Policy briefing

January 2016

Insurance Fraud Task Force Final Report

On 18 January, HM Treasury published the final report of its Insurance Fraud Task Force, chaired by former Law Commissioner David Hertzell. Insurance fraud is a serious issue, which has been estimated to cost policyholders up to £50 each per year, and the country more than £3 billion, not to mention time spent by the legal and medical services in dealing with these cases.

The task force explores relevant issues including the scale and impact, regulators and legal frameworks and what has already been done to tackle fraud, before making a range of targeted recommendations, that aim to:

- tackle fraudulent activity ranging from organised or premeditated crime to opportunistic fraud, with the overall objective of ultimately reducing costs for consumers;
- improve consumer trust in the insurance sector and raise the public profile of insurance fraud as a criminal activity;
- encourage greater use of data sharing and collaboration between the insurance sector and regulatory bodies to better prevent organised insurance fraud; and
- reflect and support the government's intentions to clamp down on unnecessary whiplash claims, which are a major source of fraud, and strengthen regulation of claims management companies.

Next Steps: the Government and relevant trade associations and professional bodies will review the recommendations and feed back over the next several months.

Overview and background

The Task Force is made up of representatives from the Association of British Insurers (ABI), Citizens Advice, the British Insurance Brokers' Association (BIBA), the Financial Services Consumer Panel (FSCP), the Insurance Fraud Bureau (IFB) and the Financial Ombudsman Service (FOS). HM Treasury and Ministry of Justice officials support the Task Force and attend its meetings.

The Task Force was chaired by David Hertzell, former Law Commissioner who oversaw the recent insurance contract law reform.

Although the Task Force considered all types of insurance fraud, it did stress the importance of personal injury (PI) claims, and established a Personal Injury Working Group to look at this area, and included representatives from the Association of Personal Injury Lawyers (APIL), the Motor Accident Solicitors Society (MASS), National Accident Helpline, BLM Law, Covéa Insurance and Aviva Insurance.

The final report was published on www.gov.uk/government/publications/insurance-fraud-taskforce-final-report, and included a joint foreword by Treasury Economic Secretary Harriett Baldwin MP and Minister of State for Civil Justice Lord Faulks QC.

The need for legal system reform

Developments in the legal system in England and Wales since the 1990s have led to significant changes in the market for PI claims in England and Wales and how they are sourced, funded and dealt with. Coupled with an apparent shift in public attitudes to claiming compensation for minor injuries, this has led to a substantial rise in the number of PI claims in particular for minor whiplash despite rates of road traffic accidents (RTAs) falling.

These developments have created a lucrative market for claimant representatives, as the number of new entrants has demonstrated – not least in the appearance of and growth in claims management companies (CMCs).

It has incentivised unscrupulous CMCs to play a role in encouraging fraudulent claims. As well as causing a social nuisance through their reliance on cold calls, also known as 'claims farming', CMCs have been reported to pressurise otherwise honest people to exaggerate or make up claims:

- **Whiplash:** whiplash is currently the most frequent type of personal injury claim. The government sought to address this problem by introducing greater independence to the market by creating the new MedCo Portal which ensures medico-legal reports are independently sourced. The Task Force supports MedCo as it will introduce greater independence and transparency into the medico-legal reporting system, removing the perverse financial incentives that are in place to produce a clinical diagnosis of minor soft tissue injuries. MedCo will also introduce minimum standards for Medical Reporting Organisations (MROs) and oversee a robust new accreditation system for the medical experts who write the reports used in support of whiplash claims.
- **Noise-induced hearing loss**: civil justice reforms since 2010 have reduced the profitability of pursuing some low value PI claims, which has in-turn led some claimant representatives moving into other areas such as Noise-Induced Hearing Loss (NIHL) claims. This has seen a substantial increase in the number of claims and, therefore, cost of litigation to defendants. Stakeholders representing insurers and defendant solicitors stated that (1) a significant number of NIHL claims submitted are of poor quality without any medical evidence or real prospect of success; (2) since audiologists are not sourced through an independent system, some unscrupulous audiologists are acting as professional enablers, and stakeholders are raising concerns about the quality of audiograms; and (3) a pre-action protocol with fixed recoverable cost arrangements was introduced for employers' liability claims up to £25,000 in July 2013, but a number of features of this protocol are not suited to NIHL claims, such as the fact that it is not suitable for multi-defendant cases. This means that the majority of NIHL claims are settled outside the pre-action protocol where guideline hourly rates, rather than fixed costs, are recoverable.

