Think piece

Number 123 March 2016

INDEPENDENTLY PROMOTING DEBATE AND FRESH THINKING IN THE FINANCIAL SERVICES INDUSTRY

Insurance Fraud Task Force: the problem and the overall conclusions

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- Insurance fraud is a costly phenomenon: in 2015 the ABI estimated it cost the sector about £3bn a year, and given the highly competitive market, insurers also spend an estimated £200m a year combating it.
- The Government established the Insurance Fraud Taskforce in January 2015 on the basis of three major concerns: the cost for honest policyholders, the erosion of social cohesion and trust if fraud becomes widespread, and the diversion of the proceeds of fraud to other criminal activity.
- The Taskforce made a total of 26 recommendations and a series of advisory comments, all across four broad topics: policyholder understanding and education, the use and reliability of data, the role of regulators and some specific personal injury issues.
- There is no simple profile of a fraudster. However fraudsters normally fall into two broad categories; organised criminals and opportunistic chancers. There is also a grey area of negotiation, error and misunderstanding which may not be fraudulent but shows many similar characteristics.
- We have an evolved privatised supplier market with specialist law firms, claims management companies and medical experts. An accident, as one consultee described it, has gone from being a misfortune to a business opportunity.
- The Taskforce recognised the importance of ensuring access to justice and that in order to achieve this claimant organisation must earn a reasonable profit in the absence of legal aid.

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CII Introduction: with an estimated cost of £3 billion per year, plus another estimated £200 million per year spent combating it, fraud has been the bane of the general insurance sector. In this Thinkpiece, former Law Commissioner and now Chair of the CII Professional Standards Board David Hertzell returns to the Thinkpiece series to describe his recent work as Chair of the Insurance Fraud Task Force, which has been tasked by the Government to develop concrete proposals on how insurance fraud could be tackled.

Fraud may be as old as insurance itself. However in the early days the discipline of mutuality and personal contact probably discouraged dishonesty. Now most insurance transactions are automated and depersonalised. It is much easier to steal from a computer than from a person.

However there is no firm evidence as to the overall amount of insurance fraud or whether the position is improving or deteriorating. That is probably inevitable as the purpose of fraud is to obtain money by deception without detection. In 2015 the ABI estimated the total amount of fraud at £3bn per annum. That is no more than an educated guess. In a highly competitive market insurers spend money on fraud prevention and detection, possibly as much as £200m per annum – another educated guess. Whether the real figure is half of these numbers or twice as much it is still a lot of money. Some associated costs such as benefit fraud, unnecessary NHS costs and court costs fall outside insurance and are paid for by the taxpayer. Other businesses such as utility companies and retailers have experienced similar patterns of fraud from road traffic claims and bear similar costs. These costs are all ultimately paid for by honest policyholders, customers and taxpayers.

The Insurance Fraud Task Force

The Government established the Insurance Fraud Taskforce in January 2015 on the basis of three major concerns: the cost for honest policyholders, the erosion of social cohesion and trust if fraud becomes widespread and the diversion of the proceeds of fraud to other criminal activity. There may have been a fourth. It is difficult for insurers to deal with the problem alone as many of those involved in the wider picture such as telecom companies or professional regulators would not perceive insurance fraud as a particular issue for them.

The core members of the Taskforce were the ABI, the IFB, BIBA, the FOS, the CAB and the Financial Services Consumer Panel (FSCP). The members broadly balanced insurer and consumer interests. The Taskforce was assisted by a wider advisory group with a membership including regulators, loss adjusters, lawyers, the police, academics as well as insurers and brokers. The Taskforce established a personal injury working group whose members balanced claimant and defendant interests. The Taskforce published an interim report in March 2015 and a final report in January 2016. The personal injury group produced a report to the Taskforce in July 2015. Over the course of 2015 members of the Taskforce met a wide range of consultees and attended many meetings and conferences. The Taskforce made a total of 26 recommendations and a series of advisory comments. The report and minutes of meetings are available on the Taskforce website: www.gov.uk/government/groups/insurance-fraud-taskforce. The problem of insurance fraud will not be solved in a year but the Taskforce drew together a wide range of interested parties and views.

The criminals and the chancers

The Taskforce was able to identify some general themes. There is no simple profile of a fraudster. However fraudsters normally fall into two broad categories; organised criminals and opportunistic chancers. There is also a grey area of negotiation, error and misunderstanding which may not be fraudulent but shows many similar characteristics. It was recognised that different deterrents apply to the different types of fraudster and that fraud can occur either at the application or claims stage. Indeed there is often a link between the two.

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A great deal of opportunistic fraud takes place in a difficult climate for business and for financial services.

Consumers are disenchanted with business following the financial crash and media stories about price obfuscation, executive excess and tax avoidance. Financial services generally are not highly regarded and there is a perception that insurers will "rely on the small print" to avoid paying claims. However unfair this might be academic research shows that many opportunistic fraudsters were "getting their retaliation in first" or claiming to seek compensation from an unfair system. The problem is not helped by a generally poor understanding of insurance and policy terms.

Research reveals that a major cause of dispute with policyholders was that the consumer bought the wrong product or did not understand the terms of their policy. In addition some opportunistic fraudsters thought they were unlikely to be caught or that if they were nothing much would happen.

