Consumer insurance fraud/abuse as co-creation and co-responsibility: a new paradigm

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Co-Creation and Co-Responsibility: A New Paradigm

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Abstract

Insurance fraud and abuse—international concerns—are inherent in the proposition of insurance and prevalent in insurer-insured interactions. While the subject of considerable industry and regulatory attention, this little-researched area of consumer behavior and consumer ethics represents persistent social policy questions and problems at multiple levels. This paper addresses the issue by first defining insurance fraud and its origins in contract, as well as consumer- and insurer-management. The authors conclude by re-envisioning the problem as one of co-creation by the consumer-insured and insurer personnel, proposing a framework for its study and resolution.

Introduction

Effective market relationships hinge upon good-faith exchange and in the consumer setting the most prevalent and costly examples of dysfunction may be those of consumer insurance fraud and abuse.[1]

Industry redress of the problem of insurance fraud/abuse within the property-casualty segment has varied, contingent upon its nature. In the United States, solutions range from consumer education and policy disclosures intended to raise awareness of illegitimate/unethical consumer behavior, to the formation of large, well- financed Special Investigative Units (SIUs) by insurers to investigate claim validity and pursue fraud and abuse not only through claim denials, but the courts (Dornstein, 1998; Hays, 2010).[2] Industry has also formed inter-organizational coalitions to exchange information and coordinate law enforcement cooperation, addressing shared losses, and thereby, shared interests (Lesch and Byars, 2008). And, in 2000, and 2005, the industry held "roundtable" discussions among system constituents (industry representatives, consumer groups, law enforcement, and academia) exploring the use of regional and national public communication campaigns—a form of social marketing—to reduce the economic, ethical and legal issues (Coalition Against Insurance Fraud, 2000; 2006).

Separate from contractual obligations, legislative and regulatory frameworks, and/or legal interpretations of either, *consumer morality*, and *insurer morality* are *social constructions* in which deviance from the negotiated norms represent violations of social expectations. Industry offers a dual response to *consumer* transgressions by a) framing and reinforcing honest and loyal behavior, and b) identifying and deterring abnormal (fraudulent/abusive) behavior. Very little research has emerged on attributions of *insurer* morality. As such, insurance fraud originating from either source is an important but under-studied aspect of the marketing process *centering* on the ethical component.

This paper opens by describing the context of property-casualty insurance fraud/abuse as it arises during the process of exchange, and then models the conflict between the parties to the relationship as a matter of contract (breach), normative incongruence, and dysfunctional co-production. The authors conclude by posing a series of propositions for how to examine insurance fraud in the context of contemporary marketing concepts. The focus is upon single-claims fraud/abuse mostly associated with the property-casualty segment of the insurance industry, and to the exclusion of the involvement of organized crime syndicates.[3]

Origins of Fraud/Abuse in 'Moral Hazard'

The *contractual view* on the origin of fraud is rooted in the agreement of the parties, described by Smith and Roberson (1971; p. 1166) as

> "…a promise by one person (the "insurer") to pay a sum of money or to give something of value to another ("the insured or a "beneficiary") upon the happening of a contingency or fortuitous event which is beyond the control of the contracting parties and in which the promisee has an interest apart from the contract."

In so doing, the **insured** transfers risk (of loss) to the **insurer,** and for consideration (premium paid), the insurer agrees to indemnify the insured for losses sustained. Owing to the asymmetry of information between the parties, both are subject to the perils of *moral hazard,* e.g., the failure of either to behave diligently or in good faith at any point in the exchange (Ericson, Doyle and Barry, 2003, p. 11), thereby increasing (decreasing) the likelihood of circumstances resulting in a valid, approved/claim paid. Baker's (2000) review of the concept of moral hazard reveals the rich historical dimensions, including those arising from the character of the insured/claimant that led to its treatment as a risk itself. Actuarial practice may account for this as a cost for a segment of business, underwriting having accounted for the quality of applicant, and the claims department evaluating for fraud and abuse. Dornstein (1998) affords a colorful and evolutionary account of the express forms of expression of moral hazard in the property-casualty business in the United States, including the role of organized crime and the rise of insurer efforts in response. The CAIF publishes a weekly electronic newsletter with contemporary examples of fraud and abuse advanced by both parties—insured and insurer.[4] Thus, the very existence of insurance as a market proposition inherently sets the stage for fraud and abuse.

In this exchange, *consumers* have largely been the focal point for the study of fraud, although state regulators and the courts function as insureds' venue to address complaints concerning so called "bad faith" and other unprofessional if not illegal transgressions by insurers. For example, early evidence from one study suggests that actual paid-claims were found to be substantially higher in one state (Washington) where *statute* provided for individual action against insurers believed to have unreasonably denied a claim (Insurance Research Council, 2009), although in most states *tort* remains the basis for action (Tennyson and Warfel, 2008). Ericson and Doyle (2006) report the results of interviews of sales and management personnel in the life insurance industry in Canada and the United States, concluding that deceptive practices in that segment are prevalent and institutionalized, and that regulatory efforts fall short of needed consumer protections. Berardinelli (2008) has outlined recently- revised claim settlement practices at one large property-casualty insurer in the United States (Allstate) which he asserts places profits above policy-holders, resulting in "…consistent underpayment of claims…" (p. 43). Allstate has argued otherwise of course, although it has recently (2010) agreed to the terms of a multi-state settlement with implications in all locales in which it does business, addressing its use of software, claimant communication and other matters associated with claims management and regulatory oversight (Hunter, 2007; Multi-State Market Conduct Regulatory Agreement, 2010).[5] It is clear that asymmetries of information on the part of both parties provide fertile ground for persons or companies whose motive(s) are less than pure. The public conceptions of fraud and

abuse are next explored from the vantage of the current *weltanschauung*, a decidedly static, if not one-sided perspective focused on the consumer-insured as the source of the dysfunction.

The Prevalence and Public Acceptance of Consumer Insurance Fraud/Abuse

Literature on insurance fraud reveals myriad approaches to what constitutes fraud, how much of it occurs, and how it may be differentiated from abuse (Lesch and Byars, 2008; Tennyson, 2008). At one extreme, an alleged insurance fraud may only be validated through adjudication, producing estimates of prevalence of less than 1% of otherwise suspicious claim-referrals in a large state data base analyzed by Derrig (2002). Deigned "provable fraud," (Derrig, p. 275), the resulting ratio of merely suspicious referred-claims to those validated by a competent judiciary was approximately 25:1. Note that suspicious claims account for but a small portion of total claims processed by an insurer. Of the roughly 48 million claims processed by U.S. insurers in 2009, about 85,000 were identified as worthy of referral to the industry database utilized by the NICB (Pugh, 2010). On the other hand, the measurement and management of so-called "soft" fraud involving for example, "padding" and/or "buildup" should be routinely addressed by claims personnel during the claim-adjusting process, where more obvious although "forgivable" infractions may be negotiated. This may serve both an educational as well as promotional function in customer relations. The most egregious cases may not only be denied, but many states require referral to a state fraud bureau for possible further criminal investigation and data warehousing.