Claims Management Sector

A large Claims Management Company (CMC) sector has developed with PI claims accounting for 40% of the industry's total turnover in 2014/15. CMCs operate in a variety of sectors, but PI remains the largest with 917 authorised PI CMCs at the end of October 2015 despite the numbers of CMCs operating in the sector continuing to fall. CMCs assist people to bring claims who would otherwise not be inclined to. While the Task Force recognises that they can play a positive role in assisting access to justice, there are concerns about both practice and regulation in this area; and that some are set up by criminal gangs to assist them in their scams.

In 2014/15 nearly a quarter (23%) of all CMCs faced some sort of intervention from the Claims Management Regulator, either being given a warning or having their authorisation cancelled; and an increase from 18% in 2012/13. While these figures do not necessarily suggest that such CMCs are engaged in fraudulent activity, it does point to widespread poor practice in the sector.

Professional enablers

Costs within the system attract a small number of professional enablers, such as solicitors and medical professionals who play a key role using their professional standing, expertise or qualifications, to give the appearance of legitimacy to claims allowing fraudsters to succeed. While the vast majority are honest, some professionals are themselves the active perpetrators of the fraud.

- **Medical professionals**: some cases involve inflating medical bills or faking medico-legal reports for personal injuries such as soft tissue injuries.
- **Solicitors**: stakeholders stated that some claimant solicitors fail to complete adequate client identification and/or take proper instructions from clients. For example in some cases claimants may not be aware that their identity has been used for a claim.
- **Credit hire companies (CHCs)**: CHCs provide temporary replacement vehicles to non-fault parties following RTAs. In 2014, DAC Beachcroft estimated that the cost of credit hire fraud (not associated with PI claims) was in the region of £71m to £75m per year. Examples of fraud in this area include artificial exaggeration of vehicle damage and fabricating documents, for example submitting false claims for replacement cars given to motorists while their own car is being fixed.
- **Motor engineers**: some cases involve motor engineers writing false vehicle reports for damage that had not occurred and for vehicles the engineer had not seen.
- **Veterinary surgeons**: some cases involve false claims on pet insurance policies. For example a vet was imprisoned and struck off for preparing fictitious veterinary treatments claims for non-existent pets totalling nearly £200,000.

Data sharing and fraud detection

Data sharing came up consistently in Task Force meetings and throughout the review as a vital tool in the fight against insurance fraud since when data and intelligence is shared, the industry is able to make connections more intelligently to flag potential fraud and conduct further investigations. This means better use of resources and a greater chance of catching those involved in organised networks.

- **Data theft and illegal processing of data**: stakeholders linked data theft and illegal processing of data to the illegal purchase of customer data by CMCs or other intermediaries to 'farm' claims. A Sunday Times investigation found that the Driver and Vehicle Licensing Agency (DVLA) has been subjected to 264,484 attempted cyber-attacks in the last 3 and a half years, the equivalent of more than 200 a day, by criminals to hack into the government's vehicle database to clone cars and steal drivers' identities. There are reported cases of insurance company staff being targeted by claims farmers to obtain accident data.
- **Lack of understanding of insurance claims**: throughout the review it became clear that a number of organisations are wary of how to share anti-fraud data within current data protection laws and conscious of the impact of the changing landscape with the introduction of new regulations, especially forthcoming European regulations.
- **Short-term focus on competitive advantage rather than long-term focus on the common good**: stakeholders broadly agreed that data that could be used to detect or investigate fraud is not being shared as effectively as it could be, and many in the industry under-use available commercial software due to cost and associated systems changes.
- **Data sharing outside the insurance industry**: the industry and enforcement agencies improve their chances of identifying and taking action against fraudsters when data is shared across sectors. Stakeholders highlighted an reluctance and caution by some to share data between the claimant and defendant side and/or between insurers and others such as government departments.
- **Other fraud including 'ghost broking'**: ghost brokers are fraudsters who sell drivers apparently cheap motor insurance deals but issue policies that aren't worth the paper they're written on. This results in consumers unknowingly driving without insurance and all the implications that has.

