

Insurance Fraud Taskforce:

final report

January 2016

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Foreword

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. The costs of fraudulent insurance claims are passed on to customers, pushing up the prices of essential products, such as motor and home insurance, with consequences for everyone through an increased cost of living. Valuable public resources, such as those in our NHS and in the courts, are spent on dealing with fraudulent cases. It is also a source of funds for organised crime. Insurance fraud is socially corrosive, with opportunistic fraud often undertaken by otherwise honest individuals. Tackling insurance fraud helps society as a whole, which is why the Government established this Taskforce to investigate and make recommendations on how to reduce overall levels of insurance fraud.

As this report notes, there is a particular concern about the preponderance and costs of fraud in low value personal injury claims. Much has already been done to improve the legal framework in these cases. In particular, reforms to no win no fee agreements under which most personal injury claims are funded have reduced the costs of these cases, with benefits for consumers and insurers. There is a particular concern about fraud in whiplash cases and we are making the process for dealing with these claims more robust, including improvements to the medical evidence process. But it is clear that there is much more work to do. As a continuation of this important work, the Government has recently announced bold plans to reform compensation for minor whiplash injuries, with the aim of reducing bills for consumers.

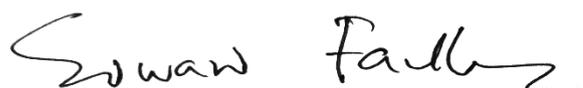
The recommendations in this report reflect and support the Government's reform programme. This report includes a robust set of recommendations that should have a significant impact, reducing the opportunity for insurance fraud, thereby reducing the costs of insurance for consumers.

We are grateful to the Taskforce members for their work over the last year, and to all those who have contributed. We would like to extend our thanks in particular to David Hertzell for his efficient stewardship of the Taskforce in compiling this final report.



Harriett Baldwin MP

Economic Secretary to the Treasury



Lord Faulks QC

Minister of State for Civil Justice

Executive summary

Insurance fraud is not victimless. It pushes up the cost of insurance for honest consumers; funds the wider activities of criminal gangs; and puts pressure on essential public services, such as the NHS and courts. Contrary to the perception of many of those who commit fraud, they are not stealing from a faceless corporation. The costs are paid by their friends, families and neighbours through higher insurance premiums. The value of detected fraud is in excess of £1 billion and undetected insurance fraud is estimated to cost the UK economy more than £2 billion a year. Furthermore the normalisation of fraudulent behaviour is socially corrosive and erodes trust.

The majority of consumers are honest: their insurance applications and claims are legitimate. Those who make genuine mistakes are not fraudsters and the Taskforce does not seek to criminalise or penalise them, not least because making a claim of any level can be stressful and daunting.

Fraud however exists on a continuum, from application fraud to bogus, fictitious or intentionally inflated claims, right through to sophisticated organised crime.

There is also no simple profile of someone who commits insurance fraud, and there are different degrees of criminality and pre-meditation. Some otherwise honest people commit fraud when the opportunity presents itself; some people commit fraud that is premeditated and some fraud can even be linked to organised crime. There are also different types of insurance fraud such as claims fraud, where an insurance claim is fictitious or intentionally inflated, or application fraud, where facts are manipulated on an insurance application form in order to obtain a lower premium. The Taskforce is mindful that different types of fraud require different solutions.

This report represents the culmination of the Taskforce's year-long review into insurance fraud. In it, the Taskforce 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. These recommendations are aimed at specific issues identified by the Taskforce and all contribute to the overall objective of reducing overall levels of fraud, ultimately reducing costs for consumers. As matters relating to financial services are reserved, the majority of recommendations apply to the whole of the UK but those relating to the legal system will apply to England and Wales only since the legal systems in Scotland and Northern Ireland are devolved.

Membership of the Insurance Fraud Taskforce

The Taskforce 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 Taskforce and attend its meetings.

Although the Taskforce has considered all types of insurance fraud, it is recognised that fraudsters have placed much focus on personal injury (PI) claims. In light of this the Taskforce established a Personal Injury Working Group to look at issues relating specifically to PI claims. The Working Group is made up of 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. They reported to the Taskforce with their recommendations in July 2015.

The Taskforce is also assisted by a wider stakeholder group composed of a range of interested parties including representatives from the insurance industry, legal profession, police, regulators and consumer representation bodies. The Taskforce held a number of roundtable events in February, April, September and October 2015 to hear the views of stakeholders on Taskforce areas of interest and potential recommendations.¹ Members of the Taskforce have also attended several seminars and conferences and met with a large number of individuals and organisations concerned about insurance fraud.

The role of the legal system

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. Some have referred to this trend as a “compensation culture”. 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). Although most claims are honest it is equally true that fraud “follows the money”.

Costs within the system attract a small number of professional enablers, such as solicitors and medical professionals. They can play a key role, consciously or unconsciously, 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. Costs in the system have also 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.

This backdrop has created opportunities for fraud. Difficulties in diagnosing whiplash reliably have meant it has been a particular target for fraudsters. In many cases there can be no objective evidence of minor whiplash, making it impossible for medical experts and insurers to verify whether the claimant ever had an injury. This is a particular problem for claims presented to insurers close to the limitation period when symptoms have long worn off. In such cases medical experts can do little more than report the symptoms as described by claimants which are easy to exaggerate or falsify. By their very nature it is difficult to determine how many such claims are bogus, but insurers suspect a substantial proportion are exaggerated or fraudulent.

Since 2010, government has introduced a number of measures aimed at controlling the costs of civil litigation. More recent reforms have focused in particular on minor soft tissue injury claims including whiplash. Measures include banning referral fees paid between solicitors, insurers, CMCs and others for PI claims, introducing fixed cost medical reports for whiplash claims and setting up MedCo which ensures medico-legal reports are independently sourced. These reforms were not solely directed at tackling insurance fraud, and affect honest and dishonest claimants alike, but have had a positive effect on fraud by reducing incentives for professional enablers and strengthening the medical evidence process.

Most notably the government has announced that it intends to end the right to cash compensation for minor whiplash claims by removing the right to general damages for minor

¹ Minutes from these events, as well as other Taskforce meetings, can be found on the gov.uk website at: <https://www.gov.uk/government/groups/insurance-fraud-taskforce>

soft tissue injuries, as well as increasing the small claims track limit to £5,000. This will bring substantial changes to the way PI cases are litigated and compensated. These are broad issues which relate to the type of compensation system preferred by society and extend beyond insurance fraud. As with previous measures, these reforms will have implications for a wide range of claimants, but it is important to note that reducing incentives for both claimants and their representatives is likely to substantially reduce insurance fraud, in particular for whiplash, and to that extent, they are welcomed by the Taskforce. Although these reforms were announced after the call for evidence had closed, the Taskforce has considered the implications of this announcement and has sought to ensure this is reflected in its recommendations.

Because of the reduction in the profitability of pursuing some low value PI claims, some claimant representatives have moved into other areas such as noise induced hearing loss (NIHL) claims. Recent years have seen a large increase in the number of notified NIHL claims and insurers have reported that as many as 85% of these are rejected. This suggests that many of these claims are fraudulent or exaggerated. The costs of these claims are substantial.

In this context regulators such as the Solicitors Regulation Authority (SRA), Claims Management Regulation (CMR) Unit and Financial Conduct Authority (FCA), play a key role in detecting and preventing insurance fraud. They have all undertaken positive enforcement action in the fight against insurance fraud. However more can be done by the SRA and CMR, both within their discrete areas of regulation, and by more coordinated action.

Data-sharing and fraud detection

Historically insurers fought fraud in isolation using small investigation teams and their own limited data to prevent repeat fraudsters. The insurance industry has increasingly recognised the importance of collaboration and sharing data and now spends in excess of £200 million per year tackling fraud. The industry has established the Insurance Fraud Enforcement Department (IFED) and the Insurance Fraud Bureau (IFB), which lead the industry's collective fight against organised insurance fraud, as well as a number of fraud databases and data sharing schemes including the Insurance Fraud Register (IFR), the Claims and Underwriting Exchange (CUE) and MyLicence.

Data sharing is vital in the fight against fraud and there is plenty of room for improvement in the quality of anti-fraud data and how it is shared. In particular inconsistent, incomplete and, in some cases, inaccurate data undermines its effectiveness. Better quantity and quality of data would make fraud easier to detect at every stage of the process, from application to claim. Improved data would also bring benefits for consumers and could improve trust between consumers and insurers. Making trusted data available at the point of quote would allow customers to rely on objective claims data rather than their memory, streamlining the process and reducing the risk of inadvertent errors which can lead to honest customers being labelled unfairly as fraudsters. Other concerns include data theft and illegal processing of data, a lack of understanding of data protection laws, a short-term focus on competitive advantage rather than a long-term focus on the common good, and poor data-sharing outside the insurance industry.

Price comparison websites (aggregators) are uniquely positioned to detect fraud at the application stage yet they do not share intelligence with insurers on suspicious consumer behaviour as effectively as they could. They are well placed to spot behaviour such as manipulating application details to achieve a cheaper quote. In many cases this can be part of legitimate efforts to shop around but it can also be a tell-tale sign of application fraud, for example where driving offences have been modified or omitted. By sharing data more effectively and taking a more robust approach to fraud prevention, aggregators could stop fraudulent applications before they were ever completed.

Policyholder attitudes and perceptions

Insurance fraud is sometimes driven by a perception that insurance is “fair game” for fraud. One reason for this is because of low levels of trust in the insurance sector which remains poor relative to other industries.

This perception is sustained for a variety of reasons, including poor understanding by some consumers of how insurance works. Particular issues raised by stakeholders included complex documentation, confusion as to how a policy works and misunderstood claims processes. This can make the process of engaging with insurers confusing. For example application and claims forms are not straightforward for many consumers. This can also lead to consumers making honest mistakes which, although are not fraud, may be mislabelled as such by industry fraud departments. Where it exists poor customer service can also undermine trust in insurance companies, particularly as insurance also suffers “bad press”. Media reports are, understandably, more likely to focus on negative stories rather than instances where insurers have offered excellent customer service or day-to-day claims handling. This can give a distorted overall image of insurers to the general public.

Insurers have also been criticised for practices relating to annual renewals, an issue which has recently been highlighted by the FCA. This can result in consumers defaulting to renew products that are not good value or have become unsuitable for their changing needs. Often consumers who negotiate with their insurer at the point of renewal secure a cheaper premium. This can frustrate consumers who may believe that the cheapest prices should be given to existing customers, undermining trust in the industry. It can also contribute to the perception it is necessary to negotiate with insurers at other stages of the process, including the claims stage. This can lead to consumers providing overly optimistic valuations or exaggerating claims in expectation that insurers will try to haggle down the settlement. Many consumers do not recognise that this behaviour is dishonest despite being at risk of submitting fraudulent claims.

This is of concern, not only because the majority of claims handled by claims investigators involve otherwise honest people indulging in opportunistic low-value crime, but because the normalisation of fraudulent behaviour is socially corrosive and undermines social cohesion by eroding trust.

Recommendations

The Taskforce has made a wide range of specific recommendations for government, industry, regulators and others, designed to tackle different types of fraud including organised, premeditated and opportunistic fraud at the claims stage; and application fraud when a policy is purchased. As well as these specific recommendations, the Taskforce has made a number of recommendations which cut across all fraud types. A full list of recommendations can be found at Annex B.

Cross-cutting recommendations

- **improving consumer trust in the insurance sector:** this is aimed at tackling the perception that insurance fraud is “fair game”. This should be achieved by insurers improving consumer understanding of insurance products by ensuring communications, as well as application and claims forms, are easy to understand; and ensuring anti-fraud messaging is targeted and hard-hitting. The ABI, IFB and IFED should develop a long-term cross-industry public communications strategy,

and the ABI and CII should commission research on how behavioural economics can be used to prevent application fraud

- **improving the data available in fraud databases and data sharing schemes:** this should be achieved by the insurance industry increasing membership of existing anti-fraud schemes and databases such as MyLicence and CUE; and following the standard definition of insurance fraud produced by the ABI. In addition, Insurance Database Services Limited (IDSL) should allow the public to check their own claims histories free of charge
- **ensuring data is shared appropriately:** this should be achieved by the ICO providing clear guidance on data-sharing practices in relation to insurance fraud with reference to forthcoming EU regulations
- **coordinating and sharing best practice:** this should be achieved by the insurance industry ensuring Board level ownership of counter fraud activity. In addition, the ABI should develop and promote voluntary 'best practice' guidance based on what the most effective firms are doing to tackle fraud, as well as considering how it resources its counter fraud activity and whether more priority should be given to this task
- **taking a more robust approach to defending claims:** this should be achieved by the ABI discouraging the inappropriate use of pre-medical offers and the insurance industry defending more court proceedings where they believe a claim is fraudulent, rather than providing cash settlements. This will reap long-term benefits
- **considering legal changes to reduce exaggerated or fraudulent late claims:** the announcement on whiplash reform at Autumn Statement 2015 will 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. The Taskforce therefore considers that further work needs to be undertaken to ensure that any late exaggerated or fraudulent claims not addressed by whiplash reform are discouraged
- **be alive to new fraud risks:** fraud is constantly evolving as criminals and opportunists find new ways to cheat the system. To some extent there is a latent "demand" to commit fraud and the Taskforce accepts that pressure on certain types of fraud will inevitably mean that others expand or emerge. With substantial reforms to whiplash on the horizon, which has been a very substantial source for fraud, there is a risk that fraudsters move further into other areas

Premeditated claims fraud recommendations

- **improving cross-industry coordination:** this should be achieved by the IFB establishing itself as a holistic intelligence hub and Claims Portal Limited allowing the IFB access to claims data
- **toughening action against dishonest solicitors:** this should be achieved by the SRA taking a tougher approach to combatting fraud, insurers providing the SRA with evidence regarding claimant law firms suspected of insurance fraud and the SRA investigating and acting robustly, and the government considering reviewing the

fining powers of the SRA and introducing a mandatory requirement for referral sources to be included on claims notification forms (CNFs)

- **improving communication between insurers and the regulators of professionals that enable fraud:** this should be achieved by the ABI producing guidance setting out what forms of contact with alleged claimants is acceptable. If a member suspects that legal representatives are acting without instruction, a standard letter should be made available, produced by claimant and defendant representatives (e.g. APIL, MASS, FOIL and the ABI) in conjunction with the SRA and IFB, for insurers to send to claimants directly to verify whether they have instructed a firm to represent them

Opportunistic claims fraud recommendations

- **strengthening regulation of CMCs:** this should be achieved by the government establishing a stronger regime for CMC regulation and ensuring that the CMR has adequate resources and powers to do its job effectively. To this end the Taskforce endorses and supports the independent review of the regulation of CMCs led by Carol Brady and will share information relevant to that review
- **clamping down on nuisance callers that encourage fraudulent claims:** this should be achieved by the government developing and delivering a coherent regulatory strategy to tackle nuisance calls that encourage fraudulent PI or other claims. In addition, the ICO should work with regulators operating in countries where nuisance calls are commonly sourced to tackle nuisance calls internationally and coordinate a communications strategy to inform consumers what giving consent to use of their data means in practice
- **tackling fraudulent claims for noise induced hearing loss (NIHL) (a growth area for insurance fraud):** this should be achieved by government considering introducing a fixed cost regime for NIHL claims. To this end the Taskforce endorses and supports the Civil Justice Council's investigation into how a fixed recoverable costs regime for NIHL cases might work, and recommends that this work should include consideration of the quality of medical evidence

Application fraud recommendations

- **improving the ability of aggregators to detect fraud at the point of quote:** this should be achieved by aggregators establishing the use of existing fraud databases and data sharing schemes on a consistent basis and proactively engaging with insurers and coming to a collective data-sharing agreement to tackle insurance fraud. This should be coordinated by the IFB

Conclusion

Throughout this review the Taskforce has been struck by the good work being done to tackle fraud and protect honest policyholders. Equally, it has been struck by the lack of liaison between many of the key participants. Historically insurance and claimant representatives have had a somewhat adversarial relationship. One of the most successful aspects of the Taskforce has been to create a forum for different stakeholders to engage in constructive dialogue, working towards a common goal. This was most clearly reflected in the collaboration of the Working Group which comprised a range of divergent stakeholder interests.

