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PROPERTY AND CASUALTY INSURANCE MARKET: ASSESSMENT OF TRENDS AND FRAUD CASES IN LATVIA VS EUROPE

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Abstract. Property and casualty insurance as an umbrella term encompasses various insurance products that cover the risks of damage caused to the assets and provide the liability insurance. As insurance business is related with money people have always tried to perform illegal activities to earn extra income. Insurance fraud as a type of financial crime has existed since the origination of commercial business. Therefore, insurance fraud, its identification and prevention is one of the most topical and essential problems in the insurance industry. The research aim is to assess property and casualty insurance market trends in line with the insurance fraud. The research mainly applies the monographic descriptive method as well as the methods of analysis and synthesis. Content analysis is used to study case laws and analyse insurance fraud cases. The research results demonstrate that in Latvia, the annual amount of compensations paid by insurance companies due to fraudulent claims may range between EUR 7.55 million (in case of 5% fraud) and EUR 30.10 million (in case of 20% fraud). Yet, 20% of fraudulent cases might basically refer to the recent pandemic years like 2021 and 2022. The most popular and serious insurance fraud cases relate to a car theft, staged accidents, submission of false documents and hidden actual causes of the fire in property insurance. The analysed court cases report fine, forced labour and even imprisonment as penalty measures for the committed insurance fraud.

Key words: property and casualty, gross premiums written, gross claims paid, insurance fraud.
JEL code: G22, G52

Introduction

The insurance business is a significant segment not only of the financial system but also social, economic and legal systems. The essence of insurance is to overtake risks from policyholders and eliminate financial uncertainty in case of occurrence of unforeseen circumstances. Insurance being a financial system indirectly promotes dishonest customers to perform illegal activities to earn extra income. More often fraud attempts occur in motor and property insurance business lines, as they are the most popular ones. Trends in insurance fraud vary consistent with the economic situation. In Latvia, there are few studies on insurance fraud; though, some relate to the research on illegal activities in insurance sector (Alfejeva, 2012, 2016). Spilbergs et al. have studied impact of COVID-19 on the dynamics of MTPL (motor third-party liability) insurance premiums and claims (Spilbergs, Fomins, Krastins, 2021), while foreign researchers have more concentrated on insurance fraud studies (Bieberstein, Schiller, 2018; Derrig, Johnston, Sprinkel, 2006; Weisberg, Derrig, 1991). Viaene et al. (2007) have studied strategies for detecting fraudulent claims especially in motor insurance sector but Adams et al. (2019) have emphasised underwriting performance in property and casualty insurance market. The present research is seen as a contribution to the research studies on property and casualty insurance market trends and fraud cases trying to fill in the gap in respective studies in Latvia. The research hypothesis is that insurance fraud as a serious criminal offence causes losses to insurance companies and increases the cost of insurance policies. The research aim is to assess property and casualty insurance market trends in line with the insurance fraud. Research tasks subject to the research aim are as follows: 1) to study the property and casualty insurance development trends; 2) to characterise insurance fraud and possible insurance fraud estimation; 3) to describe some fraud cases in Latvia.

The research mainly applies the monographic descriptive method as well as the methods of analysis and synthesis are used to study the trends and formulate regularities. Content analysis is used to study case

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laws and analyse insurance fraud cases. The information provided by Latvian Insurers Association, Insurance Europe and publications of foreign and national researchers and practitioners are widely employed for the purpose of the present research.

