indemnity from the insurer.

Insurance fraud is the most common in the area of **motor insurance**, in the form of:

1) *Concealing the insurance object – imitation of theft or robbery*;

Fraud may also involve the deliberate increase of the insurance object's value, so as to receive the largest possible amount of money after faking a robbery. Often before submitting the loss application, the car is taken for illegal sale outside Latvia, and compensation is received for it, or the car is disassembled for spare parts, which are then sold for additional gain.

2) *Faking a road traffic accident*. Unlike other countries, in Latvia road traffic accidents are mostly faked when the car has been damaged in another accident which does not constitute an insurance event. The cases may be pre-planned. Showing increased insurance object value and, respectively, setting an increased insurance amount in the contract allows fraudsters to obtain financial gain by intentionally destroying the insurance object, as the insurance indemnity in case of a loss of the object is greater than the value of the object.

However, faking road traffic accidents in recent years has become much less common, because insurers have large possibilities to perform accident mechanism analysis by involving experts.

3) *Faking theft of parts or additional parts of the insurance object.* Insurers are less willing to carry out special investigations to prove the fact of fraud, if the costs are not too high. It is controlled by deductibles and payment of insurance indemnities in return for car repair services.

4) *Incineration of the insurance object.* It is associated with over-insurance and the client's deception as to how large of a sum can be obtained in case of total destruction of the insured vehicle in an over-insurance situation. As clients become more educated in the matters of insurance, this type of fraud is decreasing.

5) *Recording and exaggerating losses.* The insured provides false information to the insurer about the nature and extent of the damage, as well as submits increased estimates or calculations for the reconstruction of the insurance object. It is often done to offset the deductible. Larger sums may also be required to be paid from the insurers by car repairers, who are controlled by insurer-appointed experts, by agreeing on the final price for the repairs with the person who draws up the estimate.

6) *Misrepresentation of conditions.* If the object has been damaged in an accident that is not an insurance event, the insured may provide false information about what happened in order to receive insurance indemnity.

Fraud is often associated with **motor vehicle third party liability insurance**, where insurance indemnity is received by a third party who does not have a relationship with the insurer that issued the insurance policy. In addition, the procedure of issuing policies is quite simplified. In cases of fraud, compensation is linked to a vehicle damaged previously in other conditions

than reported to the insurer. Involved in the fraud may be traffic police officers, vehicle technical experts and even the insurer's employees.

This type of insurance covers medical treatment and rehabilitation costs connected with bodily injuries incurred during a road traffic accident. In Latvia, no cases have been detected in which bodily injuries would be imitated or exaggerated, as it has happened in other countries. However, there have been cases where the victim wanted the insurer to pay for services that were not connected with the bodily injuries or the payment of which was not provided for by the law.

Insurers tend to not report the abuses detected to the law enforcement authorities, as the subsequent criminal procedure may be time consuming and may end with the fraudster's acquittal, which the latter could use to "reasonably" qualify for insurance indemnity.

**Property insurance** fraud schemes are similar to motor vehicle insurance, depending on the specific insurance object. As the value of the insured real estate is declining, the insured may be tempted to receive the full insurance amount stated in the insurance policy by destroying the insurance object. This is, for example, how problems with credit liabilities are being dealt with. In Latvia, there are practically no proven cases of such fraud, but the paper contains a reference to a judgement in a case where the court of first instance sentenced to actual imprisonment. The severity of the sentence was justified by the court with the defendant's behaviour – accusing the insurer's employees of falsifying evidence, accusing witnesses of perjury and denying guilt before the court.

There are no registered cases of fraud in Latvia in the area of **personal insurance**, except health insurance. However, it does not mean that such events have not occurred, but only that they have not been proven and moreover – not identified.

Cases of fraud in the area of **health insurance** depend on the state healthcare organisations. So, a person pays a visit to a medical facility with the health insurance card issued by the insurer to another person. And the medical facility adds records to the invoice for the healthcare services provided to clients paid by the insurer. These cases of fraud are almost never detected, although in one case a doctor was convicted for making such additions.

Health insurance fraud may not only imply enrichment on the expense of the insurer. Research quite clearly demonstrates manipulations of healthcare providers so that, by bypassing insurance contract limitations, to provide customers with a higher quality care than they are eligible for under the insurance contract – it is described by Victor Freeman, Matthew Wynia and David Hyman.

Allegations of fraud involving Dr. Ā. Auders once had gained widespread publicity and resulted in the conviction of the doctor.

The situation during the economic downturn has changed, as state authorities and companies, as well as the private sector cannot afford to insure their employees due to lack of finances. As the losses in health insurance increase, even the insurers have started to pay greater attention to the cases raising the loss indicators.

An insurance fraud case can be classified **by evaluation of its consequences**. Given the high latency, it is quite difficult to evaluate the harm (losses) caused by insurance fraud in monetary terms. However, this classification may be useful for criminal purposes, listing all crimes by the severity degree of the offence.

### **2.3.3. Prevalence and Social Hazards of Insurance Fraud**

State police reports have noted increase of fraud. However, a full numeric evaluation of insurance fraud has never been carried out. World organisations and researchers operate with different numbers, especially in relation to the latent part. There is no single definition of insurance fraud and thus the approach is different when assessing whether a particular case constitutes an insurance fraud or not. Also, losses caused by insurance fraud are measured differently, depending on the country.

CEA has evaluated loss from insurance fraud to be two per cent of all insurance premiums collected in the European Union, believing that it is approximately 5 to 10 per cent of all payable non-life insurance compensations. However, these figures lack argumentation, as fraud detection is only possible during investigation of the conditions stated in the loss application, which is not always carried out or which does not always end with establishing fraud.

The international network of auditors of Deloitte (Deloitte Touche Tohmatsu Limited) has gathered statistical information showing that losses of any organisation resulting from fraud are five per cent of the organisation's income. In 2009, auditing company PricewaterhouseCoopers LLP acknowledged that insurance is one of the three industries in the world, which experiences the biggest boom of economic crime. Poll figures confirm the prevalence of fraud in the insurance sector. CEA comments that this situation is the result of the more frequent fraud detection. The figures compiled by national insurance associations on the prevalence of insurance fraud are of indicative nature.

In the United Kingdom it is assumed that undetected insurance fraud cases are causing assessed injury of 1.9 billion pounds a year, but the insurance indemnity amount claimed in detected fraud cases in 2008 was 730 million pounds, of which most, around 360 million pounds, were detected in car

insurance, 110 million – in housing insurance and 240 million – in business insurance. Compared to 2007, the total amount had increased by 30 per cent. Four per cent of all applications (excluding life insurance) were fraudulent, an increase of 1 percentage point.

In Germany 28 per cent of the population believes that insurance fraud is not a crime. Losses caused by insurance fraud are assessed as 4 million euro per year, which is 10 per cent of all insurance indemnities paid.

A survey conducted in Denmark in 2009 found that 27 per cent of the population had breached insurance regulations, and 44 per cent knew such violators.

An investigation in Finland in 2009 discovered that around 47 million euros were fraudulently claimed from insurers, 53 per cent of the cases investigated were related to car insurance for a total of approximately 9 million Euros, 13.5 million Euros were attempted to be defrauded in property insurance and almost 17 million in business insurance.

In France in 2008, 62 per cent of insurance fraud cases were detected in property and liability insurance, 48 per cent – in car insurance, totalling in 53 million Euros out of 110 million Euros, and the number of cases was 80 per cent.

Italian supervisory authority ISVAP indicates in its opinion that prevalence of insurance fraud makes up three per cent of all motor vehicle third party liability claims and 0.53 per cent of all damages paid by fire and natural disaster insurers – 1.7 per cent of the total amount of damages.

Lund University in Sweden in 2002 reported that only 25 per cent of the 80 insurance fraud cases, which have been reported, were proven. In total 8 million kronas were paid.

In the Netherlands, 12 per cent of the consumers confirmed involvement in insurance fraud, 44 per cent of the population supported insurance fraud. The

four largest health insurers in 2008 detected fraudulent declarations for more than 8 million Euros. Healthcare providers requested 1.7 million Euros.

In Poland insurance industry representatives assessed insurance fraud as 30 per cent of all insurance indemnities paid.

In the USA annual losses from insurance fraud are estimated around 100 billion dollars, providing an average of one thousand dollars per family. Fraud is the most common in health insurance – about 80 billion dollars, followed by auto insurance – 14.5 billion dollars, business interruption insurance – 1.3 billion dollars, housing insurance – 1.6 billion dollars and life insurance – 1.4 billion dollars. The U.S. insurance company Progressive Insurance in 2001 surveyed more than 31 thousand residents: 29 per cent of the respondents replied that they would never report any insurance fraud cases, 9 per cent said they were willing to defraud the insurer, as long as they were sure that they would not be punished.

In Canada insurance fraudsters cause at least 1.3 billion U.S. dollars in losses each year. It is assumed that 10 to 15 cents of each dollar are spent on paying insurance indemnity to fraudsters. Bad faith insurance policy holders are paid around 10-15 per cent of the total insurance premiums collected in the market.