Estimates of the *prevalence* of claims including fraud/abusive practices vary depending upon the nature of the insurance context, settlement standards and business practices, nature of loss, and even region of the country, (e.g., 2003, Burger). For example, studies by the Insurance Research Council (IRC) of closed claim files (those in which a payment was made), show that "buildup"—the inflation of an otherwise legitimate claim, was present in twenty per cent of bodily injury claims it reviewed in a sample taken in 2007, up from eighteen per cent in 2002 (Corum, 2008). Other IRC studies have demonstrated dramatically higher rates of utilization of medical services following auto accidents in New York City in comparison with the remainder of the state, even when the economic losses were similar, suggesting localized buildup (Pitman, 2006). The same study attributed buildup in nearly one-in-two of closed claim files (42%) of those originating in the city; but only seven per cent of those from the remainder of the state. These abuses, whether arising from weather catastrophe, context of an auto accident, or other loss are often referred to as *opportunistic* fraud since they coincide with a potentially covered event.

Broadly speaking, consumer fraud/abuse may occur at any stage in the exchange, from application (e.g., misstating annual auto mileage, failing to reveal pre-existing damage to a covered item), to exaggerated injuries, "invented accidents," or conspiracy with network service providers.

Since insurance fraud/abuse arises from moral hazard, studies of public mores and attitudes addressing honesty, claimant behavior, and level of tolerance toward illegitimate practices have

been undertaken by the industry. Academic researchers have only more recently begun to characterize contributing factors.

A brief summary of large-scale, industry-sponsored survey studies was performed by Lesch and Byars (2008), tracing to the early 1990s and involving organizations such as the IRC, the CAIF, and the consulting organization Accenture. Perhaps the most insightful of these have been conducted by CAIF (1997; 2007) warranting further detailing here.

The 1997 CAIF-sponsored national telephone survey revealed that large numbers of consumers believed it commonplace for claimants to engage in various forms of insurance fraud/abuse (e.g., padding, misrepresentation of an incident, application fraud, falsification of receipts, failure to disclose prior damage). Justifications that were examined included recovery of premiums, "fair return" on premiums, belief that insurance companies profit at the expense of insureds, and attribution that rate- setting includes a component to cover fraud. Lesser agreement (< 50%) was observed for the level of (dis)respect shown to insureds from insurers, implicit reactions to what may be perceived bad faith on the part of insurers, and the perceived prevalence of misrepresentations on insurance applications ("nobody tells the truth on insurance applications"). Nearly two-thirds (63%) of respondents reported that the single largest deterrent to the commission of an insurance fraud was an insured's moral character (CAIF, 1997, p. 15.)

Subsequent clustering of respondents based upon their attitudes toward fraudulent activities produced a four-group solution. Respondents least tolerant of fraud were labeled *moralists* (31%), followed by *realists* (persons with low tolerance, but cognizant of its occurrence and rationalizing some behaviors; 22%). *Conformists* held fairly tolerant attitudes toward insurance fraud, in part owing to their perceptions of how commonly it occurs, finding it more acceptable (26%), while *critics* expressed the highest tolerance for fraud, attributing fault to insurers and seeking little punishment for infractions (21%). Analysts reported few meaningful demographic differences across the segments.

The study was replicated in 2007, and CAIF reported substantive declines in the number of participants who believed it unethical to misrepresent facts on an insurance application, file a claim for prior damage, inflate a claim to cover a deductible, and/or misrepresent an incident to pay for an uncovered loss (CAIF, 2008, p. 1).

A secondary analysis of the 1997data (Tennyson, 2002) showed males more than twice as likely as females to approve of fraudulent behavior, with differences also noted on the basis of income, region of the country and self-reported size of resident community. Persons with recent claims experience were found to be less approving of fraudulent behavior than those without such experience, leading the researcher to conclude that experience with the claim adjustment process may reduce propensity to engage in illicit acts.

The New York Alliance Against Insurance Fraud (NYAAIF) commissioned a state-wide study of consumer perceptions of the types and prevalence of insurance fraud, including general attitudes toward the issue (NYAAIF). More than one-half of those participating agreed that insurers "make too much money," with a nearly equal number (77%) reporting that it was not appropriate to inflate a claim to recover premium payments. About one-half (49.6%) agreed that rates are based on the prevalence of fraud ("everyone submits some false claims").

Conceptual Contributions to Understanding Consumer Insurance Fraud/Abuse

Limited strides have been made by researchers in framing the issue. Essentially three approaches were identified by Tennyson (2008): a moral-sociological, moral- psychological, and a contractual-economic. We first extend her distinctions, and then introduce two, additional approaches: social construction, and that of customer as co-creator.

Moral-Sociological, and Psychological Approaches to Claimant Behavior. Put simply psychology looks at individuals, at intra-individual mind-states and processes, and at intra-individual-level explanations of insurance consumer ethics, or in this case dishonest insurance consumer behavior; sociology *does not.* Studies of the issue from the sociological point of view have approached insurance fraud/abuse largely as a matter of social morality, i.e., how "right," or "wrong," or "justified" would a consumer-insured be in committing a proposed insurance fraud/abuse. Psychological perspectives focus on intrapersonal theories association with individual motivations, the maximization of individual goals, and internal processes. In the latter case such processes may include intrapersonal calculations of financial gain/loss reduction, estimates of the likelihood of detection, and/or retributive behavior (penalties). Published studies have been limited to scenario analyses (descriptive and projective), and have used both students as well as adults in field settings.

Wilke (1978) reviewed adult projections of the morality of fifteen (15) fraudulent consumer actions including a case of insurance build-up and found that 79% of respondents viewed "over claiming on insurance" as "definitely wrong." Rallapalli et al (1994) examined the role of personality traits in decision making entailing ethical dimensions, including a posed insurance-fraud including a fabricated incident. Overall, correlates of proffered illegal activity included Ss need for autonomy (+) and risk propensity (+), as well as the need for social desirability (-) and problem solving (-).

Brinkmann (2005) investigated insurance fraud as an opportunistic test of morality in a German student sample, and using scenario analysis demonstrated a modest-strength relationship between respondent willingness to "misrepresent facts for obtaining insurance" and/or "deliberately exaggerate an insurance claim," and one's level of morality. In a follow-up (Brinkmann and Lentz, 2006) comparing Norwegians and Germans, insurance fraud was relatively more acceptable than e.g., drinking a can of cola in a supermarket without paying for it or changing a

price tag (to a lower price tag) in a retail store. Norwegians tended to find insurance claim exaggerations and misrepresentations on insurance applications less acceptable than their German counterparts. Their cluster analysis-based typologies approximated those obtained earlier by the CAIF (1997).

Reconciling sociological and psychological influences, Tennyson (2008) and Brinkmann (2005) reference the potentially powerful *explanans* of rationalization and/or neutralization by claimants (see Sykes and Matza, 1957) to harmonize differences between personal beliefs/morality and social acceptance. A recent scenario-based test by Miyazaki (2009) varied a contract factor (level of deductible), social justice (insureds' perception of fairness in claim resolution), and level of insureds' ethics to ascertain projected level of claim settlement and the ethical appropriateness of claimant "padding" behavior. Results revealed that higher deductibles posed a potential justification for insurance fraud/abuse, that it would indeed be viewed by respondent insurers as "fairer" and that claimant behavior to recover the deductible at progressively higher amounts would be viewed as less unethical. Persons with lower ethics scores tended also to see unethical behavior as less unethical than those with higher ethics scores, and the deductible-ethics score interaction was such that those with lower ethical scores tended to attribute the expected claim award as less than in the case of higher deductible amounts.