Tackling insurance fraud – actions to date

Several actions have been taken over the past several years to address some of the concerns described above:

- **Insurance Fraud Bureau**: established in 2006, a not-for-profit organisation funded by the insurance industry, specifically focused on detecting and preventing organised insurance fraud. The IFB has several key roles:

detection, co-ordination and prevention. The IFB analyses data, such as the raw intelligence which is provided anonymously to the IFB Cheatline, to find trends and patterns. It works with insurers, regulators and law enforcement agencies to use this insight to investigate and prosecute. The IFB also acts as a data and intelligence hub, enabling regulators and law enforcers to share data through a single source.

- **Insurance Fraud Register (IFR):** a register of known insurance fraudsters across all insurance product lines. The consequences of appearing on the register can mean that fraudsters may find it harder to obtain insurance and will pay higher premiums. They may also find it harder to obtain other financial services, including mortgages and loans.
- **Claims and Underwriting Exchange (CUE):** a central database of motor, home and PI/industrial illness incidents reported to insurance companies and self-insured organisations such as local authorities. CUE was established in 1994 to prevent multiple claims fraud and the misrepresentation of claims histories and is currently being enhanced to improve efficiency and data standards.
- **Motor Insurers Anti-Fraud and Theft Register (MIAFTR):** a database of vehicles which have been stolen or damaged beyond economic repair. Insurers use it to prevent motor claims fraud by identifying whether the vehicle in the claim is already subject to another claim elsewhere. A programme is underway to improve the integrity, consistency and standards of the data held within the MIAFTR database to give the industry greater visibility of the history of a member and vehicles.
- **Motor Insurance Database (MID):** a database containing insurance records for 38 million motorists. It is used to identify organised application fraud as well as the abuse of motor trade policies. 'askMID' is a free tool that allows drivers to check whether their vehicle is on the MID.
- **MyLicense:** a joint initiative between the insurance industry, the DVLA and the Department for Transport which provides the insurance industry with access to DVLA driver data. The data includes convictions and entitlements and can be used at the point of quote, for mid-term adjustments and at renewal. This was enhanced in June 2015 to give insurance providers access to a "No Claims Discount" database, a digital solution, designed to replace the manual paper exchange between motor insurers and policyholders.
- **Keeper at Date of Event (KADOE):** the DVLA's 'Vehicle Keeper Enquiry' service i.e. the method by which vehicle ownership information is transmitted to and from the DVLA. The Task Force recognises the good work that the ABI and DVLA have done to secure wider access to Keeper at Date of Event software. The DVLA has agreed to extend the permitted uses of KADOE in a number of circumstances, including where the insurer believes that an accident may have been staged or where the registered keeper has been the victim of 'ghost broking', improving insurers' ability to counter fraud. Some insurers have called for further extensions to KADOE. The Task Force supports these recent changes and recognises the due diligence involved in such work.

Best practices

The Task Force noted good examples of practices undertaken by the insurance industry to tackle fraud, including:

- extending counter-fraud processes to suppliers, such as call centres;
- reviewing anti-fraud controls before rolling out 'customer journey' innovations (e.g. considering whether it is necessary to restrict value of claim allowed for photo verification of claims);
- assigning standardised Board level ownership of the issue of insurance fraud;
- undertaking anti-fraud training across the organisation;
- alerting investors/shareholders to the cost of fraud to discourage short-term approaches which negate the chance of strategic investment in fraud prevention;
- investing in the right kinds of technology to be used to prevent fraud;

- rigorous processes at application and renewal stage to block thousands of quotes or increase premiums for proven or suspected fraudsters;
- incentives encouraging good behaviour, such as no-claims bonuses; and
- the use of driver monitoring technology, better known as telematics, to tackle fraud.

Communications

- The Task Force report highlighted the CII's 'Made Simple' tool as an example of work to help demystify the language and market literature of insurance for consumers. It differs from past market initiatives that attempted to make wholesale changes in the way insurers talk to their customers through policy documents and marketing material. It tries to inform customers so they have a higher level of understanding when these conversations take place.
- The Irish Insurance Federation (IIF), the representative body for insurance companies in Ireland, launched a campaign against insurance fraud in February 2003, including radio, posters and TV advertising and a connected telephone line, 'Insurance Confidential'. The IIF reported that the campaign was a success and led to an increase in public awareness of insurance fraud, and led in part to an average fall in motor premiums between 2003 and 2006 of 45%.
- However stakeholders noted that when the campaign stopped, levels of fraud increased highlighting the importance of a sustained and concerted communications strategy with easy to understand, relevant, consistent key messages to tackle the problem.