Research results and discussion

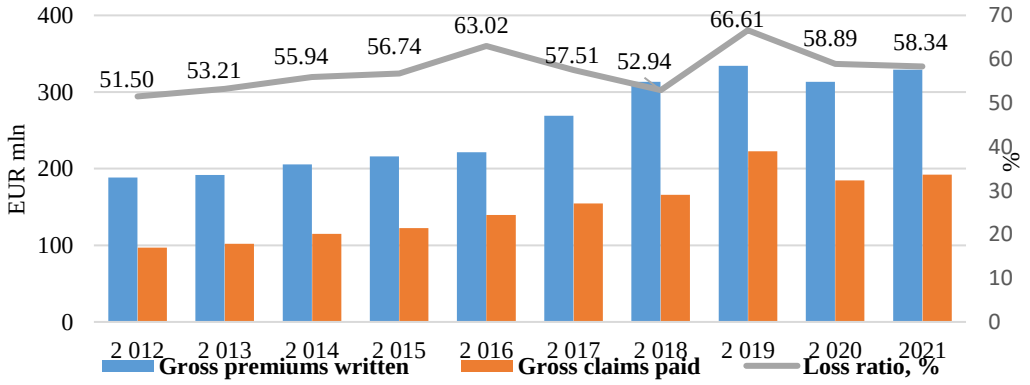
Property and casualty insurance development trends

The European Insurance and Reinsurance Federation or Insurance Europe defines property and casualty (P&C) insurance as an umbrella term which encompasses various insurance products that cover the risks of damage caused to the assets and provide the liability insurance (European Insurance, 2021). The basic groups of the P&C insurance include:

1) motor, incl. motor third party liability (MTPL) and motor own damage (CASCO);
2) property;
3) general liability;
4) marine, aviation and transport (MAT), incl. railway rolling stock, aircraft and ship ownership liability, aircraft hull and goods in transit;
5) other types of insurance such as legal expenses, credit and surety, assistance (travel) and miscellaneous financial losses.

MTPL is a compulsory insurance for all owners of transport vehicles, while CASCO is a voluntary type of insurance. In 2020, the three main insurance business lines in Europe as well as in Latvia were motor, property and general liability which accounted for 73%-91% of the P&C gross premiums written (Latvian Insurers Association, s.a.; European Insurance, 2021). The breakdown or classification of P&C groups may differ among the insurance associations or companies collecting statistics on insurance. Gross premiums written and gross claims paid are the main indicators demonstrating the demand for insurance services and activities of insurance companies. Gross premiums written are total amount of premiums written by an insurer including reinsurance and other commissions, while gross claims paid mean total amount of claims paid including proportion of claims paid by reinsurers and changes in technical reserves (Glossary, s.a.).

Figure 1 reflects the dynamics of gross premiums written, gross claims paid and loss ratio in P&C business line in Latvia.



Source: Latvian Insurers Association, s.a. and authors' calculations

Fig. 1. **Gross premiums written and gross claims paid (EUR mln), and loss ratio (%) in P&C insurance in Latvia for 2012-2021**

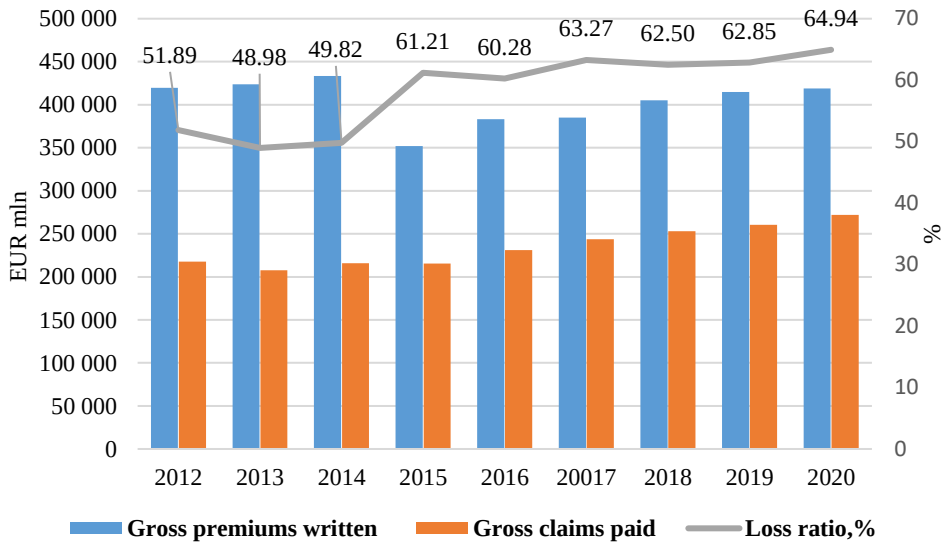
The amount of gross premiums written has quite steadily increased till 2016 with an annual rate of increase 4.14% on average. In 2017, gross premiums written experienced the fastest increase within the