In 2002 Russian Insurance Supervision Inspectorate released a statement that about 70 per cent of all insurance fraud cases are in vehicle insurance and the insurers in Russia are losing up to 15 billion rubles to insurance fraud each year. Russian Insurance Anti-Fraud Committee, together with the insurance group «Межрегионгарант», in October 2006 conducted the first public opinion survey on insurance fraud. Most of the surveyed population (44 per cent) did not believe that misinterpretation or concealment of the information provided to the insurer is a crime, 15 per cent of respondents could not provide

an answer and only 41 per cent of the population believed that such actions are criminal.

Obviously, the collected figures are fragmented and imprecise. Also there are no unified standard rates. By contrast, scientist opinions mostly estimate the prevalence of fraudulent insurance claims as 10 per cent of the claims or 10 per cent of the total amount of claims. However, these figures are based more on the empirical assessment of individual insurance industry representatives and loss applications analysis. Assessments of analysis research of David Hyman, Herbert Weisberg and Richard Derring, the USA Insurance Research Council (in short IRC) provide different fraud prevalence assessment results because the evaluation methods and processes are based on subjective perception of the researcher.

Within the car insurance fraud study, data of a damaged car was submitted to about 100 car body repair shops, in one case, indicating that the car is insured, but in another case – that it is not insured. Repair cost estimates differed on average by 32.5 per cent, to the detriment of the insured car repair. Georges Dionne and Robert Gagne reveal that car insurance indemnity amounts are positively related to the loss application control policy.

In Latvia 60-70 per cent of the insurance premiums collected by insurers are returned to insurance policy holders as insurance indemnities. A part of this amount is received by persons in fraudulent cases, where circumstances have been distorted or the amount of loss to be covered by insurance is unreasonably increased.

The media has reported that cases of fraud require 20-25 per cent of the insurance indemnities paid. However, these figures lack serious and reasoned argumentation, since insurance fraud in Latvia is a latent phenomenon. While the subjective opinions of representatives of insurers differ, the lowest specified

level of insurance fraud is 10 per cent of all applied losses, and the highest is one third.

Tab 2.1

	Insurance premiums, gross, LVL	Insurance indemnities, gross, LVL	Minimum prognosis, 10% of (2), LVL	% of (1)	Maximum prognosis, 1/3 of (2), LVL	% of (1)
	(1)	(2)	(3)	4)	(5)	6)
2005	137 921 108	61 709 044	6 170 904	4.5%	20 569 681	14.9%
2006	204 107 027	95 197 389	9 519 739	4.7%	31 732 462	15.5%
2007	331 629 549	134 370 369	13 437 037	4.1%	44 790 119	13.5%
2008	356 626 946	192 343 997	19 234 400	5.4%	64 127 486	18.0%
2009	263 767 904	172 783 546	17 278 355	6.6%	57 594 512	21.8%
2010 2q.	117 065 699	69 514 829	6 951 482	5.9%	23 171 609	19.7%
Total	1 411 118 233	725 919 174	72 591 917	5.1%	241 973 057	17.1%

Cases of fraud against insurers are not shown in the statistics of the Latvian Ministry of the Interior.

Also, the Chief Prosecutor Arvīds Kalniņš of the Republic of Latvia Prosecutor General Office, Criminal Justice Department, in the summary of 2006 indicated the number of fraud cases as a whole. The number of fraud cases against insurers is not clear.

The paper contains analysis of the Ministry of Justice reports on the number of persons sentenced based on Articles 177 and 178 of the Criminal Law in 2005-2009. Although the number of convicts indicated in the official reports is not sufficient for an in-depth analysis of insurance fraud indicators, it shows that the number of fraud convicts based on Article 177 of the Criminal Law is increasing, and the insurance fraud cases based on Article 178 of the Criminal Law may still be considered as exemptions. According to the data of

the Ministry of Justice, all convicts based on Article 178 of the Criminal Law were men aged between 30 and 49 years.

Statistics on fraud are included in the Republic of Latvia Ministry of the Interior's Informative Report for the 07.10.2009 meeting of the Saeima Defence, Home Affairs and Anti-Corruption Commission – 'The Work of Law Enforcement Agencies in Investigating Insurance Fraud Cases':

Tab 2.2

Period	Criminal procedure qualification	Body which instituted criminal proceedings	Number of criminal proceedings	Total number of criminal proceedings in the period
6 months in 2008	Article 178, Paragraph 2 of the criminal Law	State Police, criminal proceedings sent to the Prosecutor's Office to start prosecution	One	Two
	Article 178, Paragraph 3 of the criminal Law	Prosecutor's Office specialising in organised crime and other sectors, criminal investigation is continued by the State Police	One	
2008 in total	Article 178, Paragraph 1 of the Criminal Law	State Police	Three	Nine
	Article 178, Paragraph 2 of the Criminal Law	State Police	One	
	Article 178, Paragraph 3 of the Criminal Law	State Police	Four	
	Article 178, Paragraph 3 of the Criminal Law	Prosecutor's Office specialising in organised crime and other sectors	One	
6 months in 2009	Article 178, Paragraph 1 of the Criminal Law	State Police	Three	Six
	Article 178, Paragraph 2 of the Criminal Law	State police, criminal proceedings sent to the Prosecutor's Office to start prosecution	One	
	Article 178, Paragraph 2 of the Criminal Law	Instituted by Riga City Latgale District Prosecutor's Office and sent to the State Police for continued investigation	One	
	Article 178, Paragraph 3 of the	State Police	One	

	Criminal Law			

In view of these statistics, the Ministry of Interior believes that the prevalence of insurance fraud in Latvia is very limited.

The same opinion was expressed in the report of the Republic of Latvia Prosecutor’s Office, Prosecutor General Office Criminal Justice Department Pre-Trial Investigation Supervision Division to the Saeima Defence, Home Affairs and Anti-Corruption Commission – ‘The Work of Law Enforcement Agencies in Investigating Insurance Fraud Cases’ (07.10.2009). In addition, the Prosecutor General Office Criminal Justice Department Pre-Trial Investigation Supervision Division points out that it is not possible to gather statistical data on criminal proceedings in connection with insurance fraud because the provisions of the Criminal Procedure Law allow to qualify an offence for which investigation is instituted only by its belonging to a criminal offences group object. Some criminal proceedings are mentioned which have been terminated without finding a criminal offence.

In conclusion, although in Latvia there are many indicators suggestive of high prevalence of insurance fraud, the exact figures cannot be obtained.

The negative impact of insurance fraud on the society takes the form of:

- 1) Material losses due to physical damage;
- 2) Material losses caused to the state institutions by performing fraudulent activities;
- 3) Indirect material losses to insurance customers, when paying larger insurance premiums for protection against risks;
- 4) Bodily injury or even death of the victims of fraudulent organised crime schemes.

Violation of the insurance contract terms by performing unlawful acts leads to inefficiency and inequality in the insurance market. Inequality occurs, when there are costs of other persons and these persons cannot influence or

prevent these costs. Effectiveness, however, would occur when the possibility of taking advantage of fraud has been reduced to the minimum, which would be demonstrated in insurers' decisions on claims and loss prevention. The insurers' anti-fraud efforts are setting legal limitations for all insurance services provided to customers, contributing to less protection against risks than would be provided in a functioning insurance market, where there is no possibility of fraud or the likelihood is remote.

The (indirect) social consequences of insurance fraud are:

- 1) Significant loss of personal funds, at the same time losing an opportunity to invest these funds in the overall development;
- 2) Increase and strengthening of the social gap;
- 3) Promotion of organised crime;
- 4) Discrediting of legal provisions;
- 5) Loss of prestige of law enforcement agencies and other state institutions, drop of reputation of the state.

The increase of economic crimes reduces the ability of companies to be effectively managed, and to reduce labour and financial risks.

#### **2.3.4. Criminal Qualification of Insurance Fraud**

Insurance fraud can be attributed to economic crimes, but in the Criminal Law this crime is placed in the section 'Crimes against Property' (the pre-war Latvian Penal Law provided for criminal liability in case of insurance fraud).

In the Criminal Law, criminal liability for insurance fraud is provided for in Article 178. According to the first paragraph disposition, insurance fraud is intentional destruction, damage or concealment of one's own property for the purpose of receiving insurance moneys. This definition brings out only one type of insurance fraud and does not cover all cases where a person turns to the

insurer with a deliberate intention to mislead him in order to receive insurance indemnity. In addition, the Criminal Law defines insurance fraud as operations with one's own property. If the same acts were committed with property owned or held by another person, they fail to qualify as insurance fraud (must be classified under Article 177 of the Criminal Law). Legislation and case law incorrectly use the term "insurance moneys", as the intention is directed at the insurance indemnity, which could be insurance moneys or a part thereof.

The author concludes that Article 178 of the Criminal Law offers a very narrow definition of the objective side of insurance fraud, which along with the opinion on the civil nature of the insurance relationship, is not justified. Consequently, it is not possible to correctly and uniformly qualify insurance indemnity fraud and collect and analyse statistics.

Continuing the analysis, the author focuses on the insurance fraud composition, which has been truncated, unlike other forms of abduction or fraud according to Article 177 of the Criminal Law.

Summaries of the Latvian case law and opinions of Latvian scientists on the application of the aforementioned Articles of the Criminal Law are mutually contradicting, and the case law is different. While performing analysis of the Supreme Court Plenum 14 December 2001 decision, the author concludes that if the owner of the insured property has received insurance indemnity based on an application, his actions must be qualified as the totality of criminal offences pursuant to Articles 177 and 178 of the Criminal Law. The author believes that it is an attempt to improve the poor quality of the criminal law framework for insurance fraud.