Implementation of the recommendations will take time but it will also require continued collaboration. The Taskforce therefore calls on government to establish a legacy vehicle to provide oversight for the implementation of its recommendations, as well as to ensure that dialogue between different sectors, regarding insurance fraud, continues.

One year is a short period of time to tackle such a broad and complicated issue. The Taskforce is confident that these recommendations will make a meaningful impact on overall levels of fraud, ultimately reducing costs for consumers.

1 Introduction

David Hertzell, Taskforce Chair

1.1 Insurance fraud has a huge impact on honest consumers, society and business so I am delighted to have been asked by HM Treasury and Ministry of Justice ministers to chair the Insurance Fraud Taskforce.

1.2 The group was set up in January 2015 and asked to investigate the causes of fraudulent behaviour and recommend solutions to reduce the level of insurance fraud in order to protect the interests of honest consumers.

1.3 The Taskforce published its interim report in March 2015 and I am pleased now to be able to set out its final recommendations. They represent the culmination of a year of enquiries amongst members of the Taskforce, respondents to the call for evidence, the Personal Injury Working Group and a wider stakeholder group. Throughout this enquiry we were struck by the good work that many are doing to defeat fraud and protect honest policyholders. I very much hope that our recommendations will encourage those efforts and incentivise others to assist.

1.4 The Taskforce has reviewed insurance fraud within the current system for claims and compensation. Whilst it has commented on matters of concern, the Taskforce does not make recommendations that would affect the legal rights of honest and dishonest policyholders alike. The view of the Taskforce is that reform of the legal system is a matter for government and one that requires its own consultation and review.

1.5 One year is a short period of time to tackle such a broad and complicated issue. The problem of insurance fraud is deeply rooted. The recommendations in this report are merely the first steps on a long road. Mitigating and preventing fraud will require a substantial effort over a lengthy period of time and a sustained commitment in time and resource by many of the parties named in our recommendations.

1.6 I am very grateful to the Taskforce members who gave up their time to assist and to those many individuals and organisations who have invested a considerable amount of time and effort in helping the Taskforce. It would have been impossible to complete this project without your assistance.

2 Background: mapping the problem

2.1 In order to make recommendations on how to tackle insurance fraud it is necessary to understand the scale, impact and nature of the problem.

Scale and impact of insurance fraud

2.2 Measuring the scale of insurance fraud is not simple. A large proportion of insurance fraud goes undetected and not all fraud is clear cut. For example in some instances a legitimate claim may be tainted because certain facts have been exaggerated. Meanwhile it can be hard for an insurer to distinguish between legitimate negotiation, intentional deception and a mistake.

2.3 Despite these complications estimates do exist on the scale of insurance fraud in the UK.

2.4 The ABI has collated statistics from its members and estimates that the size of detected insurance claims fraud was £1.32 billion in 2014.¹ Meanwhile, it has been estimated that the level of annual undetected insurance fraud is in the region of £2.1 billion (see Annex C).²

2.5 Although the nature of the problem means that the statistics must contain an element of estimation, it is nevertheless clear that insurance fraud is a serious issue. Even using conservative assumptions, the financial losses involved justify concerns about the scale of this activity.

2.6 While existing data largely concentrates on the direct costs for consumers and insurers, there are wider consequences for society such as:

- **funding crime:** insurance fraud is often used to fund the wider activities of criminal gangs which may be linked to serious organised crime such as drug dealing, burglary³ or terrorism⁴
- **blocking courts:** fraudulent claims taken through the courts can delay justice for honest claimants
- **jeopardising road safety:** orchestrated road collisions pose a danger to innocent motorists and add to the cost of the emergency services. There has been at least one traffic-related death directly linked to such scams⁵
- **impacting on public services:** recent research suggests GPs spend a significant amount of time seeing patients they suspect are inventing or exaggerating an injury in order to claim compensation.⁶ Furthermore arson related to insurance fraud puts pressure on fire services⁷
- **social nuisance:** nuisance calls and aggressive sales pitches made by CMCs and other intermediaries who pressurise consumers to make claims are a social nuisance to many, especially the elderly and vulnerable

¹ Accessed November 2015; <https://www.abi.org.uk/News/News-releases/2015/07/You-could-not-make-up-Savings-honest-customers-insurers-expose-3-6-million-worth-insurance-frauds>

² 'Annual Fraud Indicator', National Fraud Authority, 2014.

³ Accessed November 2015; <https://www.cityoflondon.police.uk/advice-and-support/fraud-and-economic-crime/ifed/ifed-news/Pages/Ghost-broker%E2%80%99-jailed-for-three-years-.aspx>

⁴ Accessed November 2015; <http://www.postonline.co.uk/post/news/2379442/experts-reveal-significant-links-between-insurance-fraud-and-terrorism>

⁵ Accessed November 2015; <http://www.bbc.co.uk/news/uk-england-london-21473080>

⁶ Accessed November 2015; <http://www.lv.com/about-us/press/article/whiplash-fraudsters-waste-one-million-nhs-hours>

⁷ Accessed November 2015; http://www.dacbeachcroft.com/publications/publications/arson_whose_problem_is_it_anyway

- **frictional costs on British businesses:** insurers are not the only target of fraudsters. Businesses such as supermarkets have noted that they have had to install web cams in vehicle at considerable cost, to defend fraudulent claims. These costs are ultimately paid by customers
- **fraud is socially corrosive:** if we move from a “trust” to a “verify” society in which every statement must be checked, costs and process friction will increase for everybody. That is particularly the case in financial services⁸

Profiling fraudsters

2.7 The insurance sector has long been identified as one that suffers comparatively high levels of fraud.⁹ One explanation is that insurance fraud has historically been low priority for insurers¹⁰ and police.¹¹ However the establishment of the IFED and the IFB has gone some way toward addressing this. Other explanations include the view that businesses are a legitimate target by fraudsters and ‘deserving victims’, and that the nature of insurance fraud itself is characterised as being diverse in its makeup, easy to commit and with a low risk of detection.¹²

2.8 There is no simple profile of a ‘fraudster’ who commits insurance fraud and there are different degrees of criminality and pre-meditation. It may, therefore, be helpful to attempt to categorise those involved (see Boxes 2.A and B).

2.9 Insurance fraudsters have largely escaped research attention. Understanding of fraudsters is further complicated by the finding that some of those who commit insurance fraud do not believe they are committing an offence.¹³ Research into how insurance fraudsters defend and justify their criminal behaviour shows that common motivations range from ‘necessity’, greed, addiction and family/peer pressure, to revenge; and that interviewees were more tolerant of defrauding government or large private companies which they perceived to be ‘faceless’.¹⁴

2.10 The highest profile insurance fraud is committed by organised gangs who are often behind ‘cash for crash’ scams (see Box 2.A) and are willing to put the safety of others at risk for financial gain. Their fraudulent insurance activity is well planned and involves a number of collaborators. They may also be connected with other criminal activity such as money laundering and benefits fraud.

2.11 There are also those who are not involved in gangs but who commit pre-meditated fraud without assistance. These individuals are not highly organised but undertake some degree of planning and are aware that the activity is a crime, although they may rationalise the behaviour as ‘morally justified’.

⁸ ‘Trust and Honesty’, Tamar Frenkel, 2006.

⁹ ‘The Never-ending Fight Against Fraud’, D Clemmons, 2007.

¹⁰ ‘Insurance Fraud’, M Clarke, 1989.

¹¹ ‘Ducking the Answer? Fraud Strategies and Police Resources’, R Gannon and A Doig, 2010.

¹² ‘Arson’, B Goetz, 2011.

¹³ ‘Insurance Fraud: Causes, Characteristics and Prevention’, K Gill, 2001.

¹⁴ ‘White-Collar Crime: Accounts of Offending Behaviour’, Dr Janice Goldstraw-White, 2011.

Box 2.A: Examples of real life insurance fraud

These case studies highlight the diverse ways in which insurance fraud occurs and affects people's lives. Most noted that they did not consider committing an offence until the point they carried it out. Names have been anonymised.

The ghost broker: Jeff has a degree and a Masters and after graduating set his sights on becoming a businessman. He states that he never intended to become an offender. None of his family or extended family have ever been in prison. He claims that a number of factors led him to commit crime, principally related to business problems. He set up a fictitious motor insurance broker website and paid for a Google click through service to generate web traffic. He then sold fake insurance policies to those who called. Separately he took out real insurance for cars using fake details to get a cheap quote. This was to ensure that anyone checking their car on the Motor Insurance Database (MID) would see that it had been insured. By outsourcing many aspects of the process to third parties, such as call centres and accomplices, he was able to reduce his chances of getting caught. He even paid out on some insurance claims. Jeff states that he was caught because a link was made between him and one of his accomplices. He was charged with fraud and sentenced to a term of imprisonment.

Motor insurance policies bought via such 'ghost brokers' are invalid which means the purchaser is driving without insurance. Since a minimum of third party motor insurance is compulsory to drive on UK roads, the purchaser is liable to face the consequences of being caught without cover.

The insider: Robert developed a gambling habit. Until this time he had lived what he claimed to be a good life. He had a wife and child and a good job which he enjoyed and offered prospects. He had suffered a major setback when a promising sports career was ended by injury. This twist in fortunes gave way to a gambling addiction, a sentence for an insurance fraud, and a need to re-evaluate life as a single man. Robert orchestrated fraud from inside an insurance company. He was able to exploit his inside knowledge with the help of colleagues and a friend who permitted fraudulent claims on his policy. He was successful because he had a working knowledge of the insurer's weak internal processes for checking claims. He was able to make false payments so they looked like they were being paid to a third party, but in fact were paid to him (or someone working with him). Robert is not clear how the fraud was discovered but he says he was caught because one of the phones used in the commission of the fraud was traced back to him.

The exaggerated claim: Irene suffered a burglary near Christmas and was unable to claim for some stolen presents so she decided to claim for more items than had been stolen. She felt she had been the victim of a neighbour's vendetta both in being involved in the burglary and then reporting her for insurance fraud. She received a caution.

The cover-up: Anna lent her car to someone who then had an accident. Because the driver was not insured he fled the scene. She claimed that her initial shock led to panic and she reported the car stolen. She was caught when her 'stolen' car was found by the police and they confronted her with the 'thief'; the person she had lent the car to. When the police found the car, the uninsured driver's prints were found and he was arrested. At this point Anna had little alternative but to admit to the offence. She received community service.

The have-a-go claimant: A former Miss England contestant and semi-pro footballer was jailed for two months for contempt for falsifying details of her injuries and of making up a PI claim following a road traffic accident. She was caught because photos were obtained of her taking part in gruelling fitness tests for a beauty pageant whilst she claims to be suffering

from whiplash. She also lied about the vehicle's occupants at the time of the collision. She claimed that a week after the accident she had received numerous harassing calls from various CMCs and that she had been persuaded to submit a claim by one particularly pushy firm.

The 'crash for cash' scam: 'crash for cash' is the practice of staging or deliberately causing a road traffic collision, sometimes with innocent road users, in the hope of profiting from fraudulent insurance claims. A series of trials involving 70 defendants began in 2012 with 60 people convicted or pleading guilty to being involved in one of the country's largest 'crash-for cash' scams. One key player was Jim who ran a recovery, storage and vehicle hire business. He made false claims for storing damaged cars and hiring out replacement vehicles. 25 accidents considered to have the highest impact on the public, both financially and in terms of suspected organised crime involvement, were selected for detailed investigation. Those 25 accidents alone resulted in more than £514,000 being obtained for the claimants. The real figure was estimated to be more than £3m.

2.12 Not all insurance fraud is pre-meditated; some of it is opportunistic. Opportunists are generally otherwise law-abiding citizens who commit insurance fraud given the opportunity, although this behaviour may be out of character. While opportunists will usually be aware that their actions are dishonest, they might not fully appreciate that they are committing an offence due to misunderstanding of insurance or the law. For example an opportunist may discover that they can lower their premium by understating their previous claims, and may make an impromptu decision to lie on their application without considering the consequences. Alternatively, they may overstate the value of items stolen in a burglary. Household insurance fraud is often opportunistic.

2.13 Among people who commit household insurance fraud, research¹⁵ suggests that there is a near equal gender balance; claims are typically low value,¹⁶ for goods such as televisions, computers and jewellery; and approximately 50% of fraudulent claims are submitted within one year of opening the policy.