period analysed by 21.50% compared with the previous year. The increase was mainly achieved thanks to the growth in marine and motor insurance (81.68% and 42.86%, respectively). The year 2022 was the only year when insurance sector reported a drop in gross premiums written. Total decrease in the P&C insurance sector accounted for 6.28% basically due to a big drop in assistance (travel) insurance – by 44.68%, marine insurance – by 44.52%, railway rolling stock insurance – by 25.71% and motor insurance – by 13.64%. The COVID-19 pandemic has been the most significant factor impacting the decline in travel insurance. In contrast, the amounts of ship ownership liability, aircraft ownership liability and aircraft hull have grown by 198.22%, 61.94% and 47.89%, respectively. However, the percentage of these business lines in total P&C insurance are small and the increase in their amounts of premiums cannot compensate for the decrease in the major business lines. In 2021, the decline continued in marine insurance (43.56%), railway rolling stock insurance (12.14%) and motor insurance (11.49%). After softening of the COVID-19 restrictions in summer, people resumed travelling, and thus, assistance (travel) insurance increased by 30.42% compared with the year before. The proportion of travel insurance is approximately 1.5% of total insurance market. Latvia is among those European countries that experienced a moderate negative impact of the COVID-19 pandemic in 2020 (COVID-19 negativa ietekme …, 2022).

The amount of claims paid has also increased during the period analysed; though, the growth has been uneven reaching the highest rate of increase in 2019 (34.31%) and equalling to EUR 222.62 million. The largest increase was reported in property insurance, where the amount of claims paid grew by 163.25% compared with the previous year. In 2019, historically the largest property compensation in the amount of EUR 36.9 million was paid to an IT company SIA "Mikrotikls" for the warehouse building and the goods in it destroyed by the fire (Balta 2019. gadu nosledz …, 2020). This was an unprecedented case, since it was the largest indemnity case ever registered to any insurance company in the Baltic States (Apdrosinasanas nozare krizes …, 2020). Large increase was demonstrated also in marine insurance sector where the amount of claims paid grew by 188.77%. However, in absolute figures the increase was EUR 2.55 million. After such tremendous increases, insurance statistics show a decrease in the following year. In 2020, EUR 184.48 million were paid out in compensations which is a decrease by 17.13%. The largest decline was reported in property insurance by EUR 32.24 million or 41.59%, suretyship – by EUR 9.75 million or 89.75%, while credit insurance experienced even a rocketing growth 5.6 times. In general, credit insurance sector demonstrates very fluctuating trend by years, so sharp increases or decreases in this sector have to be evaluated with a precaution. In 2021, total amount of claims paid has increased by 4.12% amounting to EUR 192 million.

Gross loss ratio is expressed as percentage of the gross claims paid divided by gross written or earned premiums (Glossary, s.a.). In property and casualty insurance, loss ratio ranges between 40% and 60% (Brown, Gottlieb, 2007). The lower the gross ratio, the greater potential profitability of the insurance company, since the amount of money paid as claims is less than the amount of written insurance premiums or money to be received. In Latvia, the gross loss ratio has ranged between 51.50% (in 2012) and 66.61% (in 2019) which means that the ratio has been within the theoretical limits the entire period analysed, except for 2019, when the historically highest compensation was paid out in the property insurance business line. The average gross loss ratio has been 57.47% meaning that a bit more than 50% of gross written premiums are paid out as compensations.

Gross premiums written and claims paid in the P&C sector in Europe are reflected in Figure 2. Similar to the analysis of the respective indicators for Latvia, the figure also shows the dynamics of the gross loss ratio.