The author analyses the divergent views of criminal justice theoreticians on the qualification of criminal activities depending on whether or not an insurance indemnity has been received (analysed are the opinions of Uldis

Krastiņš, which coincides with the Supreme Court Plenum decision, and Andrejs Judins, which opposes it.)

The General Meeting of Judges of the Supreme Court Senate Criminal Matters Department and Criminal Matters Panel in 2009 did not settle this challenge, but provided an explanation of the qualifications depending on the property ownership. This also shows an attempt to justify the poor quality of the criminal law framework for insurance fraud.

The author compares the dispositions of fraud and insurance fraud in the Criminal Law and concludes that the lawmaker's goal, by providing for a less severe penalty for insurance fraud, is not clear. Consequently, the qualification questions cannot be addressed within the existing regulatory framework.

Performing an in-depth analysis of the criminal law framework and reviewing the issue of community of insurance fraud and Article 177 of the Criminal Law, the author concludes that such community is questionable from a systemic point of view, as it has no theoretical or practical basis. On the other hand, the ideal community of offences is formed, when the offender knowingly submits a false report or knowingly provides a false testimony, because such actions cause additional harm to the interests of the state. So, the community is fully consistent with the definition of the ideal community, in particular with Articles 297, 298 and 300 of the Criminal Law – in contrast to U. Krastins view. Examples of fraud from case law confirm community with several Criminal Law Articles.

The case law studied by the author is not uniform. The activities of perpetrators are not qualified correctly, which in some cases leads to the criminals staying free from any kind of responsibility.

Even in cases where the insurer has paid insurance indemnity before detecting the fraud, community with Article 177 is not detected. Performing analysis of five judgments where charges were based on Article 178 of the

Criminal Law, it is obvious that preference is given to additional qualifications pursuant to Articles 289 and 300 of the Criminal Law. In one of the five cases additional qualification was carried out pursuant to Article 210, Paragraph three of the Criminal Law.

Having studied the application of Article 177 of the Criminal Law in connection with insurance indemnity fraud or attempted fraud in seven court judgements, the author concludes that Article 177 was only applied when it was not possible to apply Article 178. In two cases, additional qualification was done based on Articles 298 and 300 of the Criminal Law. In three cases, the crime was committed in a group of two persons. Despite the objective side being similar, in four cases the court found that fraud was committed against the insurer, but in three cases – against the bank or leasing company, although the fraudsters could in no way benefit from a leasing contract. In two cases the court assumed that they simultaneously attempted to commit fraud against the insurer.

In order to understand the optimisation requirements for the criminal law framework, the paper analyses the **criminal law framework for insurance fraud in other countries**.

In the USA, most states provide for criminal liability for insurance fraud, also in the area of health care, and the penalties are severe. It is similar in Canada, which has established the Insurance Crime Prevention Bureau.

In the UK, there is the Serious Fraud Office, and the Fraud Act defines fraud as a crime committed by creating a false impression by not disclosing to another person the information which must be disclosed by law, by abusing a position in order to gain certain advantages, or by taking action against financial interests of another person. The law provides up to 10 years penalty for fraud.

In Sweden, the Criminal Law provides responsibility for the preparation of insurance fraud, and it occurs, when a person causes bodily injury to himself/herself or to another person, or destroys or damages property owned by himself/herself or another person with intent to deceive the insurer or for other fraudulent purposes.

Austrian Criminal Law provides criminal liability for “insurance abuse” – a deliberate destruction or spoilage of the insured property or causing bodily injury to oneself or another person, or causing other injuries to health.

In Germany, criminal liability is provided for fraud committed with the intention to receive a higher insurance indemnity. Arson is treated as the most dangerous type of fraud.

In France and Lithuania, just as in Russia, insurance fraud in the criminal law is not dealt with separately.

In Poland, the Criminal Law provides liability for causing an accident which is the basis for the payment of insurance indemnity to obtain compensation under the insurance contract, which is punishable by imprisonment of up to 5 years.

The Criminal Code of the Netherlands provides that, a person is punishable when he/she, with the intention to obtain illegal income for oneself or another, to the detriment of the insurer, sets on fire or blows up a property which is insured against fire damage, or who with the same intention sinks a vessel or destroys an aircraft, if this vessel or aircraft or the property located on board of this vessel or aircraft have been insured, or if he/she runs the vessel aground or causes the vessel to crash, or with the same intention destroys or damages the vessel. Another article of the Criminal Code provides criminal liability for a person who, by using a deft trick, misleads the insurer about the circumstances relating to the insurance, forcing him to enter into a contract

which he would not have entered into or would have entered into on different terms, if he knew the real conditions of the matter.

Danish Criminal Code provides punishment for a person who sets on fire their personal property or, with the permission of the property owner, the property of another person, with the purpose of deceiving the insurer. The offence is classified as a crime posing danger to the public.

Belgian Criminal Code refers to setting on fire movable or immovable property of the perpetrator, when fire has become an instrument for the realisation of evil or deceitful tendencies.

Estonian Penal Code provides for criminal liability of a person who contributes to the occurrence of any insurance event or creates a false impression of the occurrence of the insurance event in order to obtain insurance indemnity.

Substantial prison sentences for insurance fraud are provided in the Balkans: in Romania up to 12 years, in Serbia up to 10 years and in Bulgaria up to 8 years. China deals separately with a type of insurance fraud, where the subject is an insurance company employee.

Based on the analysis performed, the author has prepared **proposals for the modification of the criminal law framework:**

- 1) Must include personal and civil liability insurance types;
- 2) The term “insurance moneys” used in Article 178 of the Criminal Law should be exchanged for “insurance indemnity”;
- 3) Reference to the ownership of the destroyed property highlighting the fraudulent purpose should be removed;
- 4) Adequate penalties should be determined.

The author opposes the view of A. Mežulis about the inclusion of insurance fraud in Article 177 of the Criminal Law by offering to amend Article 178 and to add Article 210 (1) to the Criminal Law, taking into account

the existing criminal law framework for knowingly providing false information to credit institutions (the author believes that similar provisions should be introduced in respect to insurance transactions). The exact wording of these articles can be found in the author's proposals at the end of the paper.

These proposals are currently being reviewed on behalf of the Latvian Insurers Association by the Ministry of Justice Working Party for the Improvement of the Criminal Law Framework.

## **2.4. Preconditions for Insurance Fraud**

### **2.4.1. Summary of the Research Results and Analysis of the Data**

The social dimension of insurance fraud is assessed by analysing the public attitude towards this phenomenon. Public tolerance against fraud increases its prevalence, reduces the likelihood of fraud detection and reduces the level of penalties.

As a result of public pressure insurers, unwilling to damage their relationship with their clients and also wishing to save on resources, can pay insurance indemnities without any additional complex tests.

Insurance clients, whether or not they support fraud, are guided by their attitude toward a particular insurer. Having to buy insurance against their will, when required by the law or the creditor, contribute to negative attitudes of the clients.

The author analyses insurers' reputation, noticing that the majority of Latvian companies have a negative attitude towards insurers, as demonstrated by the corporate reputation measurement performed by the market, social and media research agency TNS Latvia in 2009.

### **2.4.1.1. Latvian Resident Surveys**

In collaboration with the marketing and public opinion research centre SKDS; the author conducted three sociological surveys at different times, where respondents answered three questions. This shows how opinions have been affected by the economic processes taking place during 2007-2009.

Before presenting the survey, the author analysed results of the sociological survey performed by LETA – “Nozare.lv”, in collaboration with SKDS, on the factors which hamper the Latvian people to buy insurance services, which provides relevant information for the study.

The first survey was initiated by the author in December 2006. 1058 people were interviewed, finding that less than one third of the respondents had an active negative position against insurance fraud. The rest of the respondents' opinion varied. About a third of the respondents' positions were rather negative. However, they were not ready to define it as clearly negative. By contrast, one fifth of the respondents were in favour of insurance fraud and they themselves would afford to cheat and also would support others cheating.

In order to obtain insurance indemnities, 48 respondents were completely open to the possibility to conceal or misrepresent some information. 144 respondents would likely allow it, 303 respondents would likely not allow it and 336 respondents would never allow it. Others did not have a clear answer.

Only 65 respondents stated that they would definitely report a person to law enforcement agencies who has concealed or misrepresented information in order to receive insurance indemnity. 171 respondents would likely report it, 298 respondents would likely not report it and 212 respondents would not report it at all. Others did not have a clear answer.

Only 191 respondents believed that concealment or misrepresentation or information in order to receive insurance indemnity should be criminally

punishable. 375 respondents believed that it should rather be punishable, 112 respondents answered that it should rather not be punishable and 68 respondents took the view that it should not be punishable at all. 312 respondents did not have a clear answer.

A repeated survey was carried out at the end of 2008, when the economic situation rapidly declined. Respondents were asked the same questions as in 2006.

The survey, which had 1011 respondents, showed a sharp decline in the number of respondents who had difficulties in defining their position, indicating that over time the Latvian people have been educating themselves in insurance matters and their knowledge of insurance has increased. This has allowed the respondents to define their position more accurately, while increasing the likelihood of concealing their true position. After learning, for example, from the media, that it is illegal to deceive insurers, people tend to answer the questions “as needed” and not to disclose their true opinion. Thus, an active negative position against insurance fraud in the survey in 2008 was expressed by more than one third of those surveyed. There was a slight decrease in the number of respondents whose position was rather negative, but they were not ready to clearly define it. By contrast, nearly one third of the respondents expressed support for insurance fraud. Many more people were willing to formulate their position on the criminal punishment for providing false information, but the majority acknowledged that it should not be punished criminally.