2.14 Gill et al's work on home insurance fraudsters¹⁷ found that those under 30 years of age were disproportionately more likely to make a fraudulent claim, and 60.8% of those under 45 knew of someone who had committed insurance fraud, with little difference between genders. This resonates with research by Lexis Nexis in a different class of insurance that suggests that as many as one-third (35%) of insured motorists believe that it is acceptable to omit or adjust data to reduce their motor insurance premiums on application.¹⁸

2.15 Finally there is a grey area where claims may be exaggerated in anticipation of negotiation with the insurer, perhaps due to a misunderstanding of the nature of an insurance claim. The line between acceptable commercial discussions and dishonesty can be hard to determine.

2.16 Much insurance fraud involves a combination of these types of fraudster, with organised gangs often relying on opportunists to complete their fraud. The Taskforce is mindful that different types of fraud require different solutions.

¹⁵ 'Profile of a house insurance fraudster', Mark Button, Francis Pakes and Dean Blackburn, 2013.

¹⁶ The mean, median and mode claim is £716, £500 and £501, see 'Profile of a house insurance fraudster', Mark Button, Francis Pakes and Dean Blackburn, 2013.

¹⁷ 'Insurance Fraud: the Business as a Victim?', K Gill, A Woolley and M Gill, 1994.

¹⁸ Accessed November 2015; <http://www.lexisnexis.com/risk/uk/newsroom/15-11-23-motor-insurance-fraud.aspx>

Box 2.B: Types of insurance fraud

Claims fraud is where an individual or organisation makes a fictitious or intentionally inflated insurance claim, for example someone claiming for non-existent jewellery or for a slip or trip which never took place

Application fraud is where an individual or organisation manipulates facts on their insurance application in order to lower their premium, for example someone falsely stating they have never made an insurance claim before

Opportunistic fraud is when an individual commits fraud on the spur of the moment. In some cases individuals can be encouraged or pressured to make opportunistic fraudulent claims, for example by unscrupulous CMCs.

Organised fraud is where fraud, or the encouragement of fraud, is planned, coordinated and conducted by people working together on a continuing basis. Examples of organised insurance fraud include 'crash for cash' and 'ghost brokers' (see Box 2.A).

The encouragement of fraudulent personal injury (PI) claims

2.17 Since the 1990s, there have been significant developments in the market for PI claims in England and Wales. How they are sourced, funded and dealt with have all changed. Coupled with an apparent shift in public attitudes to claiming compensation for minor personal injuries (PI) – in particular whiplash – there has been a substantial rise in the number of claims, at a time when RTAs have fallen. For example Aviva reports that between 2009 and 2013 there was a 32% increase in the number of whiplash claims, at a time when RTAs fell by 16%.¹⁹ It has been a lucrative market to be in, as the number of new entrants has demonstrated, not least in the appearance of and growth in CMCs.

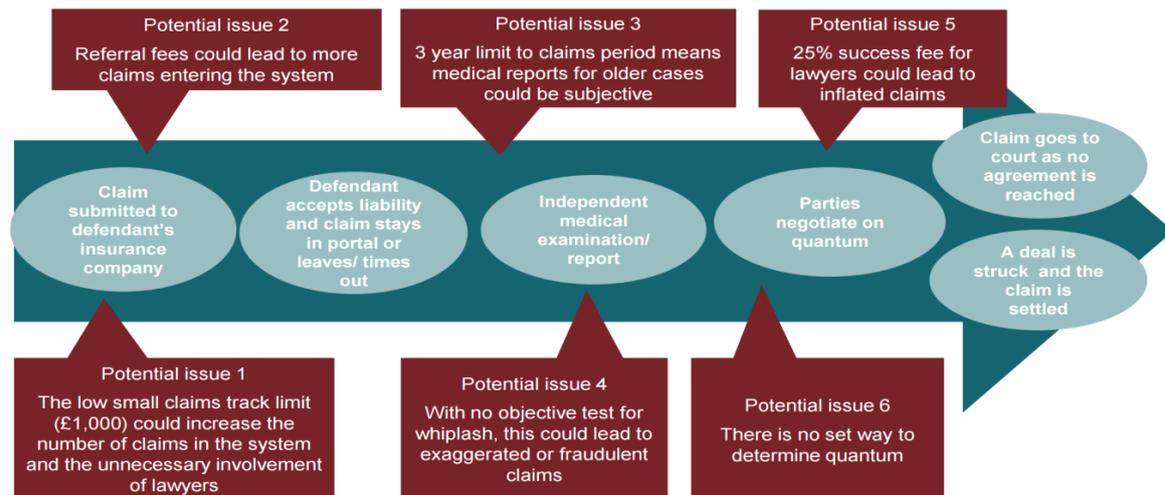
2.18 The Taskforce has considered the incentives within the UK claims and legal framework, which covers England and Wales, that might encourage fraud and also those that might deter it. The Taskforce has focused on PI, in particular RTA whiplash claims, since stakeholders highlighted that this is where the majority of recorded claims fraud occurs.

2.19 The Taskforce has also considered the financial aspects of the PI claims process (legal costs and damages) that attract: individuals to make fraudulent claims; unscrupulous intermediaries to enable and assist them; and insurers and defendant solicitors to settle rather than challenge potentially fraudulent claims (see Chart 2.A).

2.20 The Taskforce recognises that the vast majority of those acting for claimants are competent and honest. In the absence of legal aid, claimant law firms must generate business and make profits in order to continue to provide a service to those injured through the fault of others. Recoverable costs must therefore be at a sustainable level. However insurance fraud is in the interests of neither insurers nor those who act for claimants. The Taskforce encourages greater dialogue between claimant and defendant representatives in order to limit the opportunities of those who wish to exploit the legal system dishonestly, and to ensure that legal costs are both proportionate and sustainable over the long term.

¹⁹ 'Road to Reform: Reducing Motor Premiums by Reforming the Personal Injury Claims Process', Aviva, Feb 2013. (Accessed December 2015; https://www.aviva.com/media/upload/Road_to_Reform_-_Reducing_motor_premiums_by_reforming_the_personal_injury_claims_process.pdf)

Chart 2.A: Features of the UK claims process for personal injuries open to fraud



Source: Frontier Economics, *Motor insurance compensation systems with a focus on whiplash and soft tissue injuries*, March 2015

Minor soft tissue injury diagnosis – “whiplash”

2.21 Whiplash is the most frequent type of PI claim. Whiplash is a term that describes a neck injury caused by a sudden movement of the head forwards, backwards or sideways. It often occurs after a sudden impact such as a road traffic accident.

2.22 The volume of whiplash claims in the UK is very different to other comparable countries and the cost has a measurable impact on the cost of motor premiums (see Tables 2.A to D).

2.23 Minor whiplash can be difficult to diagnose with certainty as there may be no visible signs during examination. That means diagnoses are based largely on the claimant’s description of the accident and the pain or discomfort rather than objective evidence.

2.24 The government has addressed this problem by introducing greater independence to the market through the introduction of the new MedCo Portal which ensures medico-legal reports are independently sourced. The Taskforce supports MedCo. 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.

The legal system in England and Wales and “compensation culture”

2.25 Claims for PI are dealt within the civil justice system. Claims are generally brought for damages: financial compensation that seeks to put the claimant back in the position they were in prior to the injury. There are two main types of damages: ‘general damages’ for pain, suffering and loss of amenity (PSLA) and ‘special damages’. Damages for PSLA vary from a few thousand pounds for a whiplash claim to several hundred thousand pounds for a catastrophic injury. Special damages can also be awarded to cover any quantifiable loss incurred (e.g. loss of earnings) and for the costs of care or rehabilitation.

2.26 If a claim is pursued in court, it enters the civil litigation process. This involves legal costs, the costs of the solicitor bringing the claim, and the costs of the defendant solicitors (in most PI claims this is paid for by an insurer). The general position in civil litigation in England and Wales is that the loser pays the costs of both parties. As a result claimants will generally need to consider how to fund their own lawyer, as well as the defendant's costs if the claim is unsuccessful.

2.27 Most PI claims are funded under "no win, no fee" conditional fee agreements (CFAs). CFAs ensure that claimants, regardless of their income, are able to sue for compensation after an accident that was not their fault since the claimant's solicitor only charges a fee if the claimant wins the case (when an uplift can be charged on the ordinary costs).

2.28 CFAs were first allowed in England and Wales in 1995²⁰, and they were used particularly in PI cases. This usage grew after 2000 when (i) the right to legal aid was removed for most PI cases and (ii) CFAs were made more attractive for claimants (and more expensive for defendants).²¹ These changes dramatically increase the attractiveness of "no-win no-fee" deals.²² It also became common for claimants to purchase so called after-the-event (ATE) insurance²³, to cover potential litigation costs if they lose the case, such as the defendant's legal costs.

2.29 These changes led to PI claims essentially being a financially risk-free option for claimants. The financial rewards for successful claimant solicitors were improved. Conversely it became more expensive for defendants to challenge a claim unsuccessfully. These factors made it easier to bring claims and led to the development of new businesses to source claims, in particular CMCs.

2.30 This has been described as a 'compensation culture'. At best claimants are more likely to claim for genuine injuries that they would have previously put down to bad luck; at worst a significant number of claims for compensation are weak, exaggerated or simply fraudulent.

2.31 The House of Commons Constitutional Affairs Committee investigated the causes of 'compensation culture' in its 2006 report.²⁴ They exonerated personal injury litigation as the sole cause of such a culture, instead attributing it to "*complex causes, including advertising by claims management companies, selective media reporting, a lack of information about how the law works, and on occasion, a lack of common sense amongst those who implement health and safety*". It does however appear that it is easier to bring a claim for compensation for whiplash in England and Wales than it is in many other comparable jurisdictions. One stakeholder observed that "*an accident has gone from a misfortune to a business opportunity*". The Taskforce considers that there is a lot of substance in this view.

Legal costs - Track allocation in civil proceedings

2.32 Civil cases are mainly dealt with in the County Court and, in the case of more substantial or complex cases, the High Court. Once proceedings have been issued the claim is allocated to one of three tracks²⁵ designed to deal with cases of different values and complexity – the small claims track, fast track or multi-track – and each track has a financial threshold which determines what the normal track for a claim will be.

²⁰ The Conditional Fee Agreements Regulations 1995

²¹ Access To Justice With Conditional Fees 1998

²² The 1999 Access to Justice Act

²³ Insurance taken out after an accident has occurred

²⁴ 'Compensation Culture', House of Commons Constitutional Affairs Committee, 2006. (accessed November 2015; www.publications.parliament.uk/pa/cm200506/cmselect/cmconst/754/754i.pdf)

²⁵ The Civil Procedure Rules (CPR), a procedural code whose overriding aim is to enable the courts to deal with cases justly and in a manner appropriate to their value and complexity, set out the three tracks.

- **small claims track:** if the value of a case is £10,000 or less, it will generally be allocated to the small claims track. However if it is a PI claim²⁶, it will be only allocated if the value of the claim is £1,000 or less.²⁷ The purpose of the small claims track is to provide a simple, straightforward and informal way of resolving disputes proportionate to their low value.²⁸ In contrast to fast or multi-track cases the costs that can be recovered by the successful party, in a small claim costs are strictly limited, and the lack of potential costs recovery can discourage the use of legal representatives. At Autumn Statement 2015 the government announced that the small claims track will be increased to cover PI claims of up to £5000 damages. These reforms are intended to remove a significant number of claims, and to make the process simpler and cheaper for other cases
- **fast track:** claims that are allocated to the fast track are generally those with a value that exceeds the limit of the small claims track, but does not exceed £25,000. Unlike small claims track cases, the successful party would normally expect to recover its costs from the losing party
- **multi-track:** the multi-track is the normal track for any claim that does not fall within the scope of the small claims or fast track, predominantly with a value exceeding £25,000. Like fast track cases, the successful party would normally expect to recover its costs from the losing party

2.33 Stakeholders representing the insurance industry, including the ABI, have suggested that the additional risk of costs recovery in the fast track should the insurer lose provides insurers with a strong incentive to pay out for potentially fraudulent claims rather than defend them in court. They also suggested that some claims are inflated to ensure fast or multi-track allocation to ensure maximum costs recovery.

International comparisons

2.34 Many stakeholders highlighted aspects of the legal systems of other countries, such as France and Sweden, which markedly reduce the propensity for fraudulent PI claims. These include shorter limitation periods, tables of predictable damages, less involvement of solicitors and time limits for medical examinations. Such measures of course affect both honest and dishonest policyholders.

2.35 The Taskforce acknowledges that such measures may tackle PI insurance fraud. However stakeholders generally agreed that direct comparisons with other countries has to be approached with caution given cultural variations, differences in legal systems, definitions of fraud, comparative penetration of insurance and fraud detection capabilities.²⁹

2.36 Furthermore countries with tort law systems, like England and Wales, may tend to have higher claims frequency, and more fraud, as a by-product of greater access to justice and knowledge regarding the right to compensation.

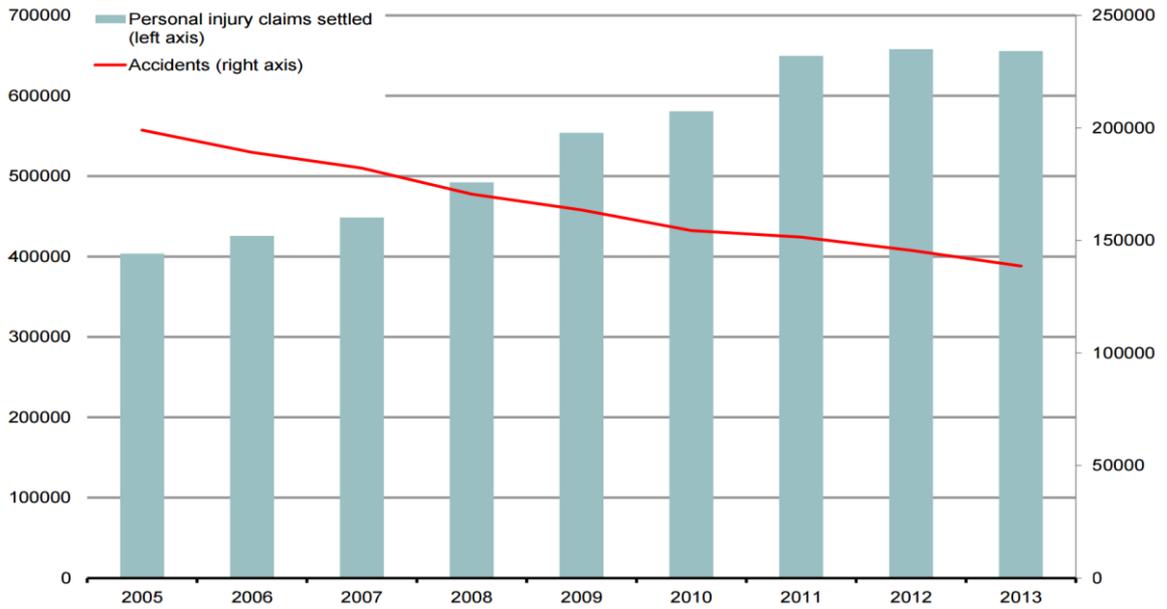
²⁶ Or a claim for housing disrepair

²⁷ Although the government has announced that the PI limit will be increased to £5000.