Source: European Insurance …, 2022, P&C Insurance, 2022 and authors' calculations

Fig. 2. **Gross premiums written and gross claims paid (EUR mln), and loss ratio (%) in P&C insurance in Europe for 2012-2020**

In Europe, a sharp decrease in gross premiums written was observed in 2015, when the indicator dropped by EUR 81.40 billion or 18.78%. Liechtenstein, the Netherlands and Ireland are the three countries which have reported the largest decline in gross premiums written (99.89%, 73.65% and 42.53%, respectively). The only explanation for the extreme drop in total gross premiums written in Liechtenstein from EUR 865 billion to almost EUR 1 billion might be the lack of data. The largest positive growth was registered in Latvia (37.69%) and Iceland (17.19%). According to Insurance Europe, in 2015, Germany, the UK, France and Italy which are among the largest insurance markets have increased their share of total P&C insurance in Europe from 64.1% to 64.5% (European Insurance …, 2016). In Italy, the decline in motor premiums by 5.26% led to a decrease in total gross P&C premiums by 25.69%. The motor insurance line is a very significant P&C business line in Italy, since its proportion is almost 56% of all non-life insurance premiums (European Insurance …, 2016). The following year, the amount of gross premiums written grew by 8.90% mainly thanks to the market improvement in the UK (41.38%), Denmark (40.86%) and Iceland (23.89%). The other European countries have experienced a smaller growth from 0.37% (Sweden) to 19.57% (Turkiva). Some countries like France and Latvia have reported decline in 2016 (European Insurance …, 2016, 2022).

Gross claims paid have demonstrated the largest increase in 2016 by 7.25%. Luxembourg and the UK were the biggest contributors to this growth, where the compensations paid increased by EUR 1.63 billion or 350.45% and EUR 27.94 billion or 107.95% respectively due to the increased amounts of claims paid in motor and property business lines.

In 2020, both gross premiums written and gross claims paid have increased compared with the previous year (by 1.06% and 4.44%, respectively) and slightly over the average rate of increase (0.30% and 2.83%, respectively) during the analysed period. Higher demand for insurance has been one of the reasons for growth. Another reason related to the growth in premiums was the increase in the value of buildings and assets (European Insurance …, 2022). Although, the total amount of gross claims paid grew in 2020, the changes per business lines varied: so, the largest decrease was observed in the motor insurance, while the largest increase – in the property insurance. The changes were basically related to the Covid pandemic, since people were forced to stay at home due to the COVID-19 restrictions and they less used transport; yet, spending time at home resulted in higher property damage and performed home repairs.

The gross loss ratio in Europe has fluctuated between 48.98% in 2013 to 64.94% in 2020 which means that 58.42% of gross premiums on average were paid as compensations within the entire period. Another reason for a high loss ratio in 2020 is the fact that many natural disasters (floods and storms) happened this year causing growth in the property insurance claims.

Insurance fraud classification and estimation

Insurance fraud as a type of financial crime has existed since the origination of commercial business. The European Insurance and Reinsurance Federation indicates that insurance fraud is a victim crime (The Impact of …, 2013). It is a significant crime that affects not only insurers but also policyholders, since the latter have to pay more for their policies to cover the losses incurred by insurance companies due to fraudulent activities committed by dishonest customers.

Fraudulent activities in insurance may be various depending on the development of insurance services and they may be encountered in any of insurance business lines. Nevertheless its long history, there is no single or uniform insurance fraud definition. Insurance Information Institute states that insurance fraud is any deliberate deception performed either by a customer, an insurance company or insurance agent in order to gain financial interest (Background on …, s.a.). Many Internet sources and insurance companies define insurance fraud as a dishonest action when a person submits a false information to an insurance company to gain financial profit.

Insurance fraud includes:

1) provision of false or incomplete information when filling in insurance applications;
2) submission of an insurance claim containing misleading or false information (also exaggeration);
3) other untruthful or misleading activities (The Impact of …, 2013).

The International Association of Insurers Supervision defines insurance fraud as activity which is intended to gain either dishonest or unlawful benefit (Application Paper …, 2011). In general, the term *fraud* means an illegal act the consequences of which lead to sanctions. Regardless of possible serious outcomes in case of insurance fraud, insurers encounter suspicious and really fraudulent claims for insurance indemnities.