Civil justice reforms

Since 2010, government has introduced a number of measures aimed at controlling the costs of civil litigation. These reforms implement and build on Lord Justice Jackson's recommendations and, more recently, have focused on minor soft tissue injury claims given that the number of these claims has increased substantially at a time when motor accidents were falling:

- reforming 'no win, no fee' CFAs so solicitors can no longer double their fees if they win, at the expense of defendants and their insurers (April 2013);
- banning 'referral fees' paid between solicitors, insurers, claims firms and others for PI claims (April 2013);
- introducing damages-based agreements (DBAs) into civil litigation (1 April 2013);
- reforming rules around After the Event (ATE) insurance policies so that premiums are no longer recoverable from the losing defendant (1 April 2013);
- introducing qualified one-way costs shifting (QOCS) in PI claims meaning that a claimant who loses their claim will not have to pay the defendant's costs (1 April 2013);
- reducing solicitors' fixed costs for processing basic, uncontested compensation claims for minor injuries suffered in motor accidents (April 2013) and introducing fixed costs for low-value injury claims up to £25,000 (July 2013);
- adding a provision which allows courts to strike out claims where there has been fundamental dishonesty by the claimant in PI cases (in Criminal Justice and Courts Act 2015);
- banning legal services providers from offering inducements to potential PI clients (in Criminal Justice and Courts Act 2015);
- fixing the cost of obtaining an initial whiplash medical report at £180 (October 2014);
- an expectation that medical evidence will be limited to a single report, unless a clear case is made otherwise (October 2014);

- defendants were given the opportunity to give their account of the incident (in writing) to the medical expert, when appropriate (October 2014);
- insurers were discouraged from settling whiplash claims without a medical report (October 2014);
- banning experts who provide treatment to an injured claimant from writing the medical report in whiplash claims (October 2014); and
- medico-legal experts and Medical Reporting Organisations (MROs) must by 6 April 2015 be registered with MedCo in order to provide initial medical reports for RTA related whiplash claims. The new system of allocation is intended to introduce greater independence whilst maintaining consumer choice, with sufficient flexibility built in to allow the market to develop. It introduces a robust accreditation scheme for medical professionals registered with MedCo, so that all claims are backed by independent evidence from trusted professionals (from early 2016).

The Task Force recognises that most of these reforms were not directed at tackling insurance fraud and affect honest and dishonest claimants alike. However stakeholders generally agreed that the reforms have had a positive effect on fraud by reducing the amount of money available to service providers in the compensation system which encouraged fraudulent activity. As many of those reforms have only been introduced recently and some are not yet in force, stakeholders agreed that their full effect is not apparent.

Some recommendations

The Task Force tabled 26 detailed recommendations across the several areas of focus:

- to improve consumer trust in the insurance sector and raise the public profile of insurance fraud as a criminal activity;
- encourage greater use of data sharing and collaboration between the insurance sector and regulatory bodies to better prevent organised insurance fraud; and
- reflect and support the government's intentions to clamp down on unnecessary whiplash claims, which are a major source of fraud and strengthen regulation of claims management companies.

We have focused on some of these recommendations in further detail.

Recommendation 1: improve consumer understanding of insurance products

The insurance industry should:

- be more mindful of policy and other documentation following the FCA discussion paper on 'Smarter Consumer Communications'. Good practice on this topic should be coordinated by the ABI:
- increase promotion of the CII's 'Made Simple' service;
- roll out the ABI and BIBA's 'Code of Good Practice' to help insurers and insurance brokers recognise and help potentially vulnerable customers.

Recommendation 2: ensure that anti-fraud messaging is targeted and hard-hitting

The ABI, IFB and IFED should oversee the development of a long-term cross-industry public communications strategy, aimed at tackling insurance fraud:

- this should include increased promotion of the IFB's 'Cheatline' service, highlighting the impact of fraud on honest policyholders, use of the media, and trusted intermediaries and communication channels outside the insurance industry;
- the ABI and CII should commission research on behavioural economics. The research should be available to all and the ABI should encourage take-up of the conclusions through its voluntary best-practice guidance.

The majority of consumers are honest and their insurance applications and claims are legitimate. However some do commit insurance fraud and this is sometimes driven by a perception that insurance is "fair game" for fraud. These factors have contributed to low levels of trust in the insurance sector, which remain poor relative to other industries and, as noted by many stakeholders, can encourage opportunistic fraud.

Insurance fraud is therefore not just a law enforcement problem or an issue of increasing awareness of how insurance works among policyholders but is informed by a range of behavioural factors. Policyholder attitudes towards fraud can be influenced by the way in which their insurance applications and claims are dealt with and the way insurers behave.