²⁸ Parties are able to represent themselves without a solicitor if they wish to do so and the judge decides what happens to a claim and will ensure an unrepresented party understands what to do and when. This means that the normal procedural rules and the strict rules of evidence do not apply, for example witnesses do not have to give evidence on oath and the presence of expert witnesses is subject to the agreement of the court; and hearings are conducted in an informal manner, often with parties sitting around a table

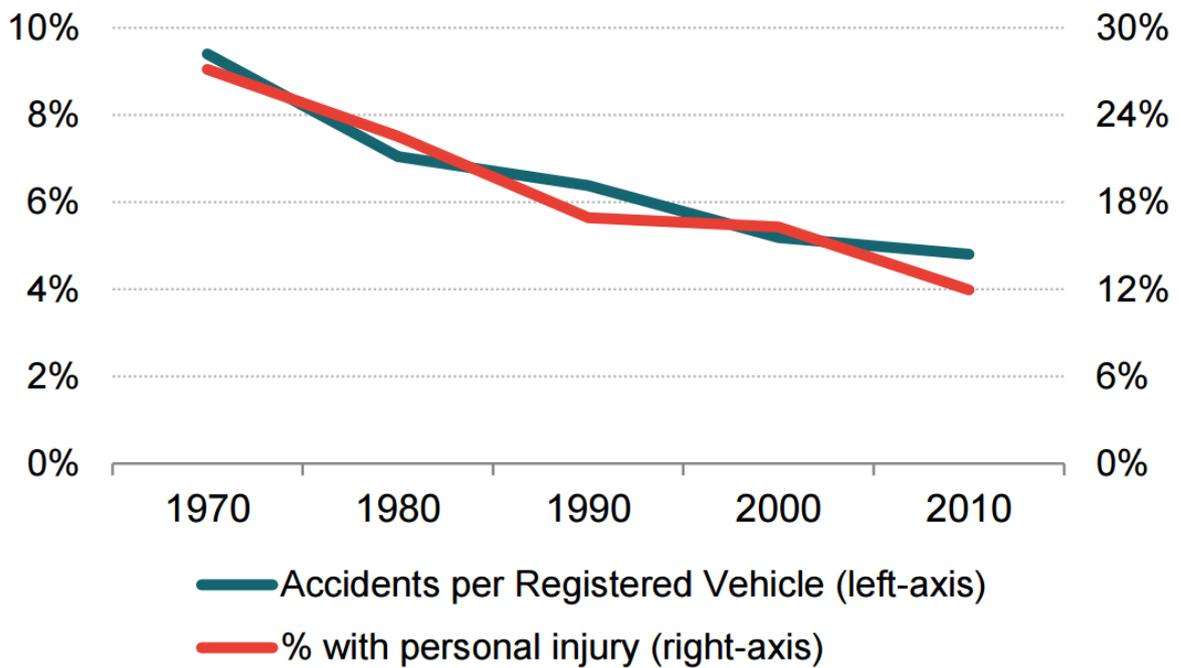
²⁹ For example the Council of Bureaux, an organisation acting for the protection of cross-border road traffic victims through initiatives such as the Green Card scheme (an international certificate of insurance), estimates that approximately 50% of its 47 member states have databases designed to tackle fraud, with 3 responding that they do not have an insurance fraud problem

Table 2.A



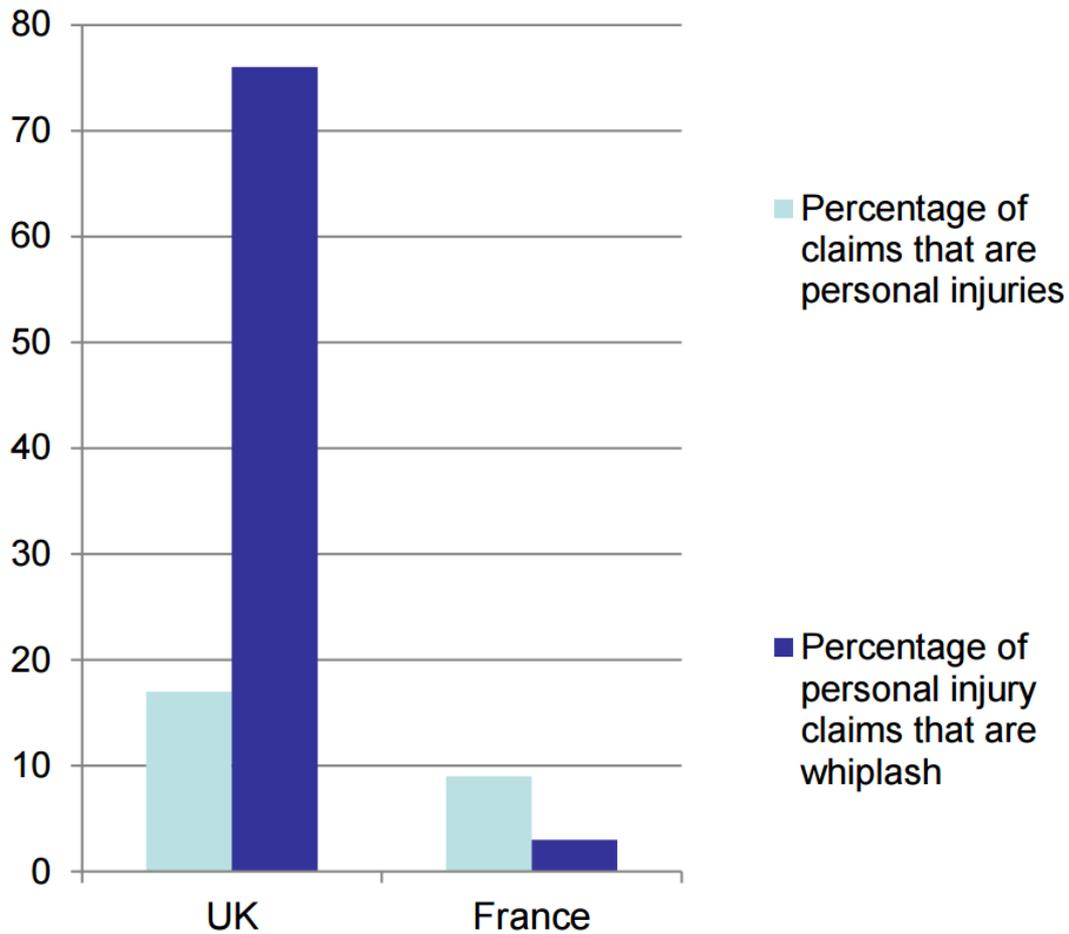
Source: Accident data from Transport Statistics Great Britain 2014, table TSGB 0801: <https://www.gov.uk/government/statistics/transport-statistics-great-britain-2014>; Claims data from Datamonitor

Table 2.B



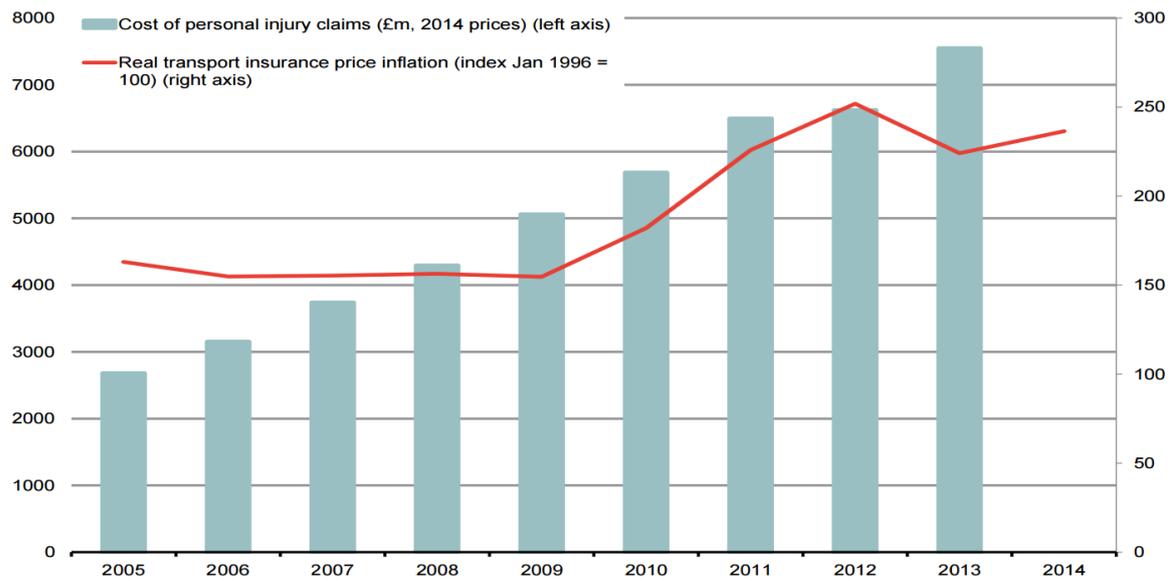
Source: German Insurance Association (GDV), Statistical Yearbook of 2014

Table 2.C



Source: CEA, 2004

Table 2.D



Source: Frontier analysis of Datamonitor data for the claims (deflated to 2014 prices) and Eurostat for transport insurance price inflation data

2.37 Nevertheless with regard to PI claims following motor accidents, the Taskforce does not believe that there are sufficient differences in the cars, roads or drivers that could explain the varied outcomes shown in Tables 2.A to 2.D: the differences are most likely to be in each country's legal and compensation system. There are some specific physical factors, for example World Bank research has found that the UK has 79% more vehicles per kilometre of road compared with the EU average,³⁰ increasing the likelihood of low velocity accidents with relatively minor injuries. However there are proportionately fewer fatalities and serious injury from RTAs in the UK than any other EU country apart from Sweden, indicating that the UK is one of the safest places to drive in Europe.³¹ It would not be unreasonable therefore to expect the overall cost of motor accident compensation to be lower in the UK than in other comparable countries however this does not appear to be the case as relative to the UK, average motor insurance premiums in France and Sweden are 40% and 46% lower, respectively.³²

2.38 Of course not all these claims are fraudulent but many stakeholders believe that the amount of money in the UK system may encourage those who are dishonest to make fraudulent claims. Higher overall costs of compensation in the UK inevitably lead to higher motor insurance premiums.³⁴

2.39 The correlation between claims costs and premiums is not exact as there are other factors involved, such as the cost of reinsurance and capital, and the influence of price comparison websites (aggregators). Claims costs however are the most important factor.

2.40 For example in France there is a firm emphasis on objective proof. With regards to whiplash, this means that injury is not recognised unless the medical professional is able to see evidence of injury, such as on an MRI scan or X-Ray. As of 2014, whiplash injuries account for c.3% of all bodily injury claims and the cost of motor and liability insurance premiums is c.40% less than the UK.³³

2.41 In Sweden, a 'Whiplash Commission' was set up and financed in 2002 to counteract a spiralling number of claims. A time limit system for the onset of symptoms is used and cases where symptoms appear more than 72 hours after the incident are generally rejected by insurers.³⁴

2.42 The Taskforce recognises that government measures set out at Autumn Statement 2015 go some way towards the position in other EU countries by removing the right to general damages for minor whiplash claims, and transferring PI claims of up to £5,000 to the small claims track.

Claims management sector

2.43 As discussed earlier, a large 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.³⁵ CMCs assist people to bring claims who would otherwise not be inclined to. To that extent they can play a positive role in assisting access to justice. However there are concerns about both practice and regulation in this area;³⁶ and that

³⁰ Accessed November 2015: <http://data.worldbank.org/indicator/IS.VEH.ROAD.K1?page=1>

³¹ Axa Whiplash Report 2013 (Accessed December 2015; <http://www.axa.co.uk/newsroom/media-releases/2013/european-neighbours-can-provide-uk-whiplash-reform-blueprint-%E2%80%93-axa-whiplash-report/>)

³² Ibid.

³³ 'The AXA Whiplash Report', Axa, 2013. (Accessed November 2015; www.axa.co.uk/newsroom/media-releases/2013/european-neighbours-can-provide-uk-whiplash-reform-blueprint---axa-whiplash-report/)

³⁴ Whilst this has been treated more as a rule of thumb, as opposed to a strict law, this minimum threshold was reinforced by the Whiplash Commission's medical group in that symptoms must be discovered within three to four days after the accident otherwise it is not classed as a whiplash injury.

³⁵ 'Annual Report 2014/2015', Ministry of Justice Claims Management Regulation, 2015.

³⁶ More than two-thirds (76%) of the public are not confident that CMCs tell the truth to their customers ('Complaints in focus: Claims management companies', Legal Ombudsman, 2015).

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 regulatory intervention from the CMR, either being given a warning or having their authorisation cancelled. This has increased from 18% in 2012/13.³⁷ 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. The IFB reports that as of November 2015, it has 56 CMCs under investigation as part of staged motor accident scams making up approximately 50% of their overall caseload.³⁸ The IFB also reports that in many 'Crash for Cash' cases, gangs have used the front of a CMC to legitimise what is for all intents and purposes an entirely criminal enterprise thereby giving credibility to their scams and enabling them to dupe more people to take part.³⁹

2.44 Analysis by the Institute and Faculty of Actuaries' (IFoA) of third party injury (TPI) and third party damage (TPD) motor insurance claims shows that the density of TPI claims correspond with the density of CMCs (see Charts 2.B and 2.C).⁴⁰ Areas in North West England see a higher prevalence of TPIs, with 55% of road accidents resulting in a claim. This compares to a national rate of just over 30%. High rates of TPI also correlate with areas with higher insurance costs (see Chart 2.D) as North West England is one of the most costly areas in the UK to buy motor insurance.

