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Factors Affecting Insurance Fraud: An Overview Study Based on Adam's (1965) Equity Theory

[1] Thi Thanh Tran, [2] Thi Mai Mai, [3] Thi Hoa Ngoc Nguyen
[1] University of Labour and Social Affairs, Vietnam
[2] Hanoi Law University, Vietnam
[3] Department of Testing and Quality Assurance, University of Labor and Social Affairs, Hanoi, Vietnam

Corresponding Author: **Thi Thanh Tran**

Abstract
Uncovering insurance fraud used to be a resource-intensive, arduous, and expensive process, while claims agents had to rely purely on statistical models to identify fraudulent claims, thus increasing the likelihood that fraud would go undetected. Fraud increases insurance costs, threatens the financial strength of insurance companies, and negatively affects the availability of insurance. A cursory review of the insurance fraud literature reveals little scholarly information. In the insurance industry, customers' perceived fairness is an important issue because it has been found that unfair treatment by an insurance company (e.g., a fair amount of deductible) may increase the customer's intention to commit insurance fraud. For example, research by Miyazaki (2009) [16] shows that the deductible amount affects the policy owner's perception of whether the claim is acceptable. On the contrary, an unfair distribution of outcomes can lead to very negative consequences. Therefore, service providers strive to increase customers' perception of fairness to maintain and develop their services (Sindhav *et al*., 2006) [20]. This study aims to explain and analyze these factors. Factors influencing the intention to commit insurance fraud in the health care insurance sector based on the synthesis of research and providing some policy implications for Vietnamese insurance businesses in the current context.

Keywords: Insurance Fraud, Adam's (1965), Equity Theory

JEL Code: G00, G20, G22

1. Introduction
The insurance industry has been an important economic factor for centuries, aiming to minimize losses and compensate damages to organizations, businesses, and individual customers. Accordingly, in this role, the insurance industry is considered a risk financing tool for participants (White and Hoppe, 2012) [26]. Insurance creates a sense of protection and a safety net, especially in the healthcare sector. But while insurance provides protection and minimizes risk and harm, it also creates risks and avenues for criminal behavior. For example, moral hazard may increase the frequency and severity of loss due to the person(s)' views on insurance personal health care and insurance (Cohen and Siegelman, 2010) [7].
In recent years, the number of empirical studies on insurance fraud has increased, along with studies on market failure, asymmetric information, and weak regulatory practices in the economy's financial sector. Globally is growing continuously (Crocker and Tennyson, 2002, Derrig, 2002, Tseng and Su, 2013) [9, 11, 24]. One of them is the huge losses due to insurance fraud in the global insurance market, affecting the development of insurance companies and the financial well-being of insured and customers aviation is not insured (Dean, 2004, Tseng and Su, 2013, Tseng and Kang, 2015) [10, 23, 24]. Insurance fraud is a prominent economic problem for the insurance industry and the nation. However, forms of insurance fraud are still overlooked or rarely disclosed (Ericson *et al*., 2003) [12].
This study aims to explain and analyze the factors affecting the intention to commit insurance fraud based on the synthesis of research based on Adam's equity theory and provide some implications policies for Vietnamese insurance businesses in the current context.

2. Literature Review

2.1 Insurance Fraud

The concept of insurance fraud has been studied from many aspects and angles. According to the International Association of Insurance Supervisors (IAIS), insurance fraud is defined as "an act or omission intended to obtain an advantage for the fraudster or other parties dishonestly "(Dean, 2004) [10]. This may occur due to:

1. Misappropriation of assets or insider trading.
2. Intentionally misrepresent, suppress, or fail to disclose a material fact or facts relating to a financial decision or transaction.
3. Abuse of responsibility, position of trust, or fiduciary relationship.

Derrig (2002) [11] defines insurance fraud as a criminal act that involves obtaining financial benefits from an insurance company or insured by false or false representations. Akomea-Frimpong *et al*. (2016) [4] explains that insurance fraud occurs when individuals deceive insurance companies, agents, or others to obtain money to which they are not entitled. This occurs when someone misrepresents the insurance policy coverage, and false or misleading information is provided or omitted in the insurance or claim transaction.