Dean's (2004) scenario analyses found no relationship between the attributed behavior of the insurer or its agent (pro- or anti-social), and the social class of the claimant (upper-class/high income vs. blue collar/modest income) on perceptions of claim padding. Women, however, made stronger moral judgments about the appropriateness of padding than did men, although respondents overall awarded nearly twice the claim required by the contract ($987 vs $500), explained by respondents as justifiable on the basis of uncovered losses (inconvenience, emotional stress, sentimental value).

Contractual-Economic. In the range of approaches to managing insurance fraud/abuse, this venue conceives of illicit claimant behavior as *expected*, and *manageable* through institutional response. Thus, through decisions in the selection of clientele in underwriting decisions, rate setting based on assessed risk, and administration of claims through validating and valuation processes, fraud and abuse may be deterred if not minimized as a cost of doing business. Perhaps the bulk of industry resources have been devoted to *deterrence* as the strategy of choice in addressing the fraud/abuse problems. From this vantage, all applicants/claimants present with the element of suspicion, and every claim must undergo investigation and evaluation against the terms of the insurance contract (Hirsch, 1999). Various models for the management of all (suspicious) claims have been advanced (e.g., Derrig, 2002), most employing layered sophistication in the processing of claims. These may range from claim-scoring for probable fraud/abuse (routine, qualitative scrutiny against a battery of fraud indicators--flags) to methods far more sophisticated (statistical techniques used in mass processing of claim files; see e.g.,

Dionne, Giuliano and Picard, 2003; Derrig, 2002). Throughout, the management of fraud/abuse are viewed by firms as business propositions.

Deterrence is costly, requiring extensive human and physical resources at several levels. A study by the Insurance Research Council (1997) showed that most of the property-casualty insurers in the United States had developed internal SIUs (76%), with more than 90% of the nation's largest insurers having such programs (Insurance Research Council, 1997; Insurance Service Office, 2000). All large insurers had SIU programs in situ, with more than two-thirds of medium-sized insurers reporting that they did, as well. The report underscored the lack of uniformity in state approaches to the issue, a finding echoed in the recent study by the Insurance Information Institute (2010), revealing the presence of state fraud bureaus in 42 states and the District of Columbia. This decentralization of approaches to enforcement of anti-fraud legislation is consistent with the relegation of regulation of insurance activities to the states as a result of the McCarran-Ferguson Act of 1945. The industry has established two organizations key to detection and clearing of fraudulent claims outside of those processed internally, including the National Insurance Crime Bureau (comprised of investigative staff and claims-data collection services) and the Insurance Services office (warehousing and processing of suspicious claim referrals). While return on investment (ROI) may be expected to differ among insurers (heterogeneous managerial practices), ROI during the late 1990s was reported to be in the neighborhood of approximately 27:1 (Insurance Information Institute, 2010). Earlier, one large insurer reported a return of $6 for every $1 spent on internal special investigators (Anderson, 1990).

Yet, *post hoc* industry surveys of paid, closed claim files continue to reveal the *widespread presence of fraud and abuse* even after deterrent efforts. How can this be explained?

Insurance as a Social Construction

Baker's (1994) narrative-based analysis of the insurance process and case law surrounding adjudication of bad faith claims illustrate the tension between parties to an insurance contract. The need for the insurance product is rooted in dependence of the insured upon the insurer's promise to pay, recognizing that the insurer must balance the claim against the future needs of other policy holders as well as a profit motive or its equivalent. To the extent that an insurer avoids-reduces payments, it ensures a pool of funds for future claimants, the insurer enjoys a smaller loss ratio and may increase its profitability. The *sales story* however, (posed by the marketing departments of the industry), does not disclose this fact, rather, choosing to emphasize only the value of security resident in the promise, ambiguously conveyed through symbols and slogans with which we have all grown familiar: Good Hands, Good Neighbors, and so on.

Moreover, as *credence goods*, the typical insured knows very little about the specific terms of coverage. As pointed out by Glenn (2003), the exchange begins with the insured's application and payment, and is then followed by issuance of the contract without *ex ante* review of the terms. *In this context, consumers buy what they cannot fully know, or understand.* Moreover, the level of information in the environment is such that there is virtually no way for the consumer to evaluate quality of performance *ex post*, since few consumers actually annually initiate a claim and no comparative environmental data on insurer performance (e.g., processing methods, processing time, benchmarks for valuation, bad faith prosecutions, valuation practices) is available (Schwarcz, 2009). Search and decision parameters are limited to price, and resulting in what Schwarcz has termed the 'race to the bottom' of quality. The paucity of insights into the value of the insurance proposition, extant insurer claims practices, and complexity of insurer bureaucracy necessitate insurer construction of what Baker has termed *sales stories*. These promotional distillations comprise the positioning strategies of the firms and are largely devoid of comparative attributes useful to decision making about insurance, or, insurers.
Claims stories, (used by claims personnel and claims departments), on the other hand, bring the conflict between the firm and its (larger) pool of policyholders on one hand, and the motives of the individual claimant on the other, into sharp relief (Baker, 1994). Here, in the presence of conflict, the industry employs three typical recitals: a) the responsibility to define and enforce the limits and terms of the policy, b) the obligation to the larger community of policy-holders by maintaining solvency, indeed, the very institution of *Insurance*, and c) the obligation to identify and deter any fraud/abuse by insureds as a moral/legal requirement.

Thus, the public construction advanced by insurers and shared by customer-insureds is one of promise, security, protection, and guardianship (Stone, 1994). The private exchange at the moment of claim presentation, as a matter of contract, reverts to the terms of the contract. The resulting gap—public proclamation vs. private practice--has increasingly (though not consistently) been filled by judicial opinions expanding contract terms in redress of claim denials (Baker, 1994). The positioning strategies of firms, void of any hard attributes, create expectations beyond the capacity of the firm to deliver in all cases, with the resulting customer-

insureds' surprise if not dissatisfaction with firm performance. Ericson and Doyle (2003) are concerned with changing and widening the perspective from focusing on individual-psychological and sociological explanations of *customer* dishonesty to how the *insurance system* and its agents respond as a "private justice" or rather "private injustice" system, in which the insurer system internalizes and then actually instrumentalizes fraud (see esp. pp 319, 322). Instead of treating insurance fraud as something clearly given (a factual breach of penal law norms or contractual conditions), insurance fraud is also understood as a system element, as something which is constructed (measured, defined, negotiated) and *managed* in insurer-insured interactions. Under such circumstances, (including a lack of involvement by the insureds in the creation of policy terms and bureaucratic practices), it becomes easier to understand some insureds' pure or rationalized behavior toward insurers to include illicit activity (claim padding, buildup), or other attempts to recover deductibles, or treat insurance as a financial investment from which a return should be expected. These behaviors may result from simple ignorance, and/or may reflect a measure of rationalizing to neutralize a less than ethical act with the tacit understanding that "everybody does it" and/or the cost is "built in" to the policy premium. Consistent with industry surveys on acceptance of fraud and abuse, additional explanation may be found in the notion of *opposition norms* advanced by Nee (1998). Some insureds (e.g., the *militant-critics*) represent a segment with values inconsistent with authority (insurers) and the latter are tolerant of them. Both parties are aware of the "slippage" surrounding settlement practices, and both agree *on both sides*, that "Everybody does it."