2.45 One practice consistently raised by stakeholders is that some CMCs encourage fraudulent claims through the use of direct marketing over the phone or by text, and other forms of advertising (also known as 'claims farming'). Stakeholders expressed concern that some CMCs masquerade as consumer research or marketing companies in order to 'farm' claims.

2.46 Other examples of poor practice among some CMCs raised by stakeholders include

- CMCs pursuing claims against wishes of victims,⁴¹ or without their consent
- handling stolen or illegally purchased customer data to 'farm' claims⁴²
- opaque processes surrounding how some PI CMCs source claims
- CMCs coming back under different names after being banned

2.47 Numerous other issues were brought up in responses to the call for evidence which are not directly linked to fraud. These included some CMCs charging unjustified fees, including exit fees, and/or failing to refund upfront fees; not protecting rights of customers and/or engaging in contractual disputes; delaying the progress of claims and/or failing to progress claims properly at all; and failing to provide adequate advice and/or keep customers informed.⁴³

2.48 One well-documented route for farming fraudulent claims is nuisance calls. Some CMCs hold personal data about consumers without their knowledge, and may pressure them to make a claim.

³⁷ Claims Management Regulation Annual Report 2014/2015, Ministry of Justice, 2015. (Accessed November 2015; https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/444434/CMR_Annual_Report_2015_WEB_final_.pdf)

³⁸ Accessed December 2015; <https://www.abi.org.uk/News/News-releases/2015/11/Clampdown-on-the-compensation-cowboys>

³⁹ 'Crash for Cash - Putting the brakes on fraud', Insurance Fraud Bureau, 2012.

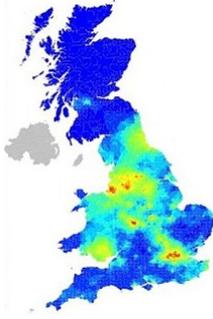
⁴⁰ Institute and Faculty of Actuaries Third Party Data Working Party 2015 Report (Accessed November 2015; www.actuaries.org.uk/news-and-insights/media-centre/media-releases-and-statements/liverpool-remains-personal-injury).

⁴¹ Accessed November 2015: <https://www.cityoflondon.police.uk/advice-and-support/fraud-and-economic-crime/ifax/ifax-news/Pages/Bogus-personal-injury-claims-investigation-sees-claims-management-company-director-jailed-for-12-months.aspx>

⁴² Accessed November 2015: <http://www.bbc.co.uk/news/uk-england-dorset-32548321>; and Accessed November 2015: <http://www.bbc.co.uk/news/business-26291075>

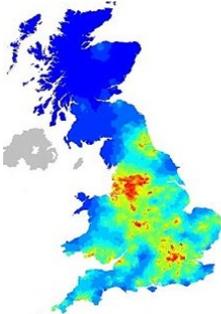
⁴³ Legal Ombudsman CMC Evaluation and Impact Report 2015

Chart 2.B: Density of third-party injury (TPI) insurance claims



Source: The Institute and Faculty of Actuaries

Chart 2.C: Density of claim management companies (CMCs)



Source: The Institute and Faculty of Actuaries

Chart 2.D: Five most expensive regions in the UK for comprehensive car insurance



Source: Confused.com car insurance price index Q3 2015

Nuisance calls and texts

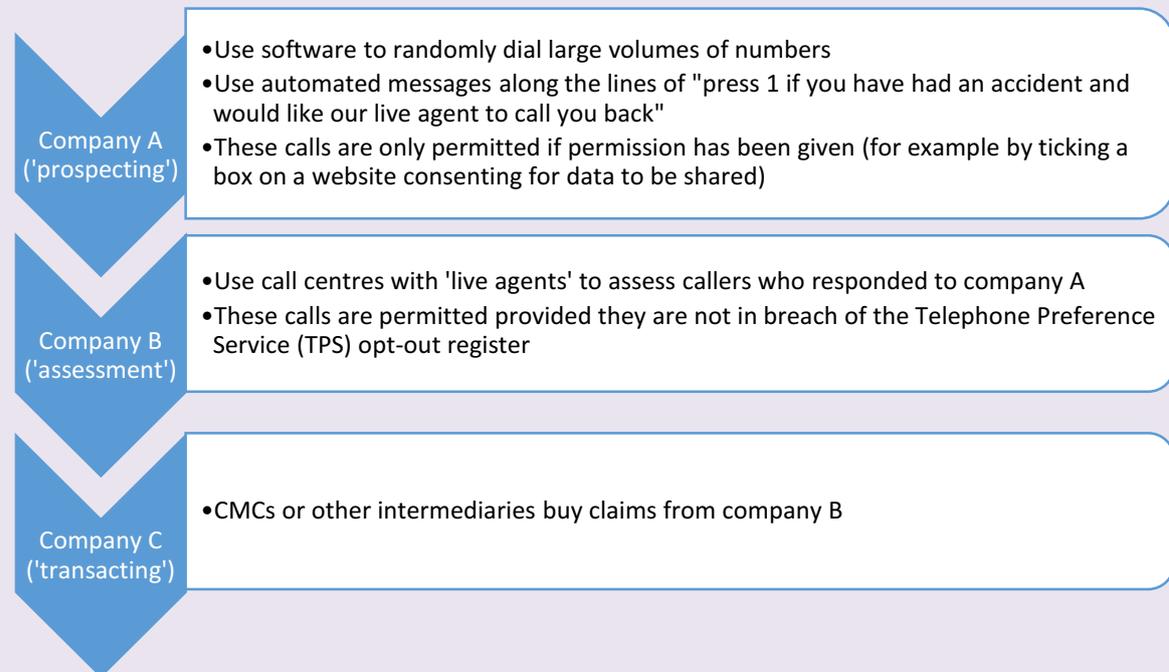
2.49 The Taskforce acknowledges that direct marketing, such as telephoning consumers, and sending texts or emails, is a legitimate activity that contributes financially to the UK economy.

2.50 Direct marketing is the preferred method of marketing for many businesses to promote products and services directly to existing or potential consumers, often those who have indicated previously that they would like to be contacted. It is an attractive option for many as it allows businesses to generate a response from targeted customers, boosting sales and increasing customer loyalty. As a result, small businesses can focus their limited marketing resources where they are most likely to get results.

Box 2.C: Who makes nuisance calls

Some CMCs contact consumers directly. However many nuisance calls are made by separate companies undertaking different stages of a claim.

This makes it hard to pinpoint the source of the nuisance call since company A is often based abroad to avoid regulation, and contracts between companies B and C are often loose.



Company A is sometimes labelled a 'phoenix' company because some only exist for short periods of time, changing its number every few months.

Stakeholders highlighted that for company A, it is often very cheap to make these phone calls, and since they are often based abroad and use techniques to hide their number,⁴⁴ the prospect of being caught for breach of privacy laws is low.

2.51 At its best, direct marketing can be useful and informative to consumers helping them find the best deal and most suitable products for their needs. However at its worst direct marketing

⁴⁴ Such as caller/CFI ID spoofing, the practice of causing the telephone network to indicate to the receiver of a call that the originator of the call is a station other than the true originating station. For example a Caller ID display might display a phone number different from that of the telephone from which the call was placed.

can cause anxiety and fear, especially to people who are elderly or vulnerable,⁴⁵ and nuisance callers can pressurise otherwise honest people into making fraudulent claims.

2.52 The Information Commissioner's Office (ICO), the UK's independent body set up to uphold information rights, received 175,000 reports of nuisance calls and texts in 2014, with insurance claims including accident claims consistently topping the list of reported concerns.⁴⁶ Research by National Accident Helpline and Populus⁴⁷ found that many find nuisance calls distressing and 40% of those surveyed received more than nine cold calls on their landline every month. Further research by Trading Standards⁴⁸ revealed that about 40% of the phone calls received by older and vulnerable residents in Scotland are nuisance calls.

2.53 During the review evidence, was presented to the Taskforce suggesting some nuisance callers use tactics to encourage consumers to commit insurance fraud:

- an undercover investigation by the Sunday Times⁴⁹ exposed an accident claims company that was encouraging clients to fabricate or exaggerate injuries
- a survey of insurance brokers by BIBA provided anecdotal evidence of cold-calls where people were incorrectly told they would be eligible to lodge a claim for industrial deafness despite having never done any industrial work
- a member of the Personal Injury Working Group reported his own experience of nuisance calls including the use of so called 'government guidance' suggesting it is acceptable to claim for discomfort after a road traffic accident if the vehicle was subject of more than £3,000 worth of damage
- stakeholders reported that some CMCs pretend to be organisations, such as the National Accident Helpline (NAHL), Claims Portal Limited⁵⁰ or Motor Insurers' Bureau (MIB),⁵¹ in order to obtain details to pursue a claim
- the ICO has issued written warnings to more than 1,000 companies it believes are actively buying and selling lists of names and numbers used for cold calling and texts⁵²

2.54 While it is thought that a significant number of nuisance calls may be from overseas, the data for these calls originates from the UK. In addition any leads produced would be sold in the UK.

2.55 Electronic marketing is regulated by the Privacy and Electronic Communications Regulations (PECRs) which sit alongside the Data Protection Act 1998. Direct marketing is permitted when consumers consent to their data being used. However it is against the law for anyone to send spam texts unless consent has been given.

2.56 Consumers are often unaware that they have given this consent. They may have inadvertently done so by ticking a box on an online shopping form to receive future marketing emails (the opt-in method), or the box may have been pre-ticked and the user has failed to un-

⁴⁵ Accessed November 2015: <http://www.channel4.com/info/press/news/how-to-stop-your-nuisance-calls-channel-4-dispatches>

⁴⁶ Accessed November 2015; <https://ico.org.uk/action-weve-taken/nuisance-calls-and-messages/>

⁴⁷ Accessed November 2015: <http://www.nahlgrouplc.co.uk/news/government-must-act-now-to-stop-intrusive-cold-calling-2>

⁴⁸ Accessed November 2015: <http://www.actionfraud.police.uk/nuisance-calls-make-up-40per-cent-of-calls-to-elderly-and-vulnerable>

⁴⁹ Accessed November 2015; http://www.thesundaytimes.co.uk/sto/news/uk_news/article1577190.ece

⁵⁰ Accessed November 2015: <http://www.claimsportal.org.uk/en/news-and-announcements/#>

⁵¹ Accessed November 2015: <http://www.mib.org.uk/media-centre/news/2015/november/scam-alert/>

⁵² Accessed November 2015: <https://ico.org.uk/about-the-ico/news-and-events/news-and-blogs/2015/11/nuisance-call-crackdown-continues-with-letters-to-1-000-companies-trading-names-and-numbers/>

tick it in order to make clear no further correspondence should be sent (the opt-out method). Under forthcoming EU regulations⁵³ opt-outs will no longer be an acceptable form of consent.

2.57 There are various steps that individuals can take to minimise the number of nuisance calls and texts they receive. Most telecom service providers offer a range of services, usually for a small charge or for free, that can help to reduce the need to answer unwanted calls.⁵⁴ Also a range of telephone handsets and plug in devices are widely available which are effective in helping to block different kinds of scams calls. Registration with the Telephone Preference Service (TPS),⁵⁵ run by the Direct Marketing Association, can also stop unsolicited calls.

2.58 Individuals can make complaints to the Office of Communications (Ofcom) about silent and abandoned calls,⁵⁶ and to the Information Commissioner's Office (ICO) about spam texts, telesales calls, automated calls and spam emails.⁵⁷ Nuisance calls or messages that appear to be fraudulent in nature can be reported to Action Fraud,⁵⁸ a government-supported initiative providing a fraud reporting and advice centre.

2.59 The Taskforce acknowledges that the actions detailed above can only have limited success and ultimate responsibility for minimising the volume of such calls falls to regulators enforcing data privacy laws, such as the ICO and Ofcom; and the referral fee ban, such as the FCA, SRA and CMR.

Professional enablers

2.60 As well as CMCs, stakeholders highlighted other intermediaries that can play a role in the encouragement of fraudulent claims.

2.61 To assess the losses suffered after a genuine accident a claimant often requires the services of various professionals to value and present a claim to an insurer. Professional enabler is the term given to professionals such as recovery and storage companies, motor engineers, car repair body shops, hire car companies, doctors and solicitors whose professional standing, expertise or qualification gives the appearance of legitimacy to claims allowing fraudsters to succeed. In some cases firms may have weak controls but may not be complicit in fraud. In others they can be actively complicit in submitting and progressing fraudulent claims, from staged accidents to fictitious PI claims.

2.62 The Taskforce recognises that only a minority of professionals are engaged in fraudulent activity. Nonetheless their role can be crucial.

2.63 Cases involving professional enablers include

- **Medical professionals:** some cases involve inflating medical bills or faking medico-legal reports for personal injuries such as soft tissue injuries. For example the General Medical Council (GMC), which regulates medical doctors in the UK, suspended a GP for six months for dishonestly preparing a 'bogus' report to

⁵³ The General Data Protection Regulation (GDPR)

⁵⁴ These include 'Calling Line Identification Display', 'Automatic Call Rejection' and 'Choose to Refuse'. For example 'Choose to Refuse' allows consumers to block numbers by specifying numbers that they do not want to receive calls from; 'Caller Display' enables a consumer to choose to ignore calls that withhold their number; and Anonymous Call Rejection blocks incoming calls that withhold their number, although this may include some calls that consumers want to receive.

⁵⁵ TPS works by removing a registered number from telephone marketing lists. It is a legal requirement that all organisations do not make unsolicited calls to numbers registered on the TPS unless they have consent to do so. However Even if a number is registered with the TPS, individuals can still receive communications from companies that hold their data if they have ticked a box on a website, opting in to receiving communications. More information about the TPS can be found at <https://complaints.tpsonline.org.uk/consumer>.