Levi and Burrows (2008) [14] explains that insurance fraud is said to occur if a person or persons lie to an insurance company, intermediary, or any other party to gain the advantage, which can happen at the underwriting stage or during the claim filing period. The argument is also consistent with Otiso (2021) [18] identified three main types of fraud: policyholder fraud, intermediary fraud, and internal fraud. The first category includes fraudulent acts committed by the insured. The second category comprises fraud committed by intermediaries (Brokers and agents) against insurers or policyholders, while the third category involves employee(s) in collusion with others. For example, intermediaries can be fraudsters, pass on insurance premiums, and, in addition, can falsify records (Lindberg and Seifert, 2016) [15]. Pedneault and Kramer (2015) [19] adds that insurance fraud can also be committed by third parties, thus introducing a fourth component of insurance fraud.

However, based on scope, Otiso (2021) [18] divides insurance fraud into internal and external fraud. In particular, Yusuf *et al*. (2017) [27] and Viaene and Dedene (2004) [25] argued that fraud within corporate insurance exists in the form of internal fraud (committed by employees) and fraud by insurance companies (committed by the insurer).

Meanwhile, insurance fraud can also originate from external parties or stakeholders directly related to the insurer. This comes in the form of policyholder/consumer fraud, a fraud committed against the insurance company in purchasing an insurance policy or making claims by falsely claiming insurance bonds or payments (Derrig, 2002) [11]. Then, intermediary fraud is fraud committed by insurance intermediaries (independent brokers or independent insurance agents) against insurance companies or buyers (Akomea-Frimpong *et al*., 2016) [4].

In this study, the external fraud explained above is divided into two: fraud committed by the consumer or insurance policyholder against the insurance company (insurance policyholder fraud) and fraud committed by independent brokers or agents against insurance companies (intermediary fraud).

Adam's Theory of Justice

Perceived fairness refers to a person's judgment of whether an effort relative to the outcome obtained is acceptable or reasonable. Previous research has shown that perceived fairness is one of the most important factors influencing human exchange (Bolino and Turnley, 2008) [5]. It has been found that a reasonable distribution of resources can increase people's trust and loyalty to the exchange. Equity is a complex multidimensional concept derived from equity theory (Adams, 1963, Adams, 1965) [2, 3]. Other authors argue that equity originates from equity theory although the concept of equity originates from social and equity theory (Frederickson and Rohr, 2015) [13]. Equity theory states that people are often concerned with whether the outcome of an exchange is fair from the perspective of those involved (Colquitt *et al*., 2001) [8]. Both equity theory and distributive justice theory suggest that individuals, in general, use the concept of fairness to evaluate.

Factors Affecting Insurance Fraud According to Equity Theory

According to Adams (1963), Adams (1965) [2, 3], fairness refers to the degree to which people perceive and compare themselves with the circumstances of others. People will try to maintain fairness by comparing the inputs and outputs others provide and receive from the same behavior. However, the theoretical perspective on attitudes toward conformity and dependence on organizational perceptions has led to more specific models of the factors that influence these perceptions (Tennyson, 1997) [21]. One prominent theory is the issue of institutional justice. Based on this perspective, perceptions of institutional fairness can influence individuals' evaluations of organizational legitimacy. In turn, perceptions of institutional legitimacy influence attitudes toward organizational legitimacy with honest dealings with the organization (Cialdini, 1989) [6].

Extensive surveys and empirical research have demonstrated that perceptions of procedural fairness and distributive justice are important in influencing attitudes to comply with or cooperate with authorities (Abel-Smith, 1992) [1]. Procedural fairness depends on perceptions of the fairness and consistency of the process for determining outcomes. Distributive justice focuses on the fairness of the outcomes, especially when comparing outcomes across participants.