31 respondents fully permitted and 151 respondents would rather permit a possibility to conceal or misrepresent information in order to receive insurance indemnity. 295 respondents would rather not permit such a possibility and 337 respondents would not permit it at all. Others did not have a clear answer.

Only 27 respondents would definitely report a person to law enforcement agencies who has concealed or misrepresented information in order to receive insurance indemnity, 124 respondents would likely report it, 298 respondents would likely not report it and 262 respondents would not report it at all. 301 respondents did not have a clear answer.

Only 155 respondents believed that concealment or misrepresentation of information in order to receive insurance indemnity should be criminally punishable. 403 respondents believed that it should rather be punishable, 188 respondents answered that it should rather not be punishable and 111 respondents took the view that it should not be punishable. Others did not have a clear answer.

1060 respondents took part of the survey carried out at the end of 2009. More than one third of the respondents took an active negative position against insurance fraud in 2009. The number of respondents who expressed their support for insurance fraud remained unchanged, representing approximately one third. The results indicated that one part of the people could not clearly formulate their opinion with regard to deceiving insurers. On the one hand, due to increased general awareness, people know that providing false information to insurers is unlawful, but they tend to justify it, so they cannot accurately express their views in responding to the survey questions. Several people were willing to formulate their position on the criminal punishment of providing false information to insurers, admitting that it should rather not be criminally punished.

Thus, 73 respondents would fully permit a possibility to conceal or misrepresent some information in order to receive insurance indemnity, 279 respondents would rather not permit it and 387 respondents would not permit it at all. Others did not have a clear answer.

Only 44 respondents would definitely report to law enforcement agencies a person who has concealed or misrepresented information in order to receive insurance indemnity, 136 respondents would likely report it, 335 respondents would likely not report it and 324 respondents would not report it at all. Others did not have a clear answer.

This time as many as 168 respondents believed that concealment or misrepresentation of information in order to receive insurance indemnity should be criminally punishable. 361 respondents believed that it should rather be punishable, 164 respondents believed that it should rather not be punishable and as many as 149 respondents took the view that it should not be punishable. Other respondents did not have a clear answer.

On the question of the sociological portrait of insurance fraud supporters, it appears that their characteristics are not uniform. Thus, any average Latvian resident could decide to provide false information to an insurer in order to obtain unlawful insurance indemnity (commit insurance fraud), given the right situation. That characterises the public attitude toward the issue of insurance fraud in general.

#### **2.4.1.2. Survey of Judges**

Given that the overall public attitude toward insurance and insurers also affects the behaviour and opinions of judges, as well as the fact that judges are professional lawyers, their ability to evaluate insurance fraud cases is more qualitative and more objective than that of an average representative of society. Consequently, judges are in a dual situation which is affected by the underlying factors – on the one hand, the overall opinion of the society supporting fraud may not be totally ignored, and on the other hand, the position is determined by the awareness that criminal acts should be adequately qualified and the persons who committed crimes should be duly punished.

The author interviewed judges in forty two judicial institutions. Most of the judges responded that they cannot comment on the nature of the problem because they do not have appropriate knowledge and have not encountered this phenomenon in real life.

Ten courts sent 23 interview questionnaires completed by judges, which mainly expressed that the respondents did not have much information on the matter.

Many judges stated that the image of insurers is negative because they often wrongly refuse to pay insurance indemnity.

With regard to the problems encountered during pre-trial investigation in criminal matters relating to insurance fraud, the following problems were mentioned:

- 1) Investigation is carried out superficially (6 responses);
- 2) Intention is difficult to prove (4 responses);
- 3) Insurers are wrong in poorly documenting the conditions of the potential insurance fraud reported (4 responses);
- 4) Incomplete regulatory framework (3 responses);
- 5) Insurers are exaggerating and elements of crime are often non-existent (here and below – 1 response);
- 6) Lengthy investigation periods;
- 7) Difficulties usually arise due to the lawyers, who by references to a number of contracts and annexes unreasonably complicate the litigation process;
- 8) The initial decision on the prosecution of insurance fraud is not well motivated;
- 9) All of the above mentioned reasons interacting.

One judge noted that there were no difficulties at all with this category of criminal cases. None of the interviewed judges thought on this

and other issues that judges would lack knowledge about insurance, which according to the author is a doubtful statement.

In terms of difficulty when examining civil disputes with insurers, the following opinions were stated:

- 1) Insurers often deny insurance claims wrongly and this is where such disputes begin (8 responses);
- 2) Insurers enter into low quality insurance contracts with vague rules and permit several interpretations. Besides, they are more focused on protecting the interests of insurance companies and less on protecting the client (3 responses);
- 3) Insurance fraud may not be the subject of a civil dispute – two responses (the author disagrees with this statement);
- 4) Regulatory framework for insurance and related issues is incomplete (here and below – one response);
- 5) When entering into insurance contracts, insurers do not explain the clients their rights. Contracts tend to contain technical errors, while unfounded refusal to pay insurance indemnity is only one of many civil disputes relating to insurance;
- 6) An insurance contract as such practically does not exist, it is replaced by an insurance policy and insurance terms that cannot be amended by the insured, as these are standard forms. Insurance legislation is known for its artificial complexity, non-transparency and frequent amendments;
- 7) There are problems with expert's reports.

Eight judges that had not encountered civil investigation related to insurance disputes stated that they could not properly judge it. Two interviewees indicated that there had been very few cases related to insurance disputes (only one case was mentioned, where a person wanted to get double insurance indemnity), therefore they could not express a competent opinion.

Views on the types of insurance, which are at the most risk of fraud, were the following:

- 1) Car insurance (CASCO) in connection with theft (13 responses);
- 2) Car insurance (both OCTA and CASCO) in relation to road traffic accidents (11 responses);
- 3) Property insurance in connection with fires (9 responses);
- 4) Property insurance in connection with burglary and theft (4 responses);
- 5) Health insurance (3 responses);
- 6) Life insurance (one response).

The following views were expressed in relation to the liability provided for insurance fraud in the Criminal Law, considering the usefulness of extending the article so that it would apply to the cases of fraud of any type of insurance:

- 1) It would be appropriate to extend the contents of Article 178 of the Criminal Law so that it would refer to insurance fraud cases in any type of insurance (15 responses);
- 2) Do nothing (2 responses);
- 3) The legislation initiative should come from insurers, since judges currently do not see such a need, as the number of cases initiated and reviewed is quite small (here and below – one response);
- 4) At the moment, changes in legislation are not urgent, but legislation should be changed in the near future due to expected increase of insurance fraud.

When asked about the possible categories of people that are most commonly involved in insurance fraud, the following responses were provided:

- 1) Persons working for private companies (9 responses);
- 2) Anybody (4 responses);

- 3) Persons working for state institutions or enterprises (3 responses);
- 4) Persons who have casual employment (3 responses);
- 5) Persons who have a tendency to live at the expense of others, and who possess corresponding character traits (lack of respect for other individuals and their possessions, etc.) or who are capable of working but who are not studying and do not have a permanent job (one response);
- 6) Long-term clients or those who have used insurance services only once or twice.

The judges expressed the following views on whether it would be an acceptable idea to establish specialized courts in Latvia to deal with specific insurance-related cases:

- 1) Yes for both criminal and civil cases (6 responses);
- 2) Yes for civil cases only (one response);
- 3) At the moment it is not possible to create such courts, as the number of cases is small (14 responses);
- 4) It is not right to have a specialised court for each area, for example, housing disputes, road traffic accidents and others, but rather there should be appropriate training programs for the existing judges (one response);
- 5) Yes to criminal cases involving insurance fraud and other financial crimes, thus the specialized courts could have a broader focus (one response).

As to whether there are legally unresolved issues relating to insurance or any actions that need to be taken to prevent or fight against fraud, the judges stated that:

- 1) The legal framework is generally adequate and insurance procedures are sufficiently regulated, including a mechanism for establishing signs of fraud;

- 2) The civil law framework is sufficient, but in certain cases there are problems with the application;
- 3) Unresolved issues certainly exist but nobody has thought of how to tackle them;
- 4) Criminal cases brought before the court are not complicated and in reviewing them one is unlikely to face problems with application of laws;
- 5) Insurers must cooperate in gathering information about risk customers who have frequent car accidents or theft, and upon proving fraud;
- 6) There may be situations within the health insurance system, where the insured, without even realising that their actions are illegal, may simultaneously receive services from several institutions exceeding the limits or transfer their policy to another person;
- 7) Cannot comment, as they have not had adequate judicial practice (the most common answer).

#### **2.4.1.3. Results of Expert Interviews**

The author interviewed three experts: anti-fraud specialists of the leading Latvian insurance companies.

Discussing the difficulties faced when investigating insurance fraud cases, all experts said that the regulatory framework is incomplete and representatives of law enforcement institutions lack knowledge about insurance. In addition, it was noted that law enforcement agencies lack technical materials, it is difficult to prove the intent and that the insurer is not the victim in criminal proceedings.