⁵⁶ Ofcom don't investigate individual cases but complaints can lead to them launching investigation and ultimately taking action. More information about how to make a complaint to Ofcom can be found at <http://consumers.ofcom.org.uk/complain/phone-and-broadband-complaints/privacy>.

⁵⁷ More information about how to make a complaint to the ICO can be found at <https://ico.org.uk/concerns/marketing>.

⁵⁸ Information received by Action Fraud is forwarded to the National Fraud Intelligence Bureau (NFIB), which receives reports from a number of sources including other police forces, and the data is analysed with a view to demonstrating links between apparently separate cases. Further details about the role of Action Fraud can be obtained by calling 0300 123 2040, or by visiting their website at: http://www.actionfraud.police.uk/report_fraud.

support a soft tissue injury claim.⁵⁹ Stakeholders also raised concerns that some medical examinations are conducted over the phone or via Skype

- **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. Stakeholders also suggested that a small minority of law firms are set up by criminal gangs to assist them in their scams
- **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.⁶⁰ 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. Organised fraudsters in this area sometimes own or have links with motor engineers who provide false valuation of damage to vehicles
- **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. For example in one case an insurance company paid out £7,810 for a vehicle that a consultant motor engineer declared written off – although it transpired he never actually saw the vehicle⁶¹
- **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 £200,000⁶²

Late notified claims

2.64 PI claims need to be brought within the limitation period which is generally 3 years from the date when the claimant was aware that the accident caused their injury. Beyond this accident victims will not normally be able to make a claim.⁶³ Late notified claims are claims that are presented to insurers close to this limitation period.

2.65 Although the Taskforce recognises that there may be legitimate reasons for a delay in bringing a PI claim, there are concerns that many such claims are weak, exaggerated or fraudulent, and may be encouraged by 'nuisance calls'.

2.66 Furthermore stakeholders reported that a significant percentage of minor RTA PI claims, such as minor whiplash, are notified after one year. In the context of these claims there is likely to be no benefit in undergoing a medical examination at this stage, making it hard for medical experts and insurers to then verify whether the claimant ever had an injury and if so how serious.

Noise induced hearing loss (NIHL)

2.67 Civil justice reforms since 2010 (detailed in Chapter 3) have reduced the profitability of pursuing some low value PI claims.

⁵⁹ Accessed November 2015: <http://www.chesterstandard.co.uk/news/132672/chester-gp-suspended-for-whiplash-scam-.aspx>

⁶⁰ 'Credit Hire Fraud Report 2015', DAC Beachcroft Claims Ltd, 2015.

⁶¹ 'Crash for Cash - Putting the brakes on fraud', Insurance Fraud Bureau, 2012.

⁶² Accessed November 2015: <http://www.rcvs.org.uk/news-and-events/news/surrey-vet-struck-off-following-imprisonment-for-pet-insurance/>

⁶³ The court has a discretion to allow an extension to the 3 year period (Section 33, Limitation Act 1980)

2.68 This had led some claimant representatives moving into other areas such as NIHL claims (see Box.2.D), with a substantial increase in the number of claims and, therefore, cost of litigation to defendants. The government has therefore asked the Civil Justice Council (CJC) to consider the issue and to make recommendations, in particular (i) as to how a regime of fixed recoverable costs might work, and (ii) how the handling of NIHL claims might be improved by both claimant and defendant representatives (including how evidence is obtained and presented). The final report is due to be published in April 2016.⁶⁴

2.69 Statistics show an increase in claims notifications in this area, a large number of which do not result in compensation payment. The costs of these claims are substantial. The estimated overall cost of NIHL claims to insurers has risen from just below £83 million in 2010 to more than £360 million in 2014. Between 2010 and 2013 there was an increase of almost 250% of NIHL claims notified, with a total estimated cost of over £400 million⁶⁵ (see Table 2.E).

2.70 NIHL claims are not a new phenomenon. Many claims are generated from exposure to noise in the workplace in the 1960s and 1970s, such as in Britain's heavy industries, when the understanding of the impact of noisy work environments on hearing was poor and precautions were only just starting to be put in place.

Box 2.D: What is noise-induced hearing loss (NIHL)

NIHL is a permanent hearing impediment caused by damage to the sensitive hair cells inside the inner ear or damage to the auditory nerve as a result of repeated exposure to loud noises over time.

Hearing tests for NIHL are conducted by an audiologist, who produces results in the form of an audiogram. An audiogram is a graph that plots hearing levels across various sound frequencies for the left and right ear.

The result is measured on a scale of dB as compared with a person with 'normal' hearing i.e. the standard expected hearing levels according to the claimant's age and gender; and is usually broken down into categories of disability according to the degree or severity of the hearing loss.

What is tinnitus?

Tinnitus is the term for hearing sounds that come from inside your body, rather than from an outside source. It's often described as "ringing in the ears", although several sounds can be heard, including buzzing, humming, grinding, hissing or whistling.

There is no objective test for tinnitus and diagnosis is based on the history of symptoms given by the claimant.

2.71 NIHL claims fail for a variety of reasons, including a lack of medical evidence that the hearing loss resulted from exposure to noise in the claimant's workplace, or because the claim falls outside the limitation period for making a claim.

⁶⁴ The terms of reference, membership and updates from the CJC working group on Noise Induced Hearing Loss can be found at <https://www.judiciary.gov.uk/publications/noise-induced-hearing-loss-working-group/>.

⁶⁵ Institute and Faculty of Actuaries UK Deafness Working Party

2.72 The industry average claims failure rate, the number of claims that do not result in payment to the claimant for a range of reasons, was 65% in 2013⁶⁶ and the industry has reported that this rate is on the increase, with one insurer reporting a claims failure rate of 85% in 2014.⁶⁷ This was reported by a number of insurer stakeholders as a common experience.

2.73 Some stakeholders stated that such trends are the result of regulatory and/or legal changes affecting supply/demand. It is notable that in Tables 2.E to 2.G, whilst the number of claims in the two peaks are similar total costs are considerably higher in the second.

2.74 Common concerns in this area related to

- **medical evidence:** stakeholders representing insurers and defendant solicitors stated that a significant number of NIHL claims submitted are of poor quality without any evidence or real prospect of success. This is sometimes due to the fact that some claims, such as those including tinnitus, are hard to verify (see Box 2.D). ABI data shows that tinnitus is included in approximately 58% of successful NIHL claims, and increases the average damages paid by over 20%¹
- **accreditation and independence of audiologists:** some stakeholders raised concerns that since audiologists are not sourced through an independent system such as MedCo, some unscrupulous audiologists are acting as professional enablers. Stakeholders also raised concerns about the quality of audiograms
- **solicitors' fees:** a pre-action protocol with fixed recoverable costs arrangements was introduced for employers' liability claims up to £25,000 in July 2013. However some stakeholders representing insurers and defendant solicitors stated that there are a number of features of the pre-action protocol that 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,⁶⁸ are recoverable. In 2013 the average compensation payment for a NIHL claim was £3,100, while average claimant legal costs were £10,400,⁶⁹ making it sometimes easier and cheaper to settle a potentially fraudulent claim. This means that for every £1 paid to the claimant over £3 was paid to their lawyer. As stated above, the government has asked the Civil Justice Council to consider options for fixed costs for these cases

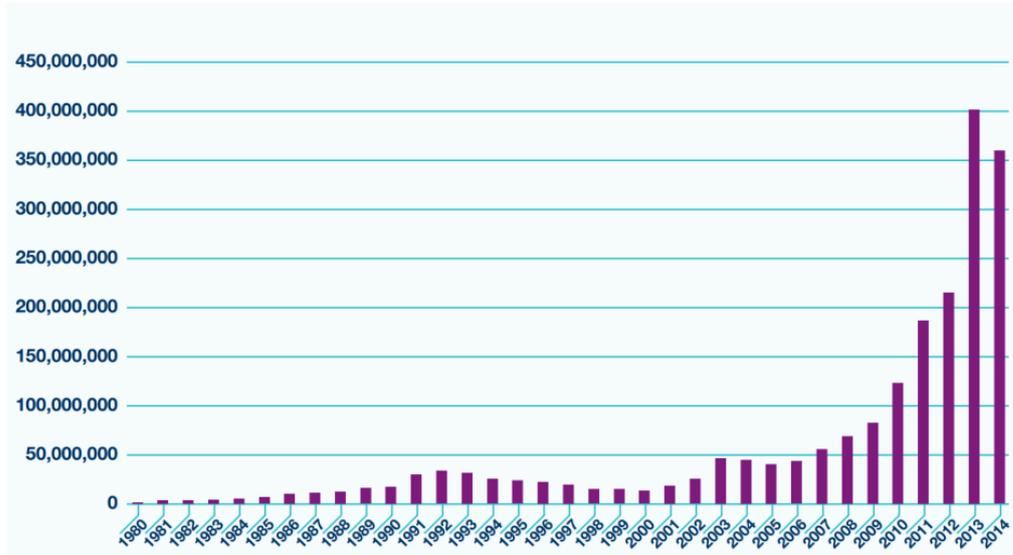
⁶⁶ ABI analysis of NIHL claims data from 2013

⁶⁷ Accessed November 2015: <http://www.aviva.com/media/news/item/uk-aviva-calls-for-clampdown-on-spurious-industrial-deafness-claims-17459/>

⁶⁸ Claimant legal costs in the Portal are fixed at £900+VAT for EL claims with a value up to £10k and £1600+VAT for EL claims between £10k and £25k

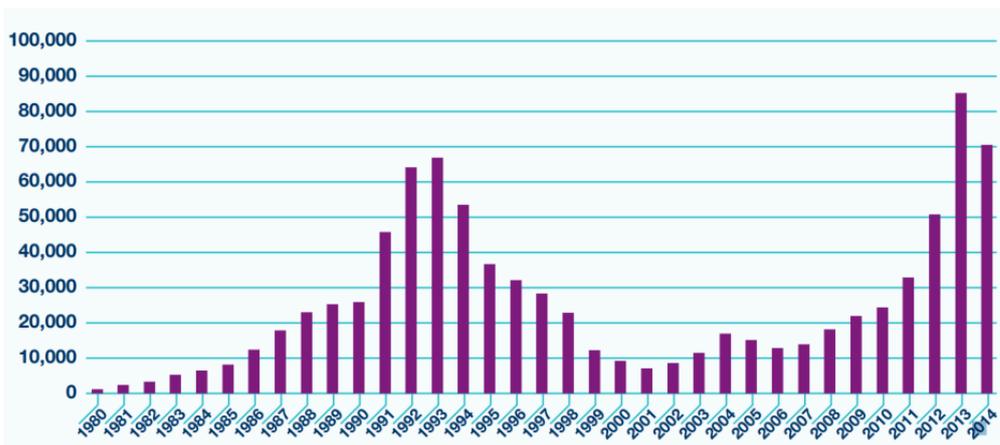
⁶⁹ ABI analysis of NIHL claims data from 2013

Table 2.E Total NIHL costs incurred by notification year



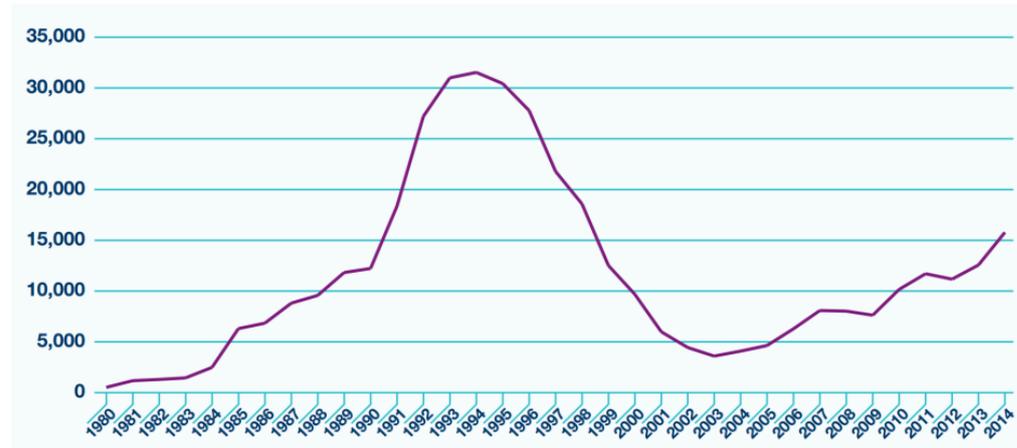
Source: Institute and Faculty of Actuaries UK deafness working party

Table 2.F Total number of NIHL claims notified by year



Source: Institute and Faculty of Actuaries UK deafness working party

Table 2.G: Total number of NIHL claims settled for non-nil (where there has been compensation awarded to the claimant) by year



Source: Institute and Faculty of Actuaries UK deafness working party

Data sharing and fraud detection

71% of stakeholders reported that data is not being used adequately in fraud detection and investigation⁷⁰

2.75 Data sharing came up consistently in Taskforce 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. Examples of effective fraud databases and data sharing schemes can be found in Chapter 3.

2.76 Many firms within the insurance industry already spend considerable amounts of resources internally on tackling fraud and stakeholders representing industry noted that internationally the UK has a reputation for advanced fraud detection techniques and strong industry capability.

2.77 Concerns raised by stakeholders did not relate to the quantity of anti-fraud data but its quality, analysis, proper use and access.

2.78 Concerns about data sharing and fraud detection among stakeholders commonly related to the quality of data in fraud databases and quality of data available at the point of quote. These issues are explored in further detail below. Other concerns included

- **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.⁷¹ For example 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

⁷⁰ Based on responses to the call for evidence following the publication of the Insurance Fraud Taskforce interim report

⁷¹ Accessed November 2015: <http://www.bbc.co.uk/news/business-26291075>

cars and steal drivers' identities.⁷² There are reported cases of insurance company staff being targeted by claims farmers to obtain accident data.

- **lack of understanding of data protection laws:** 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.
- **a short-term focus on competitive advantage rather than a 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. The Taskforce recognises that anti-fraud measures may sometimes be seen as providing a competitive advantage, and the cost of storing and processing data can be high. However fraud overall will only be curbed if good practice around prevention is shared among those who are likely to become targets. Improving data sharing practices and investing in anti-fraud databases will reap long-term benefits both commercially, and for industry and society more generally
- **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

Respondents' data concerns

2.79 Data in fraud databases such as CUE, a central claims database, or data sharing schemes such as MyLicence, an initiative which provides the insurance industry with access to DVLA driver data, should be as accurate as possible in order to increase their reliability and strength in detecting and investigating insurance fraud.