Much reported fraud in the UK involves personal injury and in particular road traffic claims. The personal injury market in the UK is unlike that in other European countries especially for high frequency low value claims. We have an evolved and developed privatised supplier market with specialist law firms, claims management companies and medical experts. An accident, as one consultee described it, has gone from being a misfortune to a business opportunity.

The Taskforce recognised the importance of ensuring access to justice and that in order to achieve this, claimant organisations must earn a reasonable profit in the absence of legal aid. Nonetheless the Taskforce was made aware of difficulties in the regulation of law firms and claims management companies (CMCs), the problems of cold calling and claims farming. The Taskforce did not consider that its terms of reference, the members' expertise or the composition of the consultees were an appropriate basis to recommend changes to the English legal system particularly as changes would affect honest and dishonest alike. However fraud, especially organised fraud, took place within the framework of the existing system and therefore the Taskforce commented on those areas the government may need to address.

Main themes of recommendations

Following discussion with consultees and taking into account the time available the Taskforce divided its work and recommendations into four broad topics: policyholder understanding and education, the use and reliability of data, the role of regulators and some specific personal injury issues.

Policyholder understanding and education

A key observation was that improving consumer understanding of insurance is a very long term project. However some useful initiatives have already been noted:

- the CII *Made Simple* project and other efforts to improve the presentation of information to consumers. These should remain a priority: not only do they improve the reputation of insurance but they also counter the victim mentality that fuels some opportunistic fraud;
- the IFB *Cheatline* can make honest policyholders aware that they might be subsidising the dishonest;
- there exists research showing that the design and content of document or on-line material can incentivise or discourage policyholder honesty.

Further research should be undertaken by the ABI and CII into these areas as well as behavioural economics. As a matter of good practice the Taskforce considered that fraud should be a senior management or board issue in order to ensure that effort and resources are devoted to prevention over the longer term.

The use and reliability of data

The effective use of data is key to combatting both application and claims fraud. However although it was recognised that much data was of high quality, there was a concern that it was not used effectively and that some data was inaccurate. Even where data is available, take up was sometimes low and it was not always shared effectively especially with those outside insurance such as the government or banks. A number of recommendations were posed to improve the take up and sharing of data, particularly suggesting proper systems to check and appeal data. This is especially pertinent given the public suspicion of "big data".

Take-up of critical schemes such as *MyLicence* or CUE should be increased and some thought should be given as to how that could be expanded beyond insurers, on what basis should access be given and how the cost should be funded. The Taskforce thought that the IFB could develop a role as a central data coordinator and that weak data sources such as that for arson should be improved. In order to facilitate data sharing the Taskforce considered the Information Commissioner's Office (ICO) could issue some clear and tailored guidance on data sharing for the insurance sector.

The role of regulators

Several regulators across different sectors have a relevance to insurance fraud even though this may be outside their core concerns. That ranges from telecom regulators and nuisance calls to professional bodies such as solicitors and doctors and commercial concerns such as CMCs. There should be better coordination amongst regulators on fraud facilitated by the IFB and a greater emphasis on fraud prevention amongst professional regulators again with information and actions coordinated at a senior level by the IFB. In some cases, that may also require enhancement of the regulator's powers. Whilst it was appreciated that only a very small minority of professionals facilitated insurance fraud, their capacity for widespread harm is considerable. Their involvement also caused significant reputational damage to the profession concerned.

Specific personal injury issues

No recommendations were made about the current English and Welsh legal system. However the Taskforce made a number of suggestions within the existing framework. The ABI should discourage the use of inappropriate "pre-med" offers. Whilst a quick claims settlement might provide a short term benefit in the long run over use encourages the perception of "easy money" from insurers. The government should consider how to discourage late claims for minor injuries as whilst such claims could be genuine many seem to be the product of claims farming. The government should also consult on a mandatory statement of referral source on Claim Notification Forms and should consider how to implement an improved process for noise induced hearing loss claims where costs have risen steeply in relation to compensation recovered.

It was surprising to learn that some claims seem to be progressed without any proper authority from the alleged claimant to their representatives.

Surprisingly some claims seem to be progressed without any proper authority from the alleged claimant to their representatives. It was recommended that a standard letter should be agreed by claimant and defendant organisations allowing insurers to contact a represented claimant direct to confirm that instructions have actually been given to bring a claim.

The Taskforce recommendations were based on widespread consultation and the Taskforce is optimistic that some positive steps will be taken by all concerned to counter what is a long term problem. However the Taskforce is also aware that many of those involved work outside insurance and that the pressures and exigencies of everyday business life mean that fraud even for insurers may fall down the priority agenda. In order to ensure that positive activity is sustained perhaps the most important recommendation made by the Taskforce is that a legacy body should be established to oversee progress and report to the government.

Fraud is socially corrosive and costs honest policyholders a lot of money. Fraud can be effectively combatted but only if effort and resources continue to be devoted to detection and prevention over the long term.

David Hertzell was a Law Commissioner for Commercial and Common Law in the period 2007-2015 and was a leading force on the implementation of both consumer and commercial insurance contract reform. He is now at law firm BLM and insurance consultants Mactavish where he is helping to inform educate and prepare the firms' customers in advance of the implementation of the Insurance Act. David is currently the President of the British Insurance Law Association, Chair of the CII Professional Standards Board and a member of the AIRMIC Board. He is a pension fund trustee and sat as the independent member on the audit and risk committee of the Judicial Appointments Committee. He was awarded at the British Insurance Awards 2015 for making a major contribution to the development and reputation of general insurance claims in the UK.