An opinion was suggested that all types of insurance are exposed to fraud. However, insurance fraud is most common in car insurance in connection with theft and property insurance in connection with fires. Fraud is also widespread in car insurance in connection with traffic accidents and

property insurance in connection with burglary, health and accident insurance. Somebody mentioned cargo and different liability insurance for large amounts, which is linked to international criminal schemes.

Experts believe that law enforcement authorities are reluctant to deal with insurance fraud investigations due to the lack of knowledge about insurance and incomplete regulatory framework. In addition, it is relatively difficult to prove a criminal offence in insurance fraud – it requires not only knowledge but also a very long time, so there are very few law enforcement agents who wish to investigate such criminal activities.

Expert opinions differ on the issue of the categories of people who are involved in insurance fraud most frequently.

Expert opinions differ on the issue of involvement of insurance company workers in insurance fraud. Similarly, expert opinions are divided on the issue of involvement of lawyers, doctors, car repair shop workers and other specialists in insurance fraud.

All experts pointed out that the Criminal Law need to be amended in relation to criminal liability for insurance fraud. Additionally, there are problems with using detective services requiring amendments to the Criminal Procedure Law.

#### **2.4.1.4. Discussion in a Group of Students**

The author organised a discussion in a group of law students, a significant share of which were working in their profession. At the time of the discussion, the students had finished a course of Insurance Law studies.

The students named the following possible reasons for insurance fraud: insurers cheat their customers, so insurance fraud by clients is justified; people just need money; eight students out of seventeen were ready to defraud an insurer themselves, but seven group members would never do it.

To confirm the presumption on the negative public attitude against insurers, 11 participants revealed that they would not report to law enforcement agencies the concealment or misrepresentation of information, if they found out about it. Only two students explicitly confirmed that they would report it, and one student would likely report it.

Only eight students felt that misrepresentation or concealment of information provided to the insurer is a criminal offence, five admitted that liability should be incurred by reaching a certain amount and two felt that there should be no responsibility at all.

The following suggestions were made during the discussion on the actions required to fight insurance fraud:

- 1) Insurers must earn customer loyalty;
- 2) Insurance contract terms should be more carefully designed;
- 3) Insurers should investigate the reported cases more carefully;
- 4) The public should be educated in insurance matters;
- 5) Real and fair punishment must be defined for unlawful conduct related to insurance;
- 6) The state must improve the economic situation.

#### **2.4.2. Analysis of Possible Preconditions of Insurance Fraud**

Based on the results of the surveys, interviews and the debate, as well as the author's observations and empirical findings, the paper concludes that the social phenomenon of the support for insurance fraud may be explained by the following influences:

- 1) Fraud in the insurance field can be compared with economic crime, against which the general attitude of the public since Soviet times has been tolerant (in any case more tolerant than against other crimes);

2) Insurance fraud is a relatively simple way to improve your financial situation with a relatively low risk of being caught – it is especially important at times of economic recession, when the financial ability of individuals and businesses is significantly reduced;

3) Producers of motion pictures and other popular art are consciously or unconsciously advocating successful criminals – an image of an intellectual, especially in relation to financial crimes, which also includes insurance fraud;

4) When reviewing applications of possible insurance fraud, it is quite a difficult task to distinguish true victims from scammers. Therefore, in the fight against dishonest customers, in a doubtful situation insurers may make a mistake by wrongly denying insurance indemnity due to fraud. This fact in the people's minds is exaggerated and distorted, so they accuse insurers of knowingly misleading their clients in the selfish interests of the insurer (as indicated by the stereotype which states that “all insurers are swindlers”). The situation gets even more complicated, because in Latvia there is no well-established methodology for identification of insurance fraud, and the insurer bears the burden to prove any fact that releases it from the obligation to pay indemnity;

5) Insurance companies have not been able to make a “black list” of policyholders, which would prevent the recurrence of fraud;

6) The principle of publicity in respect of public fraud cases has not been observed but is concealed fearing that publicity will have a negative effect on the competitiveness of the insurance company;

7) The attitude of law enforcement authorities (police, prosecutors and courts) toward insurance fraud is not adequate and professional enough, which creates a false impression of the public hazard of these offences. Insurance fraud investigation in individual cases is difficult because of corruption;

8) Health insurance fraud is promoted by the fact that medical institutions, when providing treatment services, are issuing invoices for services that they did not provide, or in seeking to increase their revenues, provide services that are not necessary in a specific situation.

In concluding the analysis, it should be noted that one of the universal factors that may discourage potential fraudsters from committing a crime, is the fear of being caught and the shame of being publicly condemned, but in case of insurance fraud these are absent.

### **2.4.3. Impact of Economic Processes**

Economic processes affect the criminal situation.

Various numerical evidences has been analysed for the impact of economic processes on insurance fraud and non-violent crimes. During a recession the number of fraud cases has increased. The paper analyses the evidence provided by Denise R. Osborne proving the link between crime and economic indicators in the UK, the evidence provided by Antonello Scorcu and Roberto Cellini proving the link between crime and economic indicators in Italy, the evidence provided by Masahiro Tsushima proving the correlation between the level of unemployment and crime rates in Japan and the evidence provided by Paolo Buananno and Daniel Montolio signalling the increase of property crime due to the increase of unemployment in Spain.

The Association of British Insurers found that there were pretty clear signals indicating that the recession has led to an increased volume of insurance fraud, as well as an increased number of cases, where the intention of entering into insurance contracts is the reduction of the size of insurance premium. There are signs that indicate the increasing number of cases where customers attempt to commit fraud for the first time. There are also an increasing number of people who believe that insurance fraud is acceptable behaviour. Even the

UK Fraud Prevention Service – CIFAS has stated that the number of fraudulent insurance claims during the recession has increased.

However, the impact of the recession has a time lag. Insurance clients are trying to defraud funds from insurers in order to maintain or return their previous standard of living. This behaviour is negatively affected by the faults of the Latvian insurance legislation in dealing with the problems related to the value reduction of the insured object. In personal insurance, the unlawful conduct of clients and health care providers is arising out of the disorderly health care issues. There are also problems associated with prosecution of offenders for illegal activities in the field of insurance both in a context of the criminal law and the criminal procedure.

During economic downturn, changes in individual behaviour are supported by pre-existing factors, the impact of which will intensify during recession:

- 1) The client is in need of money and sees no way for obtaining it legally in the current situation;
- 2) The public legal consciousness level is low and many do not consider insurance fraud to be a crime;
- 3) There is a public perception that fraud against insurers can be justified, because:
  - a) Insurers have a lot of money, so they can share it, nobody will suffer because of it;
  - b) Insurers cheat their customers too;
- 4) When selecting between other types of property misappropriation and insurance fraud, insurance fraud is chosen, because:
  - a) It is hard to prove the crime (the intent is often demonstrable);
  - b) One can always “make an arrangement” with law enforcement agencies.

## **2.5. Methods for Combating and Preventing Insurance Fraud**

While the calculations vary, the weight of empirical evidence shows that fraudulent activities in the insurance field are a serious problem in all insurance markets of the world, but particularly in Latvia.

New methods of detection and combat are increasingly applied in the fight against insurance fraud and its consequences, together with informative campaigns about the possible consequences and harmful effects of fraud, as well as drafting tougher laws to combat fraud.

Insurance contract is a unique type of relationship that affects the nature of insurance fraud, as well as the ways and methods used to solve this problem. As the competition increases, insurers are paying more attention to the identification of fraud and collection of evidence. The author refers to the ideas of Richard Derrig, according to which the insurers are increasingly willing to litigate and turn to law enforcement agencies in connection with fraud.

Publicity campaigns that may reduce the prevalence of insurance fraud often focus only on the possible criminal liability and related penalty. Taking into consideration the public view that provision of false information to the insurer or increasing the claimed amount cannot be criminalised, such campaigns do not solve the problem. In addition, focusing on the criminal nature of fraud may be rebutted by the negative perceptions of insurers and their fairness, which may contribute to an even greater prevalence of fraud. Thus, more attention should be paid to civic education and public awareness.

According to the views of Emile Durkheim and Peter Berger on social control, laws should be flexible enough to respond to the social realities.

The author believes that, in the context of preventing negative phenomena, the society should regularly amend the legal system to align the

rights with the public position. The role of courts is not relevant, because unlike in some other countries, in Latvia it cannot deal with the rights too freely.

Analysing the microeconomic analysis approach and the related aspects, it may be concluded that a major role in combating fraud should be granted to insurers themselves, working towards the establishment of insurance regulations and ensuring investigation of the cases reported. This is confirmed by the research of Martin Boyer, Richard Derrig, Herbert Weisberg, Pierre Picard and other scientists.

However, one must take into consideration that a particular insurer upon taking a decision on allocation of resources for investigation of suspicious cases will be led by the principle of economic expedience and will first evaluate whether this decision will enable them to compete successfully in the insurance market and only then will consider whether the decision could have a negative impact on the insurance market as a whole. It is therefore important to consider the conclusions of Ignacio Moreno and other co-authors, that fraud can be reduced by threatening to increase premiums in the future and applying discounts and a bonus (*bonus-malus*) system.