This is directly analogous to Torgler's (2008) contention that deterrence alone cannot reduce the incidence of tax fraud and that tax compliance is dependent upon a prevailing *tax morale* (Torgler et al., 2008). This may consist of a mix of social and psychological norms (e.g., societal acceptance; familial approval) and can be related not only to gender and education, but the quality of tax administration, notion of fairness, as well as trust, obedience, and awareness of the tax system. Studies of projected insurance claimant behavior, as research (above) has shown, suggest that similar factors are at work.

From this vantage, industry *shares responsibility* for reinforcement of illicit consumer behaviors. The contemporary insurance exchange process has created **contradictory** propositions of value. This conflict is at least in part, a derivative of the 'goods-based' conception of the marketing process, and demonstrates the inadequacy of the traditional (transactional) marketing paradigm in the value proposition for insurance services. Insureds are dissatisfied, as are insurers.

This review has demonstrated that the prevailing relationship between the insurer and the insured is one wherein customers are viewed as *recipients* of a service product and *originators of dysfunction* in the exchange, i.e., insurance companies are in the business of selling coverage for covered perils, as defined by the terms of the contract and interpreted by the policies and procedures of the management of the firm. Customers are *inherently untrustworthy*, and a sizable portion will behave opportunistically as a matter of personal gain, or, social expectation. In order

to maintain their fiduciary obligations to shareholders/members, and society, insurers argue that they must treat claims and customers with suspicion and impose procedures and deterrents to safeguard the integrity of the exchange and the larger society. Insurers however, contribute to the dysfunction in the system of exchange by failing to educate insureds as to proper claimant behavior (promotional simplifications; failure to address credence qualities in administration of service). Insurer business motivations may result in inconsistencies in the claims process and confusion among insureds concerning terms of coverage. The resulting lack of perceived reliability in the insurance product/service exchange has eroded trust between the parties and fosters high social and economic costs.

In this context, a new conception of insurance service and insurance fraud are needed.

Consumer Insurance Fraud/Abuse: Through the Lens of Marketing

The field of marketing is amidst a paradigm-shift from traditional focus upon the *sale of goods* to one *customer concentric* in which the parties to the relationship share, or *co-create* value (Vargo and Lusch, 2004; Lusch and Vargo, 2006; Sheth and Uslay, 2007). From this vantage, the very reason for the existence of a firm centers on satisfying the needs of the customer. The authors contend of course, that a primary source of discontent and mistrust of insurers among customer-insureds and insurers is the gap between expectations and performance—adhering to both parties. One solution may be to re-frame the very insurance proposition from this new point of view. From this vantage, insurance is formally not a good, and the value of the insurance proposition is resident in the qualities of the interaction. The dysfunction may then be dissected according to a series of tenets central to successful marketing of services. From this vantage, we depart from three pillars: a) customer as the co-creator of a service, b) the origin of value propositions and c) the service-centered view.

The Customer as Co-Creator

Authors Vargo and Lusch (above) have rightly distinguished between the co-production and co-creation of value. Value (like beauty) always resides in the eye of the beholder (customer-insured), and as an over-arching construct. The customer-insured is involved in co-production *throughout* the insurance exchange, including for example the provision of information (used in underwriting, the actuarial process and claim settlement), the provision of time and shared risk (deductible), and engagement in networks of service providers (e.g., claims representatives, health care providers, repair services) satisfying the shared objective of 'wholeness' as proposed and ultimately satisfied by the insurer. Control over the selection of some, if not most of these extended networks (e.g., auto repair, health services) also participating in the co-production may reside with the customer-insured, or, with the insurer. Resultingly, the co-production of value is in many ways both observable and tangible, and the role of the consumer-insured central to its conception and consumer satisfaction.

If consumer-insureds are uncertain of their role(s), are uncertain about the terms of coverage, and are not expert in the insurance administration process, these uncertainties are sure to contribute to lower expectations for trust and performance and higher uncertainty when confronted with a claim- opportunity. *In fact, in many cases, the resolution of an insurance claim typically does not occur until or unless the totality of the claim has been established.* Until that point, the customer-insured does not know the disposition of the value proposition, and does not know the "production" being undertaken by the insurer in the processing of the claim. This gap may be filled through the provision of information and education on desired role(s) and behavior to be undertaken by the consumer-insured, and greater disclosure by the insurer in first-party claims of the procedures and applicable standards in the event of a claim. So-called third-party claims would of course, warrant disclosure of the latter at the moment of the loss. Van Raaij and Pruyn (1998) outlined a staged-model for characterizing the service process addressing the nature of service validity (does the service address what the customer wants) and reliability (level of performance realized from the service provision). Unfortunately, there is little opportunity to specify/customize property-casualty contracts or bureaucratic services in today's market environment (low validity), and as a credence good, the considerable uncertainty in delivery (issues of reliability) looms large. Regulators are not generally in a position to regularly review/approve internal processes associated with claims management other than by exception (consumer complaint)). And, in the recent Allstate settlement (above), funds were directed to the education of regulators in the very processes and standards used by Allstate. Ambiguities abound in this soup of services.

Authors Van Raaij and Pruyn further posited five factors *mediating* the customer's processing of the service encounter, including equity (perceived fairness in disposition of the service; equitable transactions are fair transactions), discrepancy (consumer involvement in co-creation of the service will reduce the gap between what is experienced and what was expected), control (ability to exert influence of varying types and at different stages in the service encounter), attribution of effects (inference drawing about causes of better or worse service performance), and self perception (perceived role of self-contributions to service). These touchstones can be considered to frame consumer expectations, and as such, also represent standards of utility in insurer audits of successful (or not) consumer-insurer interactions. No published studies within the whole of this model have been advanced at this point to directly investigate the same.

Practically, this value-based perspective affords potential for competitive advantage, as detailed by Lengnick-Hall (1996). Success will hinge upon the alignment of production needs (insurer-side) with consumer expectations, requiring greater provision of information about the value proposition process as also outlined by Van Raaij and Pruyn (above). For large numbers of consumers, the service encounter at least in part, does not "map" satisfactorily. Survey research has established large gaps with respect to perceived equity, and this may/may not be related to the notion of discrepant role-playing throughout the encounter. Some evidence has emerged to

suggest that the equity issue derives from corporate mission and practices. Competent discharge of role by consumers may not address the independent question of equity. Depending upon the nature of the claim, consumer control may be expected to vary, and raises challenges to both parties of the encounter.

An important distinction in this regard can be found in the differences in approach taken by insurers to first-party claims (a policy-holder/customer incurs a loss), and third-party claims (as a result of tort, the liability portion of insurance applies, i.e., non-policy-holder claimant injured through negligence by the insured). As a result of the adoption of no-fault auto rules in some states (14), the insurers "work out" the losses of both parties and appeals to the courts for reconciliation are barred based on certain monetary thresholds. Otherwise, the general rule is that under the terms of first-party coverage, the insurer is required to behave in good faith as a matter of contract, going so far as to place the demands of the claimant ahead of their own in resolution of the claim ( ). In the third-party scenario, the insurer (under subrogation) has no such duties to the claimant, rather, assumes the role of *defending* the insured behaving in such ways as to "…vigorously fight every claim brought against them with the single-minded goal of minimizing expenses…" (Mootz, 2003, p. 474). In such circumstances, the posture of the parties is decidedly antagonistic and may invite bad faith by either party in an attempt to obtain an 'equitable' disposition. The power of each in this relationship is very disproportionate and has led some courts and legislatures to require good-faith dealing even in the case of third-party claimants (Mootz, 2003). Similarly, survey research (above) has underscored the predisposition of some consumer segments (e.g., 'Critics') to attribute gaps in perceived quality to insurers. Predispositions of claimants in the property-casualty setting carry a certain 'victim' quality which requires in itself careful managerial attention if the relationship is to be successful, and accurate attributions of responsibility for success are to accrue. Ironically, the essence of insurance is to "make whole" a claimant, but the reality in many cases leaves much to be desired.