The consequences of insurance fraud may encompass:

- refusal to pay indemnity;
- cancellation of the insurance policy prior to the policy expiration date;
- reporting to the police;
- demand for covering extra expenses related with the involvement of experts for investigation of the case;
- restrictions or prohibition to obtain further insurance;
- prosecution and imprisonment;
- criminal record (The Impact of …, 2013).

Insurance fraud is nothing unique; yet, the previous years with various restrictions due to the pandemic have broaden the activities and creativity of insurance frauduleuses.

The Insurance Information Institute has evaluated the COVID-19 impact on insurance business and concluded that the pandemic has caused reduction in fraud inspections and more cases of fraud due to increased amount of work of insurance companies (Insurance Fraud Report, 2023). The Institute releases biennial reports on insurance fraud analysis, including statistics on fraud detection. Hence, according to the

Report, if 18% of claims were suspected to be fraudulent in 2020, then the percentage of fraudulent cases has grown to 20% in 2022 (Insurance Fraud Report, 2023). The most common fraudulent claims included:

- false injuries;
- hiding or unrevealing of significant information;
- fake accidents;
- several claims on the same injury or accident;
- violation of employee claims (Insurance Fraud Report, 2023).

Insurers recognise that policyholders become more and more creative investing various fraud schemes to gain profit from insurance policies. So, in 2021, the most uncommon fraud schemes related to the theft of identity to submit unemployment claim, self-caused injuries, theft of a non-existing food cargo and damages caused by roofers to roofing materials or the whole roof covering in order to create situation so that the roof needs either be repaired or even fully replaced (Insurance Fraud Report, 2023).

Fraud and fraudulent claims are difficult to disclose; thus, estimates on insurance fraud may be disputable (Derrig, 2002). Bieberstein and Schiller (2018) in their study after the analysis of different authors have concluded that insurance fraud may range between 8% and 10% of all claims. Most frequently these estimates refer to motor insurance.

According to Insurance Europe, the number and extent of fraudulent cases vary among countries; yet, it may be estimated that up to 10% of all insurance claims are fraud cases (The Impact of …, 2013). There have been no extensive studies on insurance fraud conducted in Latvia; yet, insurers also estimate that 10% of all claims paid are fraudulent (Abasins, 2016). Also, a representative of the insurance company "BTA Baltic Insurance Company" has admitted that the amount of fraudulent claims equals to 10% on average of all paid indemnities, while a representative from "Compensa Vienna Insurance Group UADB" remarks that cases where fraud has been detected account for no more than 1% of all claims (Cik izplatita ir …, 2016). In general, most European countries estimate fraud between 5% and 10% of all annual paid indemnities.

Insurance Europe has collected data on several countries that aggregate information on insurance fraud and consistent with the statistics 1-3% of insurance claims are investigated for fraud in Belgium, 5-10% in Finland, 1% in Denmark, under 1% in motor insurance and under 1.5% in other P&C lines in France, around 1.9% in Italy and 2.1% in Portugal (Insurance Fraud …, 2019). However, these are figures on claims investigated for fraud which does not say that they have been real fraudulent claims. The German Insurance Association estimates that fraud equals to 10% of expenditure of all claims and 7-16% of claims are treated as suspicious: the highest percentage of 16% relates to the general liability claims. Moreover, the average amount of fraudulent claims is very often larger than the average amount of real or honest claims (Insurance Fraud …, 2019).

Alfejeva (2012) in her PhD Thesis "Criminal Law and Criminological Aspects of Insurance Fraud" states that the assessment of fraudulent claims may be based only on subjective or biased opinions of insurers. Every insurance company identifies fraud consistent with the fraudulent cases met in their practice; hence, the estimates differ. Alfejeva (2012) has calculated the possible amount of fraudulent claims of gross claims paid and possible costs of fraud to other policyholders based on minimum (10%) and maximum (33%) possible percentage of fraudulent claims. Table 1 reflects calculations and estimations based on Alfejeva sample (2012); though, the percentage of fraudulent cases ranges between 5% and 20% consistent with the recent estimations of insurers.