2.80 Concerns raised by stakeholders relating to the quality of data in fraud databases and anti-fraud schemes include:

- **inconsistent definition of proven fraud:** despite there being a standard definition of insurance fraud produced by the ABI (see Annex C), there are a number of databases aimed at tackling fraud using different definitions creating inconsistency and duplication
- **transparency of databases:** stakeholders representing consumers raised concerns that confidentiality agreements between some private databases and their members preclude consumers from finding out if their name has been flagged as a fraudster. Some fraud indicators unfairly target claimants involved in accidents who choose not to claim as a result of confusion about the need to notify accidents regardless
- **falsely identifying suspected fraud:** stakeholders representing consumers and claimant solicitors highlighted that sometimes honest consumers are falsely identified as fraudsters, for example through the inappropriate use of outdated or

⁷² Accessed November 2015: <http://www.thetimes.co.uk/tto/news/uk/article4444553.ece>

inaccurate data. This has a negative impact on such customers through personal distress, reputational damage and higher premiums

- **arson:** not all arson involves a fraudulent insurance claim but some clearly do. Without better data it is impossible to know how much and whether trends are improving or deteriorating. The Arson Prevention Forum (APF) presented evidence to the Taskforce suggesting that the number of insurance claims involving elements of arson are increasing in size, and the overall costs are large. One of the biggest barriers to understanding the scale of the problem is a lack of comprehensive arson statistics, due to different definitions of arson, for example by insurers and fire services, and a lack of co-ordination between stakeholders

2.81 The Taskforce notes these concerns. It is essential that policyholders trust the data that is held on them. Highly publicised errors in this area given overall public sensitivity could result in restrictions being imposed that would hamper the effective fight against fraud.

Quality of trusted data at the point of quote

2.82 Stakeholders agreed that the best way to challenge fraud without damaging the customer experience is to stop fraud coming through the door in the first place by stamping out fraud at the application stage. Insurers with effective application fraud prevention processes also reported lower claims fraud.

2.83 Stakeholders representing consumers noted that by encouraging purchasing insurance online, the process had become depersonalised, reducing some of the technical and cultural restraints and increasing the opportunities for fraud. The insurance industry must adapt its processes to be as rigorous as possible at the application stage.

2.84 Consumers are key players in ensuring the quality of trusted data at the point of quote since they hold an interest and insight into their claims history, and can challenge inaccurate records. However they can only do so if there is a free and accessible process to check data and an efficient and impartial appeals process.

2.85 Price comparison websites (aggregators) have become large players in the insurance market, particularly for motor policies. For many consumers aggregators act as gatekeepers to insurers. Although they do not have a direct insight into fraud, aggregators have the ability to monitor suspicious consumer behaviour, such as the practice of some customers manipulating sensitive information to achieve a cheaper quote. For this reason they have the opportunity to tackle application fraud at the point of quote, yet aggregators and insurers informed the Taskforce that current exchange of anti-fraud data is minimal. For example aggregators raised the issue that currently they are told *when* an insurer voids a policy purchased through their site, but not *why* it was voided (e.g. because of suspected fraud).

2.86 The Taskforce recognises that there are commercial factors that may incentivise aggregators not to deal with application fraud. Any counter fraud procedure which slows the quotation process would disadvantage the aggregator that adopted it and so change will need to apply to all.

Drivers of policyholder attitudes and perceptions

2.87 The Taskforce recognises that the vast majority of consumers are honest and their insurance applications and claims are legitimate. Those who do make genuine mistakes are not fraudsters and the Taskforce will not seek to criminalise them. However some policyholders do commit insurance fraud. Fraudsters can be roughly divided into criminals who have planned their activity and opportunistic fraudsters who either act on the spur of the moment or take

advantage of a situation. For some in this second group there is often the impression that insurance is “fair game” for fraud.⁷³ This attitude is based on a distrust of the insurers; and a widespread misunderstanding of how insurance works.

2.88 Insurance is a risk transfer mechanism. At a basic level insurers group together large numbers of people, or ‘policyholders’, who all face a similar risk, such as a house fire, and collect a small amount of money from each of them through ‘premiums’. If one of those people who has paid in needs to make a claim because of a house fire, there is a pot of money there to help them. Therefore when a policyholder makes a fraudulent claim they are taking money out of this pot made up of other policyholders’ money, and to cover this cost insurers charge every other honest policyholder a higher premium. Some do not understand that insurance is designed to cover the risk of an event occurring, instead believing that they deserve a refund of premiums paid where no claim has been made. They also may not realise how fraud impacts other policyholders through higher premiums. Whatever the reasons for this lack of understanding stakeholders agreed that the insurance industry could do more to communicate to customers and the media how insurance works.

Customer journey

There are low levels of trust in the insurance sector relative to other industries and organisations (see Chart 2.E). This perception is likely to be linked to how insurers communicate policies to customers. The insurance industry has a responsibility to ensure it communicates effectively with consumers in order to tackle these negative perceptions which may encourage opportunistic fraudsters.

2.89 Stakeholders suggest that when buying consumers do not always fully understand insurance products. That includes how the price is calculated and the extent of cover. For example application and claims forms, policy terms, and summaries can be long, complicated and written in language that is not consumer-friendly. This leads some consumers to make mistakes. Responses highlighted a number of terms used by insurers that are particularly confusing such as ‘excess’ and ‘personal money’; and a perception among consumers that insurers will rely on “small print” to avoid paying out claims. This mirrors research on how the insurance industry can improve communication with customers. In addition CII and FOS research confirms that insurer administration is not always perfect, for example sometimes policy terms and schedules do not tally.⁷⁴

2.90 FCA rules require all customer facing communication to be “clear, fair and not misleading”.⁷⁵ However their discussion paper “Smarter Consumer Communications”⁷⁶ highlights concerns that information provided to consumers often did not help them make an informed decision and could be insufficient, incomplete, provided at the wrong time or presented in a potentially misleading way. Research by Fairer Finance, a consumer website, found that a third of insurance policies are written at a university-equivalent reading level, making them inaccessible to large portions of the population.⁷⁷

⁷³ Trends and Issues in Crime and Criminal Justice No. 66, T Baldock, 1997.

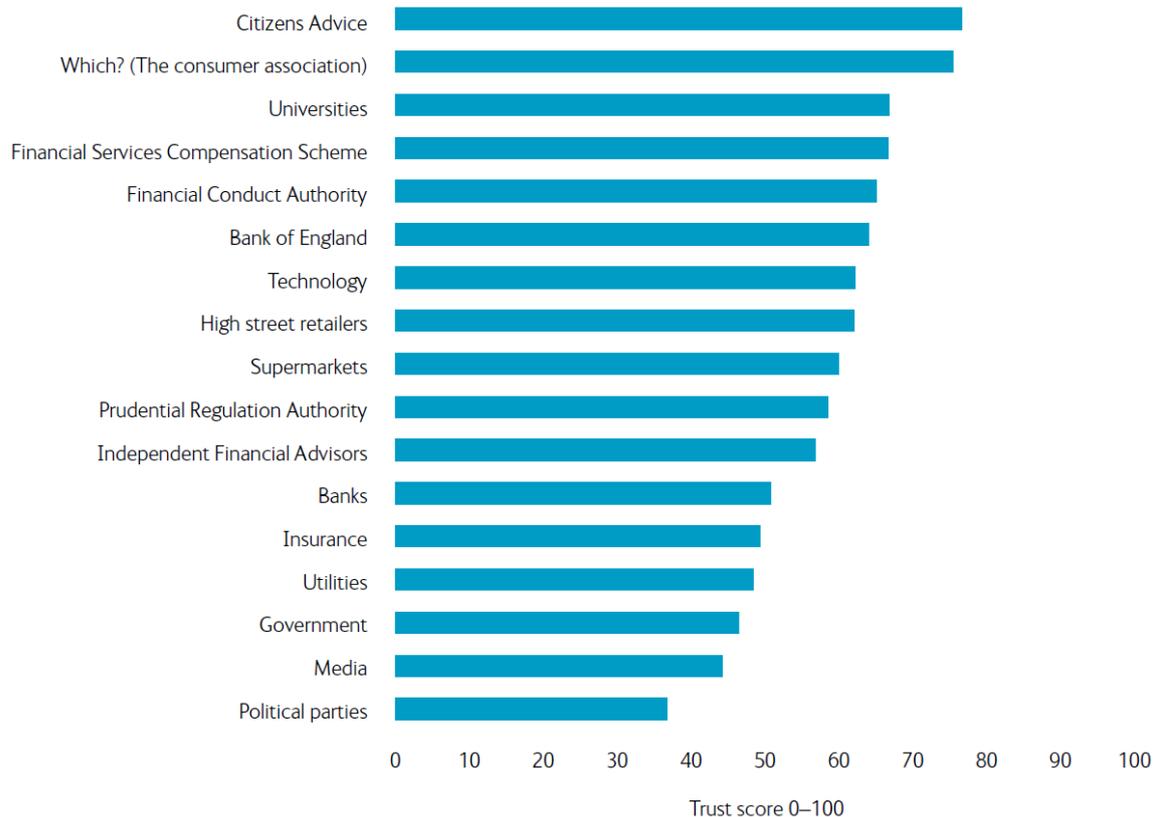
⁷⁴ ‘The Impact of the Consumer Insurance (Disclosure and Representations) Act 2012’, CII New Generation Underwriting Group, 2013.

⁷⁵ FCA ICOBS 2.2.2

⁷⁶ Accessed November 2015: <https://www.fca.org.uk/news/dp15-05-smarter-consumer-communications>

⁷⁷ Accessed November 2015: <http://www.fairerfinance.com/blog/you-shouldnt-need-a-phd-to-understand-your-home-insurance>

Chart 2.E: Consumer trust in industries and organisations



Source: *Financial Services Compensation Scheme Research, 2015*

2.91 Examples of insurer practices that may lead to a poor perception include:

- **auto-renewals:** many insurance policies contain an automatic renewal clause which dictates that a policy will be automatically 'rolled-over' to another year if the policyholder does not give notice within a certain period. This can be a good thing as continual cover is a convenience for many, especially in the area of motor insurance where cover is a legal requirement. However many insurers increase prices each year. This has led to criticism by the media⁷⁸ and consumer groups such as Which? that they are profiting from consumer inertia. This can be a particular problem for elderly customers⁷⁹ who may be less able to shop around, and are disproportionately affected since they are likely to pay higher premiums anyway to reflect higher risks. The FCA recently published results of field trials testing the potential for improved renewal notices to encourage consumers to switch or negotiate their home or motor insurance policy at renewal⁸⁰ and set out proposals to introduce new rules and guidance for firms.⁸¹ The ABI and BIBA recently launched a joint 'Code of Good Practice' to help insurers and insurance brokers

⁷⁸ Accessed November 2015; <http://www.bbc.co.uk/programmes/articles/1ZMshDHTQhv0jc0Wv6DG33v/does-an-automatic-renewal-on-your-car-insurance-pay>; <http://www.thesundaytimes.co.uk/sto/business/money/Consumer/article1593413.ece>

⁷⁹ Accessed November 2015: [http://www.ageuk.org.uk/documents/en-gb/for-professionals/research/insurance%20and%20age%20full%20report%20\(2007\)_pro.pdf?dtrk=true](http://www.ageuk.org.uk/documents/en-gb/for-professionals/research/insurance%20and%20age%20full%20report%20(2007)_pro.pdf?dtrk=true)

⁸⁰ FCA Occasional Paper No. 12: Encouraging consumers to act at renewal: Evidence from field trials in the home and motor insurance markets, FCA, Dec 2015.

⁸¹ FCA CP15/41: Increasing transparency and engagement at renewal in general insurance markets, FCA, Dec 2015.

recognise and help potentially vulnerable customers, who may need extra support when renewing motor and home insurance policies⁸²

- **dual-pricing:** many insurers price risk lower for new customers than existing ones as an introductory incentive, effectively disadvantaging loyal customers.⁸³ However most policyholders check these renewal quotes and many negotiate a reduction. This contributes to a culture where policyholders genuinely believe that everything is negotiable and that their claim will be dealt with in the same way as their premium so that they should inflate their claims in order to end up at an acceptable final figure. The Taskforce endorses FCA proposals that previous year figures should be included in a renewal quote⁸⁴
- **no claims bonuses:** the cost of insurance premiums can rise at the point of renewal if a policyholder informs their insurer about an accident, but decides not to claim, since such information can change their risk profile. However this is not always explained to policyholders. There are a number of reasons why a policyholder may choose not to pursue a claim: they may for example decide it is not worthwhile for a small amount; they may be put off by the length of time a dispute can take to resolve
- **add ons:** there is widespread evidence that consumers in some markets systematically misunderstand certain product features such as add-ons which allow firms to charge high prices after consumers have entered a relationship with the firm.⁸⁵ In particular Gabaix and Laibson⁸⁶ argue that information such as add-on prices may be 'shrouded' in markets where many consumers do not anticipate the total amount that they will pay when they are purchasing the primary product
- **pre-medical offers:** a pre-medical offer is an offer of settlement put forward once a claim has been made, sometimes by the defendant's insurers and sometimes by the claimant's solicitors, often in cases involving minor soft tissue injuries, before any medical evidence has been obtained. In the short term this can save the insurer money since the legal costs associated with defending a claim are often higher than the offer. The Taskforce appreciates that the lack of medical evidence places insurance claims departments in a difficult position with regard to whiplash claims. However many stakeholders considered the widespread use of pre-medical offers contributes to the perception that insurance claims, especially minor soft tissue injury claims, are "easy money". Insurer representatives stated that pre-medical offers are sometimes requested by the claimant's lawyer, they allow compensation to be paid to the claimant more quickly, and they would be more inclined to obtain a medical report in these cases if the quality of such reports were improved under MedCo
- **third party capture:** third party capture refers to the practice whereby an insurer approaches an accident victim with a potential claim against one of their policyholders directly, and offers to settle the claim without the need for legal advice. With the exception of not involving a claimant lawyer, the claim settlement

⁸² Accessed January 2016; <https://www.abi.org.uk/News/News-releases/2016/01/ABI-and-BIBA-launch-industry-Code-of-Good-Practice-to-help-vulnerable-customers>

⁸³ Research shows that customers are least likely to be loyal to their insurers than businesses from any other sector (Accessed November 2015; http://futurethinking.com/wp-content/uploads/2015/11/Service-benchmarking_Banking-and-Finance-2015.pdf)

⁸⁴ FCA Occasional Paper No. 12: Encouraging consumers to act at renewal: Evidence from field trials in the home and motor insurance markets, FCA, Dec 2015.