As a matter of relationship development, the specification by insurers and assumption by consumer -insureds of competent, customer role(s) at various stages in the process is necessary. Since motivation levels for participation in the process differ, and since some customers should be expected to resist this change in relationship, a transition will be required. Success will depend heavily upon coordination of corporate resources to this new way of thinking about the customer and adaptation of current processes to be more inclusive of customers as partners in production, rather than so exclusively as purchasers or users of fixed goods. Moving from a perspective of suspicion, to shared responsibility may require greater modification of internal procedures among some insurers, than others. And, since insurer standards for what constitutes the bases for a legitimate claim settlement can be expected to vary widely from insurer to insurer, a platform for consistency (validity) assumes a critical role. The very *heterogeneity* of claim settlement practices extant throughout the states and among insurers as a result of firm differentiation and regulatory distinctions, pose formidable challenges in this respect. As Derrig has pointed-out, there is little agreement among insurers on what constitutes a "fraud," although

there is likely to be greater consensus in the definition and treatment of abusive practices. In this regard, the regulatory role of the NAIC, comprised of representatives from the states, must become more pronounced. In the most recent multi-state settlement for example, monies are to be made available by Allstate to educate regulators on virtually all aspects of its software used in certain aspects of auto liability settlements in order that a proper regulatory function can be achieved. This settlement, without direct participation by the NAIC, extends to all 50 states and the District of Columbia. This illustrates a gap between the advance of the industry, and the status of capacity among regulators to carry out their function in the public interest, that in small part will be addressed through the terms of the agreement.

The Value Proposition

The core proposition in the insurance exchange is defined by the firm as the promise of indemnification at a certain level upon notice of a covered risk within a timeframe defined by the parties. At present, this is an inherently transactional perspective. The value proposition as *perceived* by the customer-insured may involve numerous additional dimensions consistent with expectations of service management, but the primary value proposition as well as satisfaction of value as created, becomes mostly (and perhaps only) tangible during the process of claims settlement. As Baker (1994), Stone (1994), and Schwarcz (2009) have pointed out, this is necessarily a highly heterogeneous, if not diffuse, proposition depending upon the nature of the gap between the claimant's construction and that posed by claims personnel. This gap can be construed at the intersection of the beliefs of the customer–insured about delivery on the promise, their role as co-producer of value, and as realized through the firm's settlement procedures. Firms may operationalize the value proposition differently based on a range of factors, over time, as a function of firm goals (Ericson, Doyle and Barry, 2003; Ericson and Doyle, 2003; Berardinelli, 2008), the regulatory environs, and the nature of the consumer-insured. This places complex burdens upon insurers that interfere with the reliability of service delivery, and contribute to consumer-insureds' confusion about appropriate behaviors. The opportunity for dissatisfaction is great, owing to the complexity of such credence products and *how they are administered and negotiated with insureds*. As a result, the construction of 'appropriate claimant behavior' is defined differently by customer-insureds as compared with insureds (Ericson and Doyle, 2003; Baker, 1994), as survey analyses have underscored (above). Underscoring this issue, the insurer *MetLife* recently reported the results of a survey of Americans in which it revealed that nearly one-half (46%) could not report the level of coverage for the contents of their homes, with nearly three-quarters (71%) reporting that their coverage included full-cost replacement of the structure in the event of a total loss. In the latter case, most coverages are limited to current market value, which historically has been less than replacement (Metlife Press Room, 2010a; Metlife Press Room, 2010b).

The nature of insurance as a service defined in part by discrete events outside of the control of either party has enabled if not perpetuated the transactional paradigm. Insurers can do more to facilitate quality customer experiences by re-framing of the role of insurance. The result should

be the reduction of alleged insurance fraud and abuse brought about by enhanced trust. How the consumer is engaged prior to any covered event, how the relationship is cultivated and maintained, and how covered events are managed through to claim payment and thereafter, all represent phases of engagement and relationship development that can clarify and inform consumer insureds about shared responsibilities in this heavily regulated service context. These present as opportunities to build trust, awareness and comprehension of the value proposition as *mutually defined within the framework of the regulatory confines*. As a matter of social construction, and more than reaction to a covered event as defined by credence qualities, insurers can be seen as co-responsible for the high levels of insurance fraud and abuse by single claimants, much of which is defined ex post facto. Tennyson (2002) found for example, that claimants more familiar with the claims process held attitudes toward fraud different from those who had not had such encounters, underlining an opportunity for agenda-setting. Recent research by Lesch (2010) demonstrated a monotonic relationship between age, and the perceived ethicality of five (5) illicit claimant behaviors, such that younger consumers were much more tolerant of the same. This underscores the role of customer as product advanced by Lengnick-Hall (1996): customers can be and most likely *are changed* as a result of their consumption of the insurance services and managing this change to the mutual benefit of the parties presents an exceptional opportunity to insurers and consumer insureds alike in the redress of insurance fraud and abuse in society. Greater insurer disclosures of the process—its expectations of consumer-insureds and disclosure of its unique terms and procedures of claim adjustment will enable higher levels of efficiency in the marketplace, and engender greater trust in the relationship. This will necessarily prompt greater differentiation in the service proposition, innovations which must of course, pass regulatory muster.

The role of integrated communications in this process can hardly be overstated. Internal communications focused on the consumer-insureds' brand experiences, across all phases and as interpreted to the contexts of production among all contact points with the firm (including third-party users) will assume critical roles in re-framing the insurance proposition. The role of social marketing in the creation of a more uniform set of expectations for what constitutes illicit behavior was earlier emphasized by Lesch and Byars (2008), its success likely to co-vary with consistency of message to the regulatory and deterrent environs among the various states. This presents as a separate but critically important challenge to such regulatory 'captains' as the National Association of Insurance Commissioners.

Service-Centered

Relationship management is central to a service orientation, and according to Vargo and Lusch (2004, p. 11), achieving customer satisfaction is inherently a collaborative process, one in which *trust* is central to success (e.g., Morgan and Hunt, 1994). It is clear from this review that trust, by definition, poses a challenge to both parties, and warrants attention not only for customer-insured satisfaction, but for its contribution to redress of insurance fraud/abuse. Lengick-Hall's (1996)

characterization of the role of the customer in co-production illustrates the many opportunities for interaction between the customer-insured and the insurer in this context. Therein, the customer-insured is a resource (as above), a co-producer (as above), a buyer, a user, and in some respects a good-in-process, since the consumptive act (claim resolution) *is expected* to change the customer. Each of these roles represents a point of collaboration (service) warranting review between the parties. None has been effectively elucidated in the literature on insurance as a process, nor, have researchers attempted to conceptualize this particular service proposition and decompose its elements.