Table 1

Possible fraud estimation based on theoretical percentage of fraudulent claims in Latvia for the period 2012-Q3 of 2022

	Gross premiums written, EUR mln	Gross claims paid, EUR mln	Insurance fraud estimates 5% of gross claims, EUR mln	% of gross premiums written	Insurance fraud estimates 10% of gross claims, EUR mln	% of gross premiums written	Insurance fraud estimates 20% of gross claims, EUR mln	% of gross premiums written
2012	188.37	97.00	4.85	2.57	9.70	5.15	19.40	10.30
2013	191.75	102.03	5.10	2.66	10.20	5.32	20.41	10.64
2014	205.47	114.94	5.75	2.80	11.49	5.59	22.99	11.19
2015	215.91	122.52	6.13	2.84	12.25	5.67	24.50	11.35
2016	221.37	139.50	6.98	3.15	13.95	6.30	27.90	12.60
2017	268.98	154.69	7.74	2.88	15.47	5.75	30.94	11.5
2018	313.11	165.75	8.29	2.65	16.58	5.29	33.15	10.59
2019	334.22	222.62	11.13	3.33	22.26	6.66	44.52	13.32
2020	313.24	184.48	9.22	2.94	18.45	5.89	36.90	11.78
2021	329.24	192.09	9.60	2.92	19.21	5.83	38.42	11.67
2022 Q 3	284.41	165.04	8.25	2.90	16.50	5.80	33.01	11.61
Total	**2 866.07**	**1 660.66**	**83.03**	**2.90**	**166.07**	**5.79**	**332.13**	**11.59**
Average	**260.55**	**150.97**	**7.55**	**2.88**	**15.10**	**5.75**	**30.19**	**11.50**

Note: data for 2022 include information only for three quarters and data are preliminary

Source: authors' calculations based on Latvian Insurers Association, 2013-2022

According to the data of Table 1, the amount of compensations paid by insurance companies due to fraudulent claims may range between EUR 83.03 million to EUR 332.13 million for the entire period analysed with the average annual fluctuations from EUR 7.55 million (in case of 5% fraud) to EUR 30.10 million (in case of 20% fraud). Yet, 20% of fraudulent cases might basically refer to the recent pandemic years like 2021 and 2022. Insurers that have paid indemnities for fraudulent claims incur losses and to compensate for them very often other policyholders have to pay higher insurance premiums. The calculated percentage of fraudulent claims against gross premiums written demonstrates that honest policyholders may have to pay 2.88-11.50% on average more for their insurance policies.

Janis Abasins, the president of Latvian Insurers Association, suggests a different estimation of costs due to fraudulent claims. The year 2015 and all insurance business lines are taken as an example. Hence, consistent with the insurers estimates that 10% of all claims paid are fraudulent and EUR 217 million were paid as compensations, then EUR 21.7 million were defrauded. Next, assuming that approximately one-third of population (650 000 natural entities) have bought insurance services, each of these 650 000 insurance clients would have to donate almost EUR 34 (EUR 21.7 million divided by 650 000 policyholders) to cover the defrauded money (Abasins, 2016). This example truly shows how much any of us indirectly might pay to cover insurers losses.

Insurance fraud is a criminal and punishable activity. Insurance Europe distinguishes two categories of insurance fraud: soft such as exaggeration of the scale of damage or injury or provision of false information