From an economic perspective, Tennyson (1997) [21] empirically tested hypothetical statements about insurance customers' attitudes toward fraud and found that an individual's attitude will be influenced by the environment, morals, or social school because of cheating. At the same time, individuals with negative perceptions of insurance organizations will express a tolerant attitude towards fraud more often. Consumers with more negative and unfair feelings experienced by insurance companies are more likely to view insurance fraud as acceptable. Thus, negative emotions toward insurance companies can cause customers to commit crimes and accept insurance fraud (Dean, 2004, Miyazaki, 2009) [10, 16]. Okura (2013) [17] researched the relationship between moral hazard and insurance fraud. Tennyson and Salsas-Forn (2002) [22] further found that insurance customers with recent experience were less likely to detect fraud than others were acceptable. Research also shows a strong link between experience claims and lower tolerance of fraud, and the relationship between experience

claims and reduced tolerance of fraud is a matter of concern. This suggests that it is not simply an indirect relationship that arises because the disputing parties have recently had more positive attitudes toward the insurance industry. However, the study also found that individuals with positive views of the insurance industry were less likely to find insurance fraud acceptable than those with neutral or opposing views.

3. Results and Discussions

This study examines customer perceptions and attitudes toward insurance fraud based on the foundation of process fairness theory. The findings show that customers intend to commit fraud due to being influenced by psychological factors when thinking that the insurance fund is a welfare fund and that customers have the right to receive worthy compensation based on the premium paid. Meanwhile, insurance is a financial relationship with a conditional return and is not equivalent. Therefore, customers' insurance benefits differ based on the insurance scope and the nature of the risk. Accordingly, besides the psychological aspect, internal issues of customer awareness and understanding of insurance also need to be researched further. In addition, besides cognitive factors, aspects of moral hazard and insurance fraud also need to be studied further. Tseng and Su (2013) examined how customer orientation affect salespeople's attitudes toward customer misconduct (planned and opportunistic fraud) concerning fraud and customer insurance fraud.

A research synthesis shows that insurance fraud reflects a general lack of public awareness about insurance and its relevance to the modern economy. Therefore, there is a need for campaigns to raise public awareness about the threat of insurance fraud. Second, the uncompromising attitude of insurance companies reflects a trend in the insurance market through practices that replace strict risk underwriting with an aggressive interest in selling large quantities and profit. This also stems from the belief that the costs of fraud can always be passed back to the insuring public through higher insurance premiums.

Additionally, regarding jurisdictional regulation, the lack of rigor in the current legal framework to tackle fraud is weak and inadequate and may suggest a lack of concern. This is reflected in the lack of clear sanctions and treatment of fraud as a serious crime. The operation of all these factors threatens the survival of the insurance organization and weakens the industry's competitive advantage in the global marketplace. Therefore, there is an urgent need for the regulator to convene a stakeholder summit on insurance fraud where all will reflect on the impact of insurance fraud on the supply of insurance products and insurance service providers and the role of each stakeholder in addressing the threat.

The future of insurance will be defined by the many everyday applications of AI that are transforming many processes across the industry's value chain, including claims management, by increasing its speed and accuracy. This improvement is due to technologies ranging from intelligent chatbots to various learning tools. Today, insurance companies can access the following AI applications to enable customer service response times for first notice of loss, automate fraud detection through the abundance of calculated data, expect ownership of sample validation volume to be received, and additional analysis costs. AI-based chatbots are one of the biggest allies in the industry as they can enhance the current claims process performed by multiple humans while conducting claim reviews, verifying policy details, and scanning the data through a massive detection algorithm before sending further payment instructions to the bank. Therefore, this application reduces user effort on the customer's side and saves energy for insurance companies while minimizing risk by detecting data patterns in reporting claims and enhancing customer experience.

4. Conclusion

This study aims to analyze customers' perceptions of insurance fraud in terms of perceived fairness but has not considered internal factors affecting customers' perceived fairness. Future studies can analyze different aspects of insurance fraud to get a comprehensive view. In addition, this study was only conducted based on theoretical overview analysis. Quantitative studies on this issue will be valuable to understand insurance fraud further.

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