One should also examine the internal motivation of insurance clients. The behaviour of insurance clients depends on the level of internalisation and activity of the social norms upon entering into an insurance relationship. If the fair conduct mechanisms of internal satisfaction are not active, individuals will not be able to evaluate the conformity of their actions with the social norms, which will lead to a greater prevalence of fraudulent activities. This is confirmed also by insurance fraud experiments conducted by Mazara, Arieli together with On Amir, Johannes Brinkmann and Uri Gneezy.

Insurance customers are willing to commit fraud, if they believe that the injury to another person is not important or does not exist at all. Thus, rationalisation of insurance fraud by self-deceit may increase dishonesty of

insurance clients. Possible action on the part of the insurers: insurance clients must be convinced of the potential damage that may be caused to the insurer, the society as a whole or its individual members.

### **2.5.1. Review of the Methods for Combating and Preventing Insurance Fraud**

European Union monitoring requirements provide for the prevention of possible effects of insurance fraud to protect interests of consumers and not distort the market.

Those insurers that successfully prevent fraudulent practices have a lower level of losses and higher profits. These benefits must be weighed against the administrative costs of identifying and proving fraud. It is not expedient to examine each insurance claim application because the expenses incurred as a result of these tests may outweigh the benefits. An insurance indemnity check is made when claiming large amounts.

In Latvia the anti-fraud method of suspicious case selection is not used. This method uses statistics to sum up a set of criteria. When the value of these criteria reaches the critical amount, the case is transferred for an in-depth investigation. This method can be used with the help of specialised software.

In Latvia, unlike in other countries, information exchange between insurers about fraudulent and suspicious transactions is not developed.

Methods for combating and preventing insurance fraud may be divided as follows:

- 1) Legal methods;
- 2) Social methods;
- 3) Corporate methods.

### **2.5.2. Social Methods**

Social methods for combating and preventing insurance fraud include a set of measures for mutual cooperation in fraud related issues with state institutions, insurance companies, public organisations and others.

One aspect is the attitude of clients toward insurers. If it is negative, the trend of supporting and engaging in fraud against insurers will be more noticeable.

As mentioned before, an important focus in insurance fraud prevention should be put on public information and education about insurance issues. The social approach to preventing insurance fraud is attempting to prove to the public that insurance fraud is unacceptable. The image of the insurance industry must be improved by promoting trust between the insurers and clients.

Insurers themselves have a major role in the organisation and financing of educational activities, but state support is required, as without it the training and information efforts cannot gain sufficient public trust.

The European Parliament adopted a Resolution on 18 November 2008 on improving consumer education and awareness on credit and finance, emphasising the need for education and awareness measures and pointing out that high quality financial education programmes, which are targeted and, where appropriate, can be personalised as necessary, can contribute to raising financial literacy, allowing consumers to make informed choices and thus allowing financial markets to function effectively. Educational needs must be defined for specific target groups of society, according to a mix of criteria such as age, income and level of education.

Financial education should be offered in a fair, unbiased and transparent manner, clearly distinguishing it from commercial advice and advertising.

The European Commission has set up an educational website, Dolceta, but the information is still incomplete. Financial education should be included

in the state-approved general curriculum for primary and secondary schools. A financial education network may be set up at the national level, including both public and private sectors, promoting cooperation and dialogue between all parties involved. In Latvia, an Insurance Law study course should be included in university preparation programs for lawyers, as well as in programs for other professionals who are in contact with insurance.

A possibility should be provided to report possible cases of fraud anonymously, for example, through special websites.

Insurers should share information on the insurance contracts concluded and insurance indemnities paid, if there are signs of fraud. In Latvia, insurers do not systematically exchange information on the security staff level. Only compulsory motor third party liability insurance has a single database of the insurance contracts concluded and insurance indemnities paid. Cooperation in other insurance classes is hindered by the regulatory framework and practices related to protection of personal data and competition, as well as the competition fight between the insurance market participants. International cooperation is occasional.

Car insurance, particularly in connection with theft, is the most subject to fraud. Latvia should join the International Convention for the Recovery of Stolen Vehicles, which addresses information sharing and data access issues related to cars stolen in the territory of Europe, for which insurance indemnity is paid. The Convention provides for the coordination of actions of the police and insurers, forming public-private partnership and ensuring operation of focal points for information exchange on the stolen vehicles.

Thus, all possible social methods are arranged in three groups:

- 1) Publishing information on insurance relationships and insurance fraud provided by the insurers, the state and other persons;
- 2) Educating the public in financial matters;

3) Information exchange involving the insurers and state institutions – either within Latvia or internationally.

### **2.5.3. Corporate Methods**

Corporate methods are the internal procedures implemented by each insurer. It is a set of measures to prevent and combat fraud.

One such method includes surveys and checks of potential clients before concluding insurance contracts. Various fraud indicators are developed and successfully applied in practice. However, overall the individual, psychological and subjective approach prevails, which contributes to the occurrence of errors, thus negatively affecting the image of the insurer.

The insurer takes a decision on the payment or refusal of insurance indemnity after examining the customer's application. The very fact of examination may prevent the insurance client from submitting a fraudulent loss application. However, a detailed examination requires large resources or the truth is very difficult to detect. Thus, the insurer must achieve balance between reducing the possible payable amount in detecting insurance fraud cases, and limiting costs of examination. Insurers are not interested in performing unreasonable or complex customer checks, as the information on the reputation of insurers is published regularly. Information about fraudsters should be published in a similar way.

A practical approach to the problem of insurance fraud and loss adjustment procedures can be found in the materials of the 9th International Conference on Strategy and Management in Cross-Border Motor Claims 2010, emphasising the importance of anti-fraud activities, because indemnities to fraudsters are paid from the premiums paid by honest customers.

Fraud management strategy should be part of the insurer's business strategy, which is composed of a general mission, business strategy and goals.

In determining the risk profile, including vulnerability to the risks of fraud, insurers should take into account the following factors:

- 1) Business size, composition and intensity;
- 2) Organisational structure;
- 3) Complexity of operations;
- 4) Products and services offered;
- 5) Cost policy;
- 6) Distribution terms;
- 7) Market conditions.

The strategy must be reviewed on a regular basis, taking into account any material changes in the insurer's risk profile. The strategy must also be properly documented and the staff should be informed about it. There should be a control system to identify and prevent unauthorised deviations. The volume and nature of activities must be proportionate. The policies and procedures for the management of insurance fraud risk should include:

- 1) Fraud management functions and responsibilities, as well as staff authorisation;
- 2) Measures for identification and reduction of the risk of fraud;
- 3) Measures for monitoring cases of fraud;
- 4) Reporting fraud or suspected fraud, as well as examination and investigation of fraud;
- 5) Registration of fraud and suspicious incidents;
- 6) Internal and external training on fraud for executives, managers and staff.

The insurer shall save all reports of all detected cases of fraud or suspected fraud, as well as internal investigation information together with analytical data. The time spent should be assessed.

The insurer should ensure adequate measures for the evaluation of information about the potential customer before accepting the offer. Risk factors must be taken into account, which tend to vary depending on the distribution channel of the insurance product. Similarly, an insurer should recognise certain products or services that are particularly at risk. The insurer must identify risk factors of fraud in all stages of the insurance process.

In order to successfully detect fraud in a particular insurance class, in some cases examination should be performed even before concluding the insurance contract by segmenting the requirements depending on the specifics of the insurance event and the customer base. It should be ensured that the insurance amount against losses and damages would be equal to the insurance object value, because over-insurance may encourage fraud. The insurer may prevent fraud by:

- 1) Developing a methodology for the conclusion of insurance contracts;
- 2) Developing a methodology for loss adjustment;
- 3) Controlling the level of losses;
- 4) Providing high quality risk management (including Solvency II).

The insurer should also have an adequate customer acceptance policy, including the usual distribution of clients and products by categories, identifying any unusual customer and product combinations and setting clear rules for these.

Due to mutual competition, insurers try not to encumber their potential clients with requests of detailed information and documents. Besides, it is not worth it to perform serious checks before concluding the insurance contract for insurance types requiring a low insurance premium and with a low probability of risk occurrence, which of course increases the risk of fraud.

Possibilities to detect and prove fraud are limited by the legal presumption, which means that the insurer is obliged to prove any

circumstances which in exceptional cases would exempt him from fulfilling the insurance contract obligations. Thus, an important factor in the prevention of fraud is examination of the applied losses, providing the structural units and security service with resources for performance of their functions. Employees should be adequately trained and training is to be repeated on a regular basis. Criteria for performing investigation should be specified. Each investigation should be planned. Indicators should be determined for detecting insurance fraud:

1) The policyholder has previously imposed restrictions by another insurer due to the provision of false information;

2) The person applying for losses has consented or supplied information regarding abnormally low amounts of loss in exchange for a quick decision of the insurer on the payment of insurance indemnity;

3) The loss application contains inconsistencies regarding the incident or the extent of damages, or there are inconsistencies in the information provided to the institutions involved in the accident investigation such as the insurer or the police;

4) The applicant submits several similar claims within a relatively short period of time.

Specific tests (software) may be developed to identify suspicious cases:

The author suggests the following procedures to protect against the risk of fraud:

1) Examination of fraudulent claims;

2) Examination of potential clients in the internal database or other sources;

3) Applicant interviews and special investigation in suspicious cases.

Insurers should use more computerised data processing systems in their work and continuously provide for their development.

Errors could be eliminated, if the insurers would select their employees more carefully and train them. Investigations must be carried out and a list of fraud experts should be created for organising receipt of outsourced services.