The tensions extant within the firm as it undertakes the claim processing phase of customer service, however, were the subject of ethnographic research undertaken by Morley et al. (2006) in review of British firms' claims handling practices. There, organizational goals associated with claims processing *efficiency* were held above those of fraud detection. Claims handlers employed non-express, as well as express models of fraud detection, mostly centered on the identification of anomalies in the "claims stories" presented by claimants, with the most successful (second-level) claims handlers utilizing a "framework of suspicion" as they assessed claim validity (p. 175). Resultingly, the management of anomalies only rarely resulted in the development of a suspicion and many false-negatives escaped scrutiny. The qualitative studies of Ericson and Doyle (2003) demonstrate the differential behaviors of claims staff in characterizing both claimants and their claims, the difficulties in categorizing fraudulent behavior and industry approaches to managing uncertainty (loss ratios) beginning with the selection of insureds and policy rates, including the management of network providers, and the impact of the claim assessment on the relationship to the insured exchange process. These processes do not in all cases bear directly on the veracity of claimant statements or validity of a particular claim, rather, they present as business propositions. The picture painted by analyses of more than 200 qualitative interviews with industry personnel in Canada and the United States is one of relationship management, where fraud tolerance is an accepted element in the dialectic. Again, the underlying lack of validity in the service proposition engenders expectations inconsistent with the goals of each party: good faith relationships.

These studies also demonstrate the lack of *reliability* in delivery of the insurance proposition, perpetuating and reinforcing self deception (Mazar and Ariely, 2006), the tendency to discount false information in a biased, self serving manner. The prevalence of self deception is well known to both parties to the insurance proposition. Palasinski (2009), also operating in the British context, interviewed a small sample of adult, male drivers to ascertain their conception of the exchange between consumer-fraudsters and their insurer, testing the validity of a typical "flag" used by insurers to screen fraudulent claimants (aggressive interactive behavior at the level of the dyad). Thematic analyses of qualitative narratives of respondent projections of how deception occurs in this setting were consistent with self deception in both verbal and nonverbal modalities, and inconsistent with the standard established as a "flag" for deceptive behavior.

In sum, dysfunctions in the relationship between the insurer and customer-insureds are not totally the realm of responsibility of consumer-insureds. Credence qualities of insurance, the manner in which the relationship has been negotiated and industry-wide promotion practices focusing on abstract promises, rather than experiential aspects of performance are contributory to the failed system. Moreover, studies have demonstrated a lack of reliability in the delivery of a standardized value proposition, contributing to a large gap between expectations and performance of the insurance proposition. Society itself has cast insurance as institutionalized governance, but one without transparency, shared responsibility in production and consumption in the reduction of shared risk. Consumers buy what they cannot know, while insurers deliver an inconsistent experience in a regulatory environment that differs across the state markets.

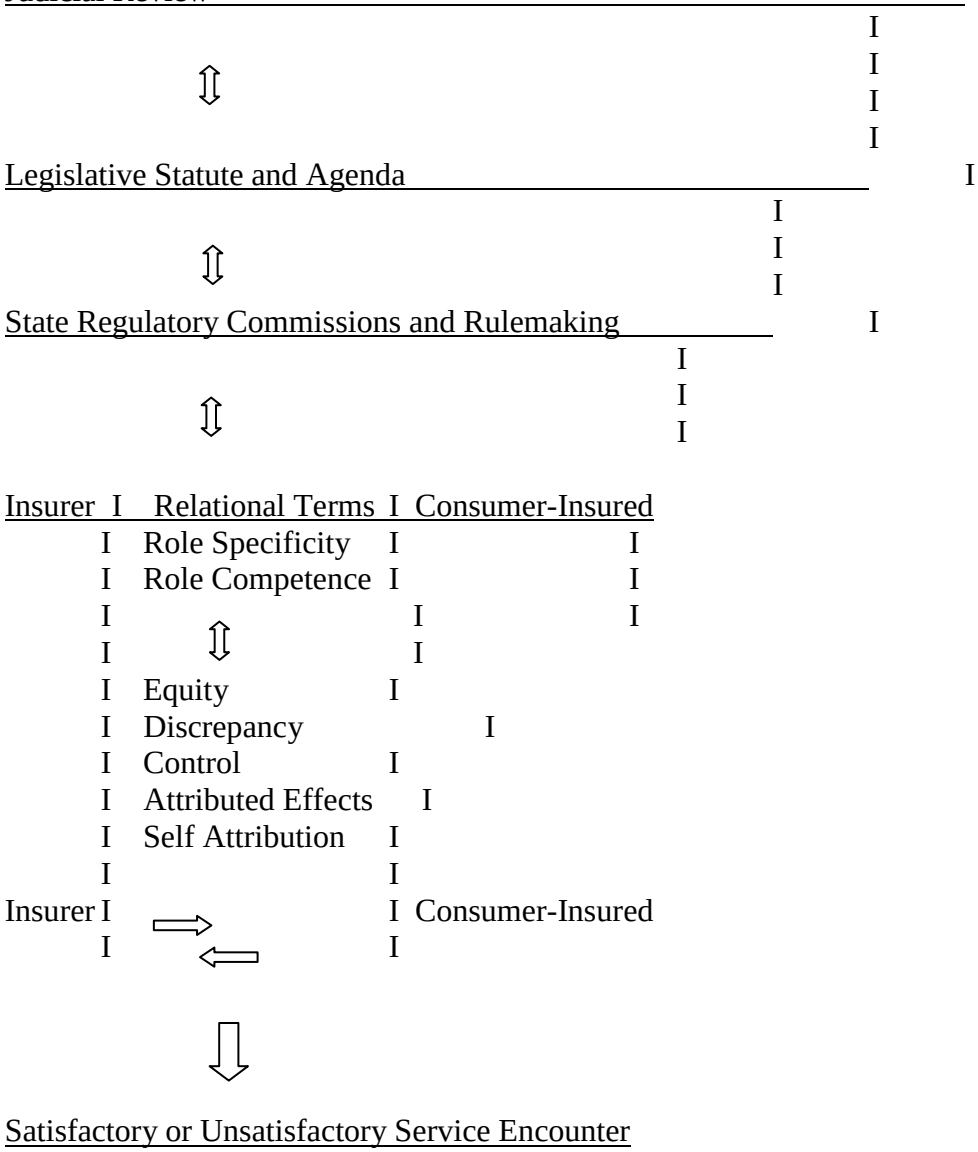
In this essay the authors have outlined the nature of consumer insurance fraud and abuse in the property-casualty industry, as first defined by insurers, then more completely to include the consumer involvement and interest. The economic and social harms associated with this jointly-held problem are considerable and continue unabated despite the provision of considerable deterrent resources. Insurers contribute to the ills of the industry through lapses in validity and reliability in production and service delivery, and by failing to properly educate consumer-insureds in their roles in the co-production of the value proposition. Credence qualities of insurance have not been adequately addressed through contemporary insurance marketing practices and as a result, the value proposition as ambiguously conceived is also contributory to the issue.

As such, what are the normative implications to managing this issue as society moves forward?

Developing a Multi-level, Multi-unit Framework for Research. The paucity of research on a problem so widespread and of such economic and social implication is to these authors, inexplicable. Scholarship on drug/alcohol abuse, for example, has posted barrels of ink, but perhaps owing to the structural (regulatory) isolation by society of the insurance industry, the topic of consumer insurance fraud has comparatively received little more than a comma in the social science and consumer behavior literatures. All parties at all levels to this concern would benefit from the formulation of a multi-level, multi-unit framework for the assessment of the "how and why" of fraudulent and abusive insurance claimant behavior. Figure One (1) outlines a point of departure. As this review has suggested, the system of actors underscores the need for a variety of studies involving the several levels and units of analysis, research questions and methods of inquiry. The authors therefore, propose a translational framework for the study of a societal issue, involving all levels of inquiry. Units of analysis at this time are confined to the most basic level, those of the relationship between the parties to the insurance proposition as outlined within the framework of co-responsibility. We propose for initial specification those terms and conceptual frameworks as outlined above. Additional specification of units for analysis and interactions at higher (governing and enabling levels) are a necessity but by definition, beyond this treatise.