and hard which is, for example, staged accident (Insurance Fraud …, 2019). Every year in Latvia some cases are filed in court for insurance fraud. In 2016, Janis Abasins, the president of Latvian Insurers Association, indicates that the lack of separate article on insurance fraud in the Criminal Law hampers the effectiveness of insurance fraud investigation (Abasins, 2016). However, since this statement is the interpretation of a journalist it should be assessed with a precaution as the Criminal Law of the Republic of Latvia stipulates the liability for insurance fraud. Namely, Article 178 "Insurance fraud" directly prescribes criminal liability for "deliberate destruction, damage or concealment of one's own property" or "forcing or persuading another person to destroy, damage or conceal insured property or otherwise affecting it" in order to receive insurance compensation (Kriminallikums, 1998). This article regulates criminal offenses against property. Lawyers providing profound comments on Article 178 explain insurance fraud as a special type of fraud which is an intentional activity to destruct, damage or conceal one's property to receive the sum of insurance (Krastins, Liholaja et al., 2019). Though, the authors of present research indicate on inaccuracies in the before-mentioned comments, namely, submitting an insurance application, a person is applying for the insurance indemnity or compensation not the sum of insurance. In addition, the lawyers emphasise that it is essential to determine the ownership of property under this specific norm, since only fraud that is committed with one's own property may be considered as an insurance fraud (Krastins, Liholaja et al., 2019). In other cases, the committed action is qualified as fraud consistent with Article 177 or 180 of the Criminal Law. Kolomijceva (2016) points an attention to the fact that in the case of insurance fraud, criminally acquired property will be only the property related to the offense but not legally obtained and hidden belongings of the perpetrator.

Alfejeva (2012) in her PhD Thesis concludes that the objective side of insurance fraud has been very narrowly defined in Article 178 of the Criminal Law. Moreover, the researcher indicates on the situation when insurance fraud may not be qualified as fraudulent case if there has been an attempt to defraud compensation in the insurance of a person. Nevertheless, worldwide this is considered to be an insurance fraud (Alfejeva, 2012). Summarising the previously analysed facts on insurance fraud, it shall be admitted that the submission of the insurance application is the only unbiased factor indicating on the intention to defraud insurance indemnity.

Analysis of fraudulent cases

In Latvia, there is very few information in mass media on insurance fraud cases, the most recent information dates back to 2016. Representatives from several insurance companies have indicated that most popular and at the same time most serious insurance fraud cases relate to a car theft, staged accidents, submission of false documents, hidden real causes of the fire in property insurance, taking damaged cars to false places of accidents and spreading around extra glasses to imitate car accident, deliberate pushing of a car into the water etc. (Cik izplatita ir …, 2016). A representative from the insurance company ERGO specifies that most frequently the company encounters fraud attempts in MTPL business line, especially when an insurance claim has been submitted some days after the purchasing of the compulsory third-party motor liability insurance policy. In such situations, more than 50% of cases raise suspicions on possible insurance fraud (Cik izplatita ir …, 2016).

Dr.iur. Jelena Alfejeva emphasises that lately very few court proceedings have been initiated due to insufficiency of evidence or statute of limitations. Insurers are not interested in reporting of detected insurance fraud cases and starting a criminal proceeding. Instead, they refuse paying the compensation (Alfejeva, 2016). This means that information on fraudulent cases becomes unpublished statistics of insurers and unavailable to public for the analysis.

However, the cases which have been subject to legal proceedings and the court has pronounced a sentence are available as anonymised court judgments. The research authors have described some of the cases. The most recent one refers to March 2023 when Person A being the owner of insured property persuaded another person to destroy this property and later the accused person deliberately destroyed the property itself by setting fire to the insured property in order to receive a large insurance indemnity (Senata Kriminallietu …, 2023).

Another case refers to Person K who concluded an insurance agreement for the insurance of a residential house. The insurance agreement stipulated that the insurance indemnity of EUR 10 000 should be paid out in the event of a fire to Person K who, promising to pay, persuaded another person to burn down its residential house. Person K did not inform the hired arsonist that the fire was done with the intention of being able to receive insurance indemnity from the insurance company ERGO. Person K was found guilty of the crime under Part 2 of Article 178 of the Criminal Law and sentenced to imprisonment for five months (Gulbenes rajona tiesas …, 2017).

The most widespread insurance fraud cases are encountered in motor insurance. Hence, Person B who had insured a passenger car registered on its name agreed with two other persons to commit a fraud on a large scale, i.e. to stage the theft of a passenger car Mitsubishi Pajero (pledged to the JSC "GE Money") and later report to the police and the insurance company on the theft. The insurance agreement prescribed the payment of the insurance compensation to the JSC "GE Money". It was envisaged to dismantle the car itself into spare parts. As a result of the fraudulent actions, Person B would be exempted from the loan payment to the JSC "GE Money" (as the loan was taken to purchase the car) and other persons involved in the crime would receive payment for committing fraudulent activities and income from selling spare parts. All persons were found guilty in accordance with Part 3 of Article 178 of the Criminal Law. Person B was sentenced to imprisonment for 2 years and 5 months as well as the other persons were sentenced to imprisonment (Rigas apgabaltiesas …, 2015).