The insurer must inform the policyholder that knowingly providing false or misleading information to the insurer may be interpreted as insurance fraud.

Activity of insurance brokers should be monitored to avoid participation in fraud.

The insurer's board and council should prevent any threats of fraud to the company which may have a negative effect on the insurer.

The insurer must ensure that all perpetrators are punished, since punishment received for submitting a fraudulent loss application reduces the fraud factor.

#### **2.5.4. Legal Methods**

The effect of laws on insurance fraud at the policy level is not observed. In some cases, the law even increases the number of insurance fraud cases. Therefore, in Latvia there is a problem with state penalties for insurance fraud and their practical application, as the legal framework is incomplete and amendments are needed in the Criminal Law and other laws. Creation of specialised courts is currently questionable due to the small number of cases.

The composition of insurance fraud as defined in the Criminal Law is not accurate, contains deficiencies and requires substantial improvements. Prior to performing the analysis of the criminal law framework for insurance fraud, the author had already concluded on the need to make necessary amendments.

The author argues against the use of good faith to justify insurance fraud by looking at the problem only in the social context and with only one objective

– to ensure the protection of consumers’ interests, which cannot be viewed as an appropriate approach to solving the insurance fraud problem.

The legal framework for insurance contracts must be put in order – a new law is needed instead of the Law on Insurance Contracts, because the legal environment has changed significantly and new insurance products have emerged. That would eliminate differences in the interpretation of laws regulating insurance relationships and promote a uniform court practice. Ensuring compliance with the existing European regulations would eliminate barriers for a unified operation of the European Union’s internal insurance market.

The task of the legislator is to establish a general framework corresponding to the structure and design of the insurance products, as well as regulate the operation of the insurers related thereto, by arranging the business environment and promoting fair competition and provision of quality services.

The author believes that the Europe-wide project “Restatement of European Insurance Contract Law” could become the basis for the new law.

## **2.6. Conclusions**

As result of the study and by attaining the goal and tasks of the work, the author proposes the following theses to be defended, which have been expressed in the form of conclusions and proposals:

1. The public perception of insurance fraud varies – it is especially evident when comparing the situation in Latvia and abroad. There is no common definition for insurance fraud. The author’s study is based on the following insurance fraud definition: “Insurance fraud is any deliberate (malicious) activity of a person for the purpose of unduly benefiting from payment of insurance indemnity, directly or indirectly, including making the insurer pay the insurance indemnity in a larger amount than is due according to

the insurance agreement or circumstances of the accident which has taken place, or achieving that the insurance indemnity is paid to another person, for example, a creditor, thus minimising credit obligations of the person”.

Considering the varied understanding of insurance fraud, as well as the application of different definitions, it is required to amend the existing legal regulation to eliminate non-uniform practices with respect to defining the insurance fraud.

For the purpose of making more reasoned judgments on improving legal regulations, as well as on possibilities of fighting and preventing insurance fraud, the events of insurance fraud may be grouped depending on the type of insurance, the mechanism of damage occurrence, circumstances of the event, characteristics of the person performing fraud or based on subjective attitude of the person involved in performance of fraud.

Depending on the mechanism of damage occurrence, there may be damages filed with the insurer which has been caused by:

(1) the person deliberately destroying, hiding or damaging any property or deliberately causing bodily harm to anybody for the purpose of benefiting from payment of insurance indemnity;

(2) the circumstances not dependent on the person, when the person intends to achieve indemnification of such damages by receiving insurance indemnity and provides untrue information to the insurer with respect to circumstances of damage occurrence; those are the cases when the circumstances of damage occurrence do not permit payment of insurance indemnity under the insurance agreement or the insurance indemnity is payable in a smaller amount than requested by the person from the insurer.

The persons performing insurance fraud may be divided into three groups: average consumers, criminally-minded persons, representatives of organised crime.

It is possible to classify the events of insurance fraud depending on the mechanism of how the insurance fraud is performed: exaggerating damages, distorting circumstances of the event, prior falsification of the event.

Insurance fraud is more common in motor vehicle insurance where it may be expressed as:

- (1) Hiding the insurance object – imitation of theft or burglary, including deliberately increasing the value of the insurance object;
- (2) Staging the traffic accident, also increasing the value of the insurance object;
- (3) Staging theft of the insurance object parts or its additional equipment;
- (4) Burning the insurance object;
- (5) Making up and exaggerating damages;
- (6) Distorting the circumstances.

Fraud with respect to circumstances of the traffic accident is often related to compulsory civil liability insurance of owners of motor vehicles, both for vehicle damages and bodily harm.

Events of fraud are also possible in property insurance, the schemes of which are similar to the ones existing motor vehicle insurance by considering the specifics related to the insurance object properties. Such insurance events are facilitated by insurance above the value.

Insurance fraud in the insurance of persons in Latvia is characterised by the fact that no events of fraud have been registered on the state level, except health insurance. It does not mean that such events have not taken place, rather that they have not been proven or the event identified.

The events of insurance fraud in health insurance have their own specifics as they depend on the state healthcare system organisation. Mostly

those are the events when the medical institution has invoiced the insurer for additional healthcare services supposedly provided to the customers.

The events of insurance fraud may also be divided according to the assessment of consequences. Insurance fraud is characterised by especially high latency. Considering this very high latency, it is quite difficult to assess the damage caused by monetary insurance fraud. This factor distinguishes fraud from other material crimes (for example, damages caused by theft or burglary are mostly obvious).

2. During developing the dissertation, the author has come to the conclusion that the topicality of the insurance fraud problem is growing and its significance is increasing.

The hypothesis proposed in the introduction of the dissertation has been confirmed by establishing, as result of the study, that specific insurance contractual relations provoke insurance fraud, but its spreading is significantly affected by inappropriate public understanding of such relations. Insurance relations are of a specific nature and they require the highest degree of good faith of the parties involved. Asymmetry of information in insurance transactions shows great moral risk which facilitates insurance fraud if supported by the public.

As the result of study, the author has obtained evidence that public opinion justifies provision of untrue information to the insurers, thus supporting insurance fraud. Moreover, the public attitude towards insurers is also negative because the insurers, when they perform verification of information provided by the customers about the potential insurance events, sometimes suspect the bona fide customers also as well as do not, in individual cases, pay the insurance indemnity due to unreasonable suspicion.

The author concludes that residents of Latvia do not feel that insurance fraud is a public problem which should be addressed. A large part of the public

even believes that defrauding the insurer does not deserve a criminal punishment. Insurance fraud is perceived as the insurers' problem only, but the funds of insurers are perceived as unlimited and unidentifiable "wallet" receiving funds from which, due to any reasons, is justified.

Negative public attitude towards insurers, social phenomenon of supporting insurance fraud may be explained by influence of the following factors:

1) Fraud in the field of insurance may be compared to economic crime, general attitude of public towards which has been tolerated since Soviet times (at least more tolerant than towards other crimes).

2) Insurance fraud is a relatively simple way to improve one's financial situation with a relatively small risk of being caught.

3) Producers of movies and other popular arts, deliberately or unconsciously, promote the image of a successful criminal – intellectual, especially related to financial crimes to which insurance fraud belongs, too.

4) When applications for possible insurance events are reviewed, it is a tough job to distinguish fraud from real victims. Therefore the insurers, when fighting dishonest customers, may as well make a mistake in a suspicious situation by unreasonably refusing insurance indemnity due to fraud. This factor is exaggerated and malformed in people's minds by attributing deliberate deception of customers to the insurers in their own interests.

5) Insurance companies have failed to come up with the unfaithful insurant "blacklist" which would, inter alia, provide the opportunity to identify this category of persons and to develop negative public attitude towards it. Such lists do exist in most of the developed European countries; they are amended on a regular basis and are functioning successfully, thereby allowing prevention of repeated fraud. As there are no such lists in Latvia, it is very much possible that even a repeated event of fraud is not identified by allowing the person to avoid

punishment several times which, in turn, increases a sense of insurance fraud impunity.

6) Compliance with publicity principles with respect to discovered events of insurance fraud has not been ensured, because they are usually concealed fearing that any publicity would adversely affect competitiveness of the particular insurance company.

7) The attitude of law enforcement institution (police, prosecutor's office, court) representatives against insurance fraud has not been sufficiently adequate and professional so far, which causes a false impression about public hazard of these offences.

8) Special attention should be devoted to the issue of reasons for defrauding insurers in the section of charged healthcare services – the reasons for fraud is that there are significant deficiencies of the healthcare system organisation.

The author has also gained confidence that insurance fraud causes negative social effects:

1) Insurance premiums are increased for all customers of the insurers by calculating the insurance indemnities paid in the events of fraud into those;

2) Resources are invested into insurance fraud fighting activities;

3) The public is losing the values destroyed by frauds for receiving insurance indemnity, thus, losing the funds which might be invested into development;

4) Activities dangerous to the public may be performed for the sake of receiving insurance indemnity (causing bodily harm, murder).

The economic recession influences insurance fraud; its distribution increases.

Recession will be followed by development of the insurance market which may increase the distribution of insurance fraud significantly, unless the

activities required for fighting and prevention of it are performed. While the number of insurance service purchasers and the volume of services increases and if the problems related to insurance fraud are not duly solved, the damage caused to the public by increase in numbers of insurance fraud will grow and this will adversely affect the competitiveness of Latvian insurers in Europe, and will result in hindering economic growth of Latvia in general.