Figure 1

The Hierarchy of Relationships and Elements in the System of Exchanges Surrounding Insurance



Relations Between the Parties: Insurer-Consumer Insured. At this time, research has largely focused on *intrapersonal processes* utilized by consumer insureds to justify or rationalize their use of insurance in a certain manner (abusive or not). Moreover, most empirical research on the consumer-side has been survey-based, descriptive, and/or projective, with very limited exceptions involving observation or ethnographic research. The authors are aware of only limited studies of counterpart constructions and accommodative-behaviors of *adjusters* during the dynamic process of claims processing (e.g., Ericson and Doyle, 2003; Berardinelli, 2008; Morley, Ball, Ormerod,

2006). The nexis of the service encounter exists at this level and the literature has paid little attention to the contributions of / by the *dyad* as the claim is addressed and a mutually satisfactory / unsatisfactory outcome is obtained. *No systematic models of the process from dyadic viewpoints (consumer-insured or, adjuster, dual construction) on a dynamic basis have been advanced. The richness of the exchange and interplay of the actors to this process remains largely unstudied.* This represents an untouched and necessary area of inquiry for the parties to the dysfunction. The insurance proposition affords many opportunities for good-faith intercourse, all worthy of mapping and the application of auditing processes in order to ascertain the nature of compliance with standards of stated performance and expected value. Value is, or is not, realized at this phase of the service process.

Conceptually, units of analysis may include intrapersonal (norms, motives, expectations; both sides of the dyad), dyadic (coordinated construction of the insurance proposition and associated expectations depicted as phased interpersonal exchange), firm-level (organizational "rules" and norms, motives, expectations), as well as societal (inter-firm practices, regulatory oversight and standard-setting/assessment, judicial and legislative review). At each level, units of analysis require specification and analyses. To date, no *translational* framework has been advanced depicting the production and consumption of this value proposition in a unified manner. Available research has focused only very limited granular components (consumer attitudes, societal norms and expectations).

Developing such empirical models may well require a summit-level assembly of representatives from all system actors, and requires a multi-lateral commitment to the value of the fruits of such studies to improved relations among the parties. The current state of affairs is exemplary of the continuing if not "dangerous divergence" between marketing and society outlined by Sheth and Sisodia (2005) and is evidence in support of their call for a *National Academy of Marketing.* Is the status of this issue not also exemplary of their call to "raise our aspirations" as a marketing community (Sheth and Sisodia, 2007)? The gaps in performance outlined in this paper strongly suggest so.

The Role of Ethics in the Value Proposition

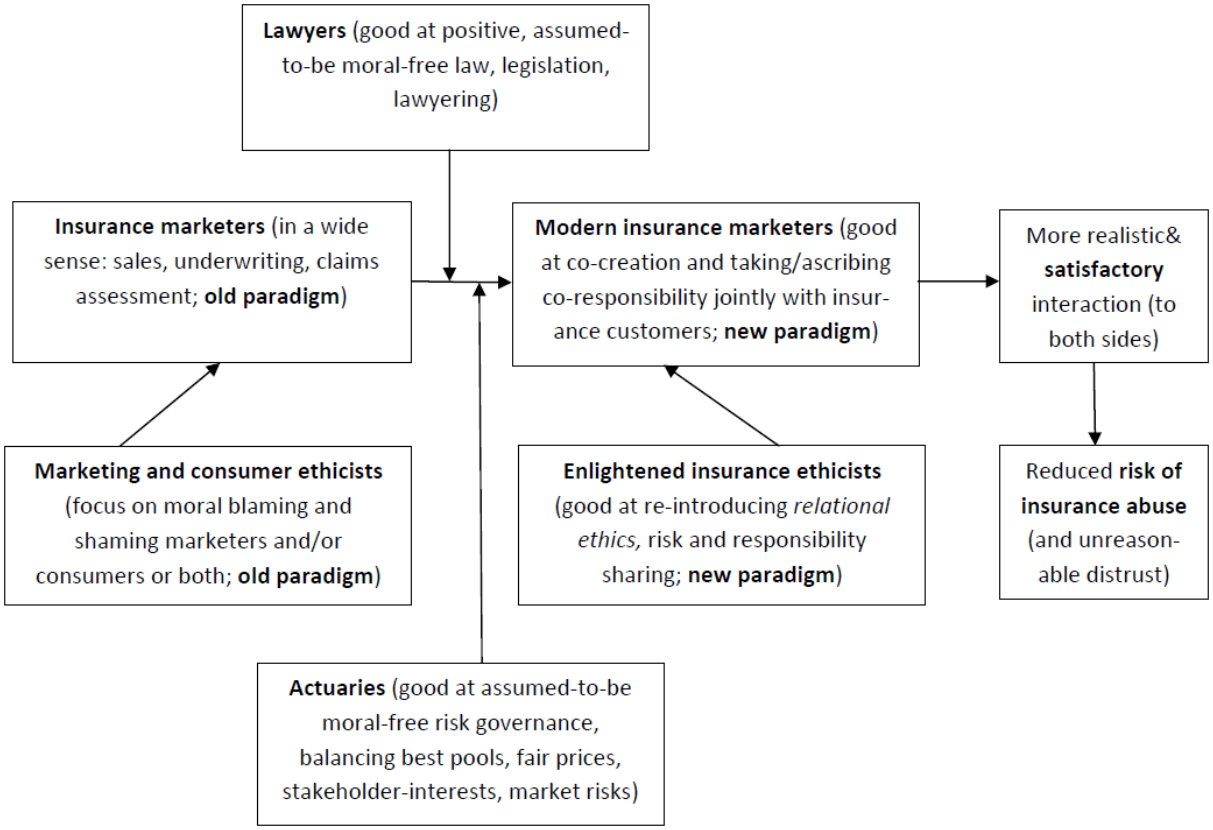
As this review has shown, moral hazard presents as an inherently ethical temptation (Brinkmann, 2005) encountered and managed in many forms, and perpetuated by both parties to the insurance contract. Historical, as well as contemporary polemics have largely focused on industry's construction of insurance fraud and abuse as arising from ethical lapses by consumers, while emerging research has revealed how insurers participate in both the co-creation and perpetuation of fraud and abuse, and how state- and self-regulation are inadequate in redress of fraudulent and abusive insurer practices. As we have mentioned above, a new paradigm of insurer-insured interaction is necessary if the parties and society are to successfully alter their definitions and metrics of what constitutes insurance fraud and abuse—and achieve more satisfying market

relationships. Put otherwise, how does one propose and then implement a new paradigm for an industry, one predicated on *co-responsibility*?[6] What will be the results of such a new perspective on the production and management of bad-faith practices as well as claimant fraud/abuse?