⁸⁵ 'Contract Design and Self-Control: Theory and Evidence', S DellaVigna and U Malmendier, 2004.

⁸⁶ 'Shrouded Attributes, Consumer Myopia, and Information Suppression in Competitive Markets', X Gabaix and D Laibson, 2006.

will usually follow the same route in all other respects. Stakeholders representing consumers and claimant solicitors suggested that the amount offered is often lower than the amount that they would receive if they were represented by a solicitor, whilst insurer representatives disagreed that was the case. The Financial Services Authority (FSA) (which was replaced by the Financial Conduct Authority) looked at this issue⁸⁷ and found that it does not cause detriment. Like pre-medical offers, several stakeholders thought that this practice contributes to the perception that insurance claims are “easy money”.⁸⁸ The ABI has published a code of practice⁸⁹ which provides guidance for how insurers should engage with unrepresented claimants to ensure they are treated fairly

2.92 In light of all these practices, consumers generally find exaggeration of a genuine claim to be more morally acceptable than out-and-out fabrication of loss. In some cases consumers may not even realise they are exaggerating a claim, as they may make a genuinely optimistic valuation or believe that they are in a negotiation in which they need to initially ask for a higher value in order to receive the correct amount.⁹⁰

2.93 This is of concern to the Taskforce not only because the majority of claims handled by claims investigators involve otherwise honest people indulging in opportunistic low-value crime,⁹¹ but because the normalisation of fraudulent behaviour is socially corrosive and undermines social cohesion by eroding trust.

⁸⁷ Accessed December 2015; http://www.fsa.gov.uk/pubs/other/third_party_capture.pdf

⁸⁸ The ABI published a voluntary code of practice in 2014 for insurers undertaking third party capture in relation to RTA claims. 15 top insurers have since signed up to the code under which they agree to ensure that claimants are fully aware of their legal options and that they do not apply pressure on potential claimants or share details of the case if they have indicated that they do not wish to pursue a claim.

⁸⁹ Accessed December 2015;

https://www.abi.org.uk/~/_media/Files/Documents/Publications/Public/Migrated/Motor/ABI%20code%20of%20practice%20-%20third%20party%20assistance.pdf

⁹⁰ O'Neill, Research Brief. Deterring opportunistic general insurance claims fraud, 2010, cited in Richards, Deterring insurance: a critical and criminological analysis of the English and Scottish Law Commissions' current proposals or reform, Insurance Law Journal, 2013

⁹¹ 'Profile of a house insurance fraudster', Mark Button, Francis Pakes and Dean Blackburn, 2013.

Tackling insurance fraud:

3 the story so far

3.1 Chapter 2 outlined the main concerns raised by stakeholders relating to: the encouragement of fraudulent claims; data sharing and fraud detection; and policyholder attitudes and perceptions. This Chapter will outline the positive efforts the Taskforce recognises have been made thus far to tackle insurance fraud. These efforts will be set out under 4 sections:

- insurance industry initiatives
- civil justice reforms
- regulatory framework
- behavioural economics

Insurance industry initiatives

3.2 Fraud is an expensive problem for insurers and the industry estimates it spends in excess of £200 million per year tackling it.¹ The Taskforce is mindful that there should be no duplication or hindrance of these efforts. It is also keen to see that current initiatives are effective and used as widely as possible. A summary of these initiatives, which focus principally on fraud detection, data sharing, best practice and communications, is outlined here.

Fraud detection

3.3 A key step taken by the industry was the establishment of the IFB 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. Over the period 2011-2014 the IFB has overseen a reduction from £392 to £336m in fraudulent organised motor claims and a 14% reduction in suspicious PI claims. The IFB's 5 year strategy (2015-19) and 2020 vision includes actions to expand the fraud under investigation to other types of insurance beyond motor, and increase the breadth of organisations with which it works to include solicitors, investigators, loss adjusters and others. The IFB also intends to expand its role and become the central intelligence hub for insurers.

3.4 Another important initiative is the industry-funded IFED, a specialist police unit part of the City of London Police dedicated to tackling insurance fraud in England and Wales. It was established in 2012 and as of end of 2015, it has secured 207 convictions at court and 281 police cautions² and has recovered assets valued in excess of £1.3 million. In addition the

¹ There has been additional investment in industry-wide initiatives and increased expenditure by insurers on internal fraud controls since the 2011 ABI member survey which suggested industry counter-fraud expenditure was around £200 million. This previous estimate was referenced in: 'No Hiding Place: Insurance Exposed', ABI, 2012.

² IFED notes that there have also been 14 conditional cautions and 10 restorative justice outcomes (where the offender meets with the victim, usually the insurer, and expresses contrition)

number of total arrests by IFED has reached 738 and the number of suspects spoken to is 672.³ At any given time, IFED has between £20-£35m of fraud under investigation.

Data sharing

3.5 The industry has established a number of data sets⁴ that have become vital elements in identifying and tackling fraud. The industry works so that privacy, protection and the safe sharing of data is ensured through clear safeguarding measures. These data sets include:

- **Insurance Fraud Register (IFR):** a register of known⁵ 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. Safeguards are built into the system, including a complaints mechanism. Proposals are being developed to permit third-party access and to develop the IFR as an effective front-end fraud prevention tool. Currently 40% of the general insurance market uses the IFR. A further 38% of the market is actively engaged in signing up to use the system
- **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. The industry is considering the possible development of a CUE travel database to minimise the impact of fraud in that insurance category. Currently there are a very low level of subscribers
- **askCUE PI (personal injury):** the ABI, the IFB, and the Motor Insurers' Bureau (MIB) also worked with solicitors' representatives (the Law Society, MASS and APIL) to establish the askCUE PI system. Under the 2015 Civil Procedure Rules (CPR) changes, claimant solicitors are required to undertake a search using askCUE PI before filing an RTA claim, otherwise the insurer can return the claim with no cost consequences
- **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
- **MyLicence:** 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"

³ IFED notes that the power of arrest is used less frequently across law enforcement, with many suspects – thought not to be at risk of absconding - voluntarily attending at the station for interview by the police.

⁴ Other than the Insurance Fraud Register, these data sets listed are all under the management of the Motor Insurers' Bureau (MIB).

⁵ For more information on how the industry classify insurance fraud, see Annex C

database, a digital solution, designed to replace the manual paper exchange between motor insurers and policyholders that confirm a motorist's no claims discount entitlement

- **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 Taskforce 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' (see Box 2.A), improving insurers' ability to counter fraud. Some insurers have called for further extensions to KADOE. The Taskforce supports these recent changes and recognises the due diligence involved in such work

3.6 The industry also makes use of wider initiatives such as the National Fraud Intelligence Bureau (NFIB), which is the UK's current fraud detection hub, operated by City of London Police.

Best practice

3.7 Throughout the review, the Taskforce came across 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
- the use of driver monitoring technology, better known as telematics,⁶ to tackle fraud

3.8 The MIB has released a 'Roadmap for 2015 and beyond', a development programme to ensure that further improvements to the quality of data sets at the point-of-quote or sale are made, including combatting fraud.⁷

3.9 The Taskforce also recognises that the ABI produces voluntary guidance on best practice which it encourages its members to follow.

⁶ Telematics insurance works by fitting a small device - commonly known as a 'black box' - that monitors aspects of the drivers' driving style such as speed patterns, distance travelled, type of roads, braking and cornering. Insurers then use this data to adjust premiums. It should lead to a fairer pricing system based upon the individual rather than a generic set of statistically-based assumptions; and encourages safer and driving.

⁷ Accessed November 2015: https://www.mib.org.uk/media/263703/idsl_roadmap_2015.pdf

Communications

3.10 The CII has launched its 'Made Simple' tool to help demystify the language and market literature of insurance for consumers. The 'Made Simple' campaign aims to give consumers the information they need to understand better the day-to-day insurance policies they buy. The idea is to create a central library of easy-to-understand information that people can go to if they want to check what something means. 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.

3.11 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%.⁸

3.12 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

3.13 The dramatic changes to the landscape of personal injury litigation as outlined in Chapter 2 led to concerns about the growing costs of civil justice in the UK legal system, covering England and Wales. In particular that costs were often disproportionate to the sums in issue.

3.14 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 recommendations⁹ 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.

3.15 The Taskforce 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.

3.16 Since many of these reforms have only been introduced recently and some are not yet in force, stakeholders agreed that their full effect is not apparent.

3.17 These reforms include (with date of commencement):

- 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)¹⁰ into civil litigation (1 April 2013)

⁸ Accessed November 2015; <http://www.irishtimes.com/business/motor-premiums-down-45-iif-1.1000968>

⁹ Accessed November 2015; <http://www.judiciary.gov.uk/publications/review-of-civil-litigation-costs-final-report/>

¹⁰ Contingency fee agreements allow solicitors to charge their clients a fee based on the level of damages recovered capped at 25% of damages in PI claims, excluding future losses, and 50% in other claims

- reforming rules around ATE insurance policies so that ATE 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);
- as of 6 April 2015, medico-legal experts and Medical Reporting Organisations (MROs) must 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)

3.18 The main intention of these reforms has been to control costs. A consequence has been some positive impact in reducing insurance fraud, although some insurers reported that claims frequency has returned to pre-LASPO levels.¹¹

3.19 Stakeholders also highlighted legislation, guidance and case law in the civil arena that is having a positive effect on addressing insurance fraud

- **Fraud Act 2006:** the Fraud Act provides the courts with a clear framework to interpret the criminal act of fraud, and the law provides a strong deterrent (up to 10 years in prison) to those considering committing fraud

¹¹ Aviva, Road to Reform: Tackling the UK's Compensation Culture, July 2014

- **Contempt of court:** the increasing use of proceedings for contempt of court where penalties for being found guilty are severe was endorsed by the Supreme Court in the *Summers*¹² case. However it is recognised this avenue is a costly process and few cases will be selected for this type of action
- **Proceeds of Crime Act 2002 (POCA):** this Act is applicable in every civil case and provides for a number of powers and orders to: deny criminals the use of their assets; recover the proceeds of crime; and disrupt and deter criminality. Between 2010 and 2014 more than £746 million of criminal assets has been seized, assets worth more than £2.5 billion have been frozen and £93 million has been returned to victims. Sustained legal challenges to POCA have frustrated attempts to recover assets attributed to criminal conduct. The Taskforce supports reforms to POCA introduced by the Serious Crime Act 2015 to improve the asset recovery process¹³
- **Independent Sentencing Council guidelines:** the Independent Sentencing Council issued new guidelines on fraud in May 2014 (coming into force on 1 October 2014) recognising the physical harm that insurance fraud can inflict, and recommending longer sentences

3.20 The government also announced at Autumn Statement 2015 its intention to transfer PI claims of up to £5,000 to the small claims court in order to remove excessive legal costs arising from minor soft tissue injury claims, and remove the right to general damages compensation for minor whiplash claims.

Regulatory framework

3.21 One of the main focuses of the Taskforce has been the UK's current regulatory framework and what aspects of it could be strengthened to prevent insurance fraud. Regulators have undertaken positive enforcement action in the fight against insurance fraud. However stakeholders were strongly of the view that more could be done. This section will focus on regulation of insurers, solicitors, nuisance calls and CMCs.

Solicitors

The Solicitors Regulation Authority (SRA)

3.22 The SRA regulate approximately 130,000 individuals and 10,000 firms in England and Wales. It regulates individual solicitors, legal businesses and their employees in areas such as training, practising certificates, behaviour, investigations and disciplinary action. These statutory powers flow from a range of legislation.¹⁴

3.23 The SRA reported that its caseload mainly consists of financial fraud, often where solicitors inappropriately use client money.

3.24 The Taskforce accepts that this is an important role for the SRA. However stakeholders stated that the SRA should do more to tackle solicitors who act as professional enablers in fraudulent claims. Common areas of concern include

- **referral fee ban:** many stakeholders argued that the SRA does not adequately enforce the referral fee ban, increasing the market for nuisance callers. The SRA

¹² *Fairclough Homes Limited v Summers* [2012] UKSC 26

¹³ These include measures to enable assets to be restrained quicker and earlier in the investigation; prevent assets being hidden with spouses; require immediate payment; and increase custodial sentences where an offender fails to pay a confiscation order.

¹⁴ Legal Services Act 2007; Solicitors Act 1974; Administration of Justice Act 1985; Courts and Legal Services Act 1990; European Communities (Lawyer's Practice) Regulations 2000

argues that it is hard to effectively enforce because firms restructure themselves, often entering into a joint venture, to avoid it

- **accepting and refusing instructions:** defendant solicitors raised concerns that SRA regulations on accepting and refusing instructions¹⁵ are open to abuse and are not adequately enforced and managed; and that some claimant representatives are acting without instructions in order to commit fraud. The SRA confirmed that insurers and defendant solicitors are permitted to contact claimants directly to ask them whether they have instructed legal representatives so long as the approach is 'appropriate' and 'proportionate'. The IFB has already done some work to combine this advice into best practice for their customers
- **identification checks:** the Working Group raised concerns that in PI cases claimant solicitors are not required to carry out client identification and money laundering checks
- **data sharing:** some stakeholders expressed concerns that insurers were not adequately sharing data relating to potentially fraudulent law firms with the SRA. Conversely some insurers claimed that when such evidence was presented, the SRA did not provide information regarding enforcement action. The Taskforce has learned that discussions are already underway between insurers and the SRA in this area. The Taskforce encourages senior level engagement between insurers and the SRA to reduce professional enabler fraud for the benefit of the solicitors' profession and honest claimants

3.25 Although disciplinary action can include the issuing of fines the SRA report that the legislation, built up over a 40 year period, gives it very different powers to issue financial penalties