Person C had concluded a motor insurance agreement with the insurance company "Balta" for the insurance of a car Mercedes Benz CLK 320. The insurance agreement provided for the payment of an insurance indemnity of EUR 5 700 in case of the car theft. Person C persuaded person D to hide the car. Person C was found guilty of committing a criminal offense provided for in Part 1 of Article 178 of the Criminal Law (for concealing one's property in order to receive the insurance indemnity) and Person D was found guilty of committing a criminal offense provided for in Part 4 of Article 20 and Part 1 of Article 178 of the Criminal Law (for supporting another person to intentionally destroy its property in order to receive the insurance indemnity). The court decided to recover compensation for the damage in favour of the insurance company "BALTA" jointly and in solidarity from both persons. Person C was sentenced to forced labour for 200 hours and Person D was sentenced to temporary imprisonment for three months (Jelgavas tiesa …, 2015).

Similar insurance fraud was committed by Person S who had concluded a motor insurance agreement with the insurance company "Baltijas Apdrosinasanas Nams" or BAN for the insurance of a car VW Passat. In this case, the insurance agreement provided for the payment of an insurance indemnity of EUR 12 000 in case of the car theft. After having hided its car, Person S reported to the police on the theft of the car and submitted an insurance claim application to the insurance company in order to receive the insurance indemnity. Person S was found guilty under Part 1 of Article 178 of the Criminal Law and fined in the amount of seven minimum monthly wages (Kraslavas rajona tiesas …, 2013).

The analysis of court decisions reveals that there are cases when a guilty person has been encouraged and advised by other persons to commit a crime in order to claim for the insurance compensation. So

Person E in order to receive the insurance indemnity of EUR 8 537 in case of the theft of a car handed over the car to its acquaintance and reported to the police for the car theft. Person E also submitted an insurance claim application to the insurance company "Baltikums". Person E was found guilty of committing a criminal offense under Part 1 of Article 178 of the Criminal Law and sentenced with forced labour for 60 hours (Liepajas tiesas …, 2014).

Types of sentences imposed by the court differ on previously committed crimes, law violations and whether the insurance fraud was committed under extenuating or aggravating circumstances.

Conclusions, proposals, recommendations

1) Property and casualty insurance includes insurance products that cover the risks of damage caused to the assets and provide the liability insurance.

2) Gross loss ratio determining the relation between gross premiums written and gross claims paid shows that 57.47% on average of gross written premiums are paid as compensations in Latvia. The respective figure in Europe accounts for 58.42% for the period of 2012-2020.

3) In Latvia, the annual amount of compensations paid by insurance companies due to fraudulent claims may range between EUR 7.55 million (in case of 5% fraud) and EUR 30.10 million (in case of 20% fraud). Yet, 20% of fraudulent cases might basically refer to the recent pandemic years like 2021 and 2022.

4) The calculated percentage of fraudulent claims against gross premiums written in Latvia demonstrate that honest policyholders might have to pay 2.88-11.50% on average more for their insurance policies.

5) The most popular and serious insurance fraud cases relate to a car theft, staged accidents, submission of false documents and hidden actual causes of the fire in property insurance. Insurance fraud is a victim crime and a criminal liability is prescribed for it. The analysed court cases evidence fine, forced labour and even imprisonment for the committed insurance fraud.

6) The research hypothesis has been proved as the insurance fraud causes losses to insurance companies and costs of insurance policies may increase due to fraudulent insurance claims.

7) Latvian Insurers Association should collect information on fraud insurance cases from the insurance companies and provide information either in annual reports or mass media to inform the policyholders on possible consequences of intentional fraud activities.

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