Recommendation 3: The insurance industry should strive to improve the quality and quantity of data available in fraud databases and data sharing schemes, including by

- following the standard definition of insurance fraud produced by the ABI and the ABI should encourage members to participate in its annual fraud statistics benchmarking exercise
- ensuring that the data available is accurate. Insurance Database Services Limited (IDSL) should allow the public to check their own claims histories through CUE free of charge, and challenge inaccurate records. There should be a free and accessible checking and appeal process for all databases used in the application and claims processes.

Historically insurers fought fraud in isolation using small investigation teams and their own limited data to prevent repeat fraudsters. The report recognises the increasing importance of collaboration and sharing data on fraud to tackle this dynamic problem. There is still capacity for fraud data to take a bigger role in preventing insurance fraud.

Coordinate and share best practice

Recommendation 5: The ABI should develop and promote voluntary 'best practice' guidance

- based on what the most effective firms are doing to tackle fraud, including a short 'checklist' on measures all insurers can take to improve their counter fraud defence.

Recommendation 6: Insurers should ensure Board level ownership of counter fraud activity

Recommendation 7: The ABI should consider how it resources its counter fraud activity

- and whether more priority should be given to this task.

The UK is an attractive place for insurers to do business and this success depends in part on its ability to tackle fraud. FCA rules provide a general requirement for firms to tackle financial crime and that its supervisory activity incorporates a focus on firms' systems and controls to tackle financial crime. Many firms within the insurance industry already spend considerable amounts on tackling fraud. Overall approaches to tackling fraud vary and some firms are more effective than others. For some firms, anti-fraud measures form part of their overall commercial strategy, with a view to establishing a competitive advantage.

Consider legal changes to reduce exaggerated or fraudulent late claims

Recommendation 10: The government should review disincentives for fraudulent late claims

Through changes to court, cost and evidence rules considering options including:

- recent claims (e.g. within 6 months) proceeding as normal through the fast track, but older claims being dealt with in the small claims track
- reducing recoverable costs by 50% if a minor personal injury claim is notified six months after the accident
- introducing a system of predictable damages for soft tissue injuries; and
- introducing rebuttable evidential presumption that no injury was suffered where claims are lodged after a specified period of time has elapsed after the alleged accident.

A significant number of minor personal injury claims are presented to insurers close to the limitation period, when symptoms have long worn off. This is a particular challenge for minor whiplash, where there can be no objective evidence, making it impossible for medical experts and insurers to verify whether the claimant ever had an injury. In such cases MROs merely report the symptoms as described by claimants which are easy to exaggerate or falsify. Many stakeholders said this is a major problem and suspect a large number of such claims are exaggerated or fraudulent. Difficulties in establishing the veracity of such claims mean it is difficult to produce statistics on how many are in fact bogus.

The announcement on whiplash reform at Autumn Statement 2015 may have significant implications for soft tissue injuries which were the primary concern among stakeholders as regards late claims. Although the whiplash reforms may address many of the issues raised by stakeholders, the scope of the reforms is not yet clear so the Task Force therefore considers that further work needs to be undertaken ensure that any late exaggerated or fraudulent claims not addressed by whiplash reform are discouraged.

Claims Fraud and tackling dishonest professionals

Recommendation 12: evolve the IFB into a holistic intelligence hub and ensure timely contribution to the evolved dataset

- The insurance industry should support the development work needed to

Recommendation 13: The Claims Portal Limited should give IFB access to Claims Portal data

Recommendation 14: The government should strengthen SRA powers against fraudulent or corrupt activity

- Consider reviewing the standard of proof used in cases put before the Solicitors Disciplinary Tribunal

Recommendation 15: The SRA should take a tougher approach to combatting fraud

- Making clear that it will give an appropriate focus to combating financial crime through its existing powers, including naming and shaming;
- Consider requiring solicitors to undertake client identification checks in cases other than just those where they handle client money;
- Work with the CMR to enforce the referral fee ban.

Recommendation 16: Insurers should provide the SRA with evidence regarding claimant law firms suspected of insurance fraud

- and the SRA should investigate and act robustly. The IFB should act as a single point of contact between insurers and the SRA.

Recommendation 17: in implementing the whiplash reforms outlined at Autumn Statement 2015

- insurers should share data with the SRA and CMR if they suspect claimant representatives of breaching the referral fee ban.

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