3. Law enforcement institutions lack the capacity and competence for investigating insurance fraud which leads to the effect that criminal procedures, with respect to discovered insurance fraud events, are either not commenced at all or is terminated due to lack of evidence, or because of the limitation period. Therefore, the insurers are not interested in reporting the discovered events of fraud to police by filing the application for initiating criminal procedure, but simply refuse payment of insurance indemnity based on formal considerations. Thus, criminal prosecution of frauds is often not performed at all and they remain unpunished.

Understanding of judges about insurance fraud varies; hence there is no uniform court practice in the insurance fraud matters.

Law enforcement institutions need to be more active and professional in solving the insurance fraud problem. The public should be aware that the state is prepared to bring the offenders to liability and that criminal sanctions will be inevitably applied to those performing insurance fraud.

Lack of financing in the crisis conditions leads to decrease in financing of police and other law enforcement institution activities which, in turn, adversely affects operation of insurance and other finance sectors.

Considering that the number of insurance fraud cases continues to grow significantly, additional financing is required for police to ensure insurance fraud investigation and police officer training.

Law enforcement institutions need to improve the work in the field of insurance fraud by learning best practices of Latvia and other countries.

When planning training of judges, the Judge Training Centre should include the training on insurance issues, purposes of legal provisions regulating insurance, their international regulation and practice as well as on possible interpretations of legal provisions in force in Latvia in the context of international regulation.

The State Police should plan the training of policemen in insurance issues in relation to legal regulation of insurance as well as the required activities in investigating offences in the financial sector.

4. The criminal law regulation of insurance fraud in Latvia is imperfect and should be amended significantly.

The criminal sanctions should be designed to discourage potential frauds from performance of fraudulent activities. It should be kept in mind that punishing should be cost-effective as keeping the offender in prison may prevent damages to the insurers, but may cause damages to the state which must maintain the prisons.

The author proposes to express Section 178 of the Criminal Law as follows:

“Section 178. Insurance fraud

(1) For a person who commits intentional destruction, damage or concealment of the property for the purpose of receiving insurance payments –

The applicable punishment is deprivation of liberty for a term not exceeding three years, or custodial arrest, or community service, or a fine not exceeding sixty times the minimum monthly salary.

(2) For a person who causes bodily harm to himself or herself for the purpose of receiving the insurance indemnity –

The applicable punishment is deprivation of liberty for a term not exceeding five years, or custodial arrest, or community service, or a fine not exceeding eighty times the minimum monthly salary.

(3) For a person who is guilty of compelling or persuading another person to destroy, damage or conceal insured property, or other influencing for the same purpose, if such has been committed for purposes of receiving insurance indemnity or benefiting from payment of insurance indemnity otherwise –

The applicable punishment is deprivation of liberty for a term not exceeding six years or a fine not exceeding one hundred times the minimum monthly salary.

(4) For a person who commits the acts provided for in Parts one, two and three of this Section, if such have been committed for purposes of obtaining a large amount of insurance indemnity –

The applicable punishment is deprivation of liberty for a term from five to thirteen years or a fine not exceeding one hundred and fifty times the minimum monthly salary.”

The author proposes to append the Criminal Law with Section 210 (1) as follows:

“Section 210 (1). Dishonest receipt and use of insurance services

(1) For a person who provides deliberately untrue information for receipt of insurance services or during use of insurance services –

Applicable punishment is deprivation of liberty for a term not exceeding two years, or community service, or a fine not exceeding fifty times the minimum monthly salary by depriving the right to conduct business for a period from two to five years, or without such deprivation.

(2) For a person who provides deliberately untrue information to the insurer for purposes of receiving insurance indemnity or benefiting from payment of insurance indemnity otherwise –

Applicable punishment is deprivation of liberty for a term not exceeding two years, or custodial arrest, or community service, or a fine not exceeding forty times the minimum monthly salary.

(3) For a person who commits the acts provided for in Parts one and two of this Section, if such have caused significant damage to the state or to rights and interests of another party protected by law –

The applicable punishment is deprivation of liberty for a term not exceeding six years, or community service, or a fine not exceeding eighty times the minimum monthly salary by depriving the right to conduct business for a period from two to five years.”

5. In due course of addressing the problem of insurance fraud prevention it should be first achieved that public attitude towards insurance and insurers remains adequate. Perception of insurance fraud and its assessment by the public should also be changed by discharging the perception of the insurer as the “wallet” which is by all means trying to avoid performance of its obligations.

Public interest in financial issues and their understanding by emphasising the role of insurance in providing financial stability may be promoted by organising the information campaigns.

While for the purpose of changing the attitude, education of Latvian residents in financial issues, especially those related to insurance, may be provided through programmes developed or supported by the state as well as by providing the opportunity to use consultations of independent experts. The consumers should be informed not only about the essence of insurance, but also about their activities and the effects of agreements they have entered into.

All interested parties should be involved in the financial education process: the state, NGOs, consumer organisations and financial institutions. A clear division of responsibilities is required, though. Financial institutions possess special knowledge to develop particular and practical educational programmes, but they cannot be the only provider of financial education and consultations. The other providers of financial education, even more trusted in the eyes of consumers, are independent institutions, for example, consumer organisations and the state. The best solution is when financial training is jointly provided by financial institutions and consumer organisations to also prevent the eventual pressure to purchase financial products aimed at the consumers. By means of seminars, meetings and leaflets, the public should be informed about what the insurance is and who is paying the costs related to insurance fraud. It should be explained to the public that insurance fraud is one of the reasons why people and businesses pay even increasing insurance premiums, the taxpayers pay larger taxes and the costs of products and services are increasing.

The content of information on financial services published on the Consumer Rights Protection Centre and the Finance and Capital Market Commission websites should be improved significantly for purposes of customer education because the published information has a lot of deficiencies and is significantly incomplete.

Unions of insurers, Latvian Insurance Association and Latvian Motor Vehicle Insurance Bureau should develop an action plan for customer education by distinguishing the activities for fighting insurance fraud. Sections of the plan related to motor vehicle insurance should be joined together.

6. By uniting within the Latvian Insurance Association, it would be necessary to develop a general insurance fraud fighting and prevention concept with appropriate recommendations to be applied in Latvia by considering the

accumulated international experience. When developing the respective general concept, the Latvian Insurance Association should involve scientists and specialists with good knowledge of practical issues in this work.

In turn, based on the general concept, each insurer, on its own or by involving the respective specialists, will be able to plan particular activities for improving the organisational structure and implementing the internal procedures.

Each of the insurers should ensure inspection of suspicious damage applications and investigation of eventual events of fraud, because it is in the public's interest.

7. Legal regulation of insurance and also the practice of application of legal provisions governing insurance in Latvia have a lot of deficiencies. Changes in legal environment as well as amendments made to the Law "On Insurance Agreement" facilitate different interpretation of legal provisions regulating insurance relations and promote non-uniform court practice in insurance disputes. The provisions of Law "On Insurance Agreement" in force may be interpreted differently, but in individual cases – even ignored.

The author believes that the legal regulation of insurance requires improvement.

Since the Law "On Insurance Agreement" was adopted, the legal environment has changed significantly, legal understanding and regulation of consumer rights has evolved. Electronic means of communication have gained a significant role in civil circulation.

Therefore, a new law is needed to regulate insurance relations according to modern requirements which would be interpreted in a uniform manner and would simplify the currently clumsy legal regulation of insurance relations. This new law may take into account the basic principles of the current Law "On Insurance Agreement" which have passed the test of time. However, the basis

for the new law should be the European project “Restatement of European Insurance Contract Law” which is recommended for use by legislators of the European countries.

8. The possibility of establishing specialised courts for deciding commercial disputes should be discussed.

For the purpose of addressing the problems related to the currently clumsy and time consuming proceedings in Latvian courts, the court reform should be implemented by separating the courts specialising in deciding commercial disputes from the existing court system. When addressing the issues of education of judges, it will be possible to devote increased attention to training judges of such kind, including the problems of insurance.

9. The insurers should cooperate more in the exchange of information.

A jointly used database should be developed for those types of insurance where asymmetry of information is the greatest and where it is required to limit the possibilities of moral risk and insurance fraud.

In the course of time, reporting methods may be considered a solution for discovering the events of insurance fraud.

Latvia should join the International Convention for Recovery of Stolen Vehicles to solve the information exchange and data availability problems with respect to vehicles stolen in European territory for which insurance indemnity has been paid as well as to receive recommendations for fighting crimes involving use of vehicles. In such way, it will be also possible for Latvian insurers to exchange best practices with insurers of other EU member states as well as to discuss the ways of improving operation of insurance agreements.

10. Insurers should exchange information with state institutions more actively for purposes of fighting and preventing insurance fraud.

It should be remembered, during performance of insurance fraud fighting and prevention activities, that they are aimed at solving publically

important problems and therefore, interaction of the state and individuals is required to attain the desired result with the least investment of resources possible.

Particularly, insurers should be provided with the possibility to receive information on reasonable conditions from the Penalty Register maintained by the State Police, from information systems of the National Health Service and other information systems of national importance based on individual evaluation. The insurers will, respectively, provide information to the above information systems about the indicators important to the state possessed by them.