Implications to Firm-Level Practices. The insurance proposition is of mutual creation, bounded by regulation and involving the imposition of standard contracts, interpreted through myriad and separate corporate and competitive lenses. As Lengnick-Hall (above) argued, the opportunity for competitive advantage will be enhanced among firms who recognize the value of customer as co-creators and transition their systems to accommodate that point of view. How to modify systems and relational dialogue challenges organizations to begin change at all levels? Pilot programs involving regulatory and consumer interests may ease this transition, and prioritizing the management of market conduct is a first step. In fact, NAIC has begun this journey, imposing reporting requirements on segments of insurers only recently, including reporting on management of claims and production of "scorecard ratios" as well as consumer complaints for performance review (see http://www.naic.org/industry_market_conduct_statement.htm for details). Due to the level of data aggregation, however, this exercise may be of limited utility in the management of firm-customer relations, and inter-firm comparisons. Re-focusing this process within the firm, and developing additional frameworks at more micro-levels proposed by Lengnick-Hall (1996), Vargo and Lusch (2004), and/or Van Raaij and Pruyn (1998) enables managers to observe and manage the insurance transaction/relationship more holistically.[7] Hopefully, such initiatives will foster insurance service innovation, improved customer satisfaction, efficiency of operations, and overall higher firm performance. And, reduce the incidence of what are mutually defined ethical lapses. Figure 2 outlines conceptual elements of the system necessary to accomplish co-responsibility.

This figure is meant to function as a summary of a key argument made in the paper and as an outline for future work ahead. Ethics and the development of ethical propositions should encourage and assist marketing in rediscovering its normative content, in particular the ideal of taking co-responsibility for customer need-satisfaction, in this case risk transfer and risk sharing. On the other hand, as insurance marketing is not only about itself but shares responsibility with the two key professions of insurance, the actuarial sciences and the law. The former establish the boundaries of core offering and design a sustainable pool in the first place, the latter take responsibility for specifying conditions and for making realistic promises, limiting expectations included. Put simply (and of course repeating ourselves): If insurance abuse is an example of risk and responsibility sharing (rather than something to blame and shame the most irresponsible risky customers), then traditional marketer, lawyer and actuarial work has only limited effect. These insurance professions should try to take their share of the responsibility by cooperating with one another and their customers, with a paradigm change in business model originating in the needs and expectations of insureds as a natural point of departure. Since insurance abuse is so

expensive as it is—by both parties-society can little afford not to innovate in its management. Enhancing ethical sensitivities of both parties is a necessary part of insurance marketing.



The Value of Social Marketing. Social marketing (see Andreasen, 1993; 2001; 2006; Dann, 2010) represents an opportunity to internalize co-responsibility for societal goals on the strategy level, such as societal security and in this case fraud prevention. The US insurance industry has coordinated national efforts around deterrence (e.g., formation of the NICB), and is engaged in the majority of the states. Select US states have undertaken campaigns, with perhaps Pennsylvania as the longest-running example (http://www.helpstopfraud.org/), or New York (http://www.fraudny.com/) with localized efforts to combat insurance fraud and abuse. The common denominator of all such campaigns is the traditional insurance marketing paradigm, i.e. predominantly addressing the consumer side of the equation. As the authors have demonstrated, a holistic approach is needed, which consequently includes the role of insurer practices. Lesch (2005) has previously commented on the highly fragmented nature of consumer messaging to this point, a weakness of the status quo which can be overcome. The Roundtable efforts of the CAIF and its partners can be read as recognition of the need to address one-way communication.[8] Recent research by Ericson et al. (2003) and Berardinelli (2008), and the Multistate Settlement speak volumes about the isolation of the industry from not only its customers, but regulators and society, as well. These large, if not growing gaps between insurer practices on the one hand, and other system actors on the other, have largely gone without redress.

Reconciling the disparate claims adjustment practices—the 'rest of the story' outlined above—must be undertaken if gains are to be stable and permanent. Under the umbrella of a new paradigm for consumer-insurer relationships, a new morality as well as new insurance climate—*morale*—must be formed if success is to be achieved. Industry members must revisit what constitutes good faith practices in administrative procedures and their disclosure *a priori* to consumers. This will only be realized if the conception of the customer shifts. Overcoming the credence –quality gap, and obligating insurers to be proactive in the process of disclosure and education has been detailed by Widiss (1995) as well. Then, among consumers—now participants in sharing responsibility for the administration of the service—a new morale could be expected to form. This, the direct result of improved trust in the process of relationship building. Again, this will require a multi-lateral summit of sorts if gains are to be made in society's well recognized problems with this issue.

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Endnotes

[1] Estimates of inefficiencies in the U.S. property-casualty market vary widely, depending upon measurement and methods (Lesch and Byars, 2008), although the Coalition Against Insurance Fraud (CAIF) recently valued economic losses suffered by the U.S. property-casualty segment of the industry at $80 billion annually (Coalition Against Insurance Fraud 2008). This number may understate the current situation as a result of the ongoing economic recession (Hays, 2010; National Insurance Crime Bureau, 2009; Towers Watson, 2010). Moreover, it has been suggested by various sources that between 3% and 10% of the $2.3 trillion expended by U.S. public and private health care entities in 2007 were based in fraudulent claims, a minority of this attributable to actual patient-behavior (Rosenbaum, Lopez and Stifler, 2009; Federal Bureau of Investigation, 2009). Comparatively, the U.S. Internal Revenue Service (IRS) reported that the tax gap—that amount of tax owed but unreported and unpaid—was (after enforcement and collection activities) about $290 billion in 2005 (The Department of the Treasury, 2009).
[2] The problem of insurance fraud/abuse is the subject of international concern as well (e.g., Montia, 2007; Ipsos-Mori, 2005; Jou and Hebenton, 2007; Lincoln, Wells and Petherick, 2003; Kim and Kwon, 2006).

[3]Unfortunately, many authors do not distinguish among the categories and origins of insurance fraud/abuse in estimates of prevalence or valuation. Unless otherwise indicated, fraud/abuse in this paper is limited to actions advanced by individual consumers associated with property-casualty claims. Criminal organizations (sometimes referred to as "rings," or "medical mills"), or other multi-claim fraudulent applications involving multiple actors and levels of organization are excluded from consideration here, but represent serious challenges in their own right. See Quiggle (2010) for examples of the nature and costs associated with criminal enterprise in the auto lines of property-casualty insurance fraud.

[4] See for example http://www.insurancefraud.org/.

[5] The final version of the multi-state agreement, including signature pages and a corrected state-by-state listing of total auto liability direct written premiums was obtained from the Illinois Department of Insurance, personal correspondence, January 26th, 2011.

[6] Cf about "rediscovering the normative roots" of insurance, as *responsibility sharing together with risk sharing* Brinkmann, 2010; Brinkmann and Doyle, 2010; Brinkmann, 2007. In such a perspective, the insurance business faces new opportunities and challenges at all levels. In the context of descriptive ethics research, the paradigm explaining moral hazard with moral neutralization among both insureds and insurers, is ripe for a similar paradigm change as we have inferred above.

[7] Another approach, more in the descriptive ethics and in the risk perception research traditions, will be the subject of an empirical pilot among insurance company staff with customers in Scandinavia, including customer ethics attributions, perceptions of company co-responsibility for the interaction climate, perhaps also including some ethical climate indicators (see Martin and Cullen, 2006 and Arnaud, 2010)

[8] A combined descriptive ethics and risk perception research approach (cf note *4 above) has such mutual listening and two-way communication in mind, inviting both sides to self-criticism, to put themselves into the shoes of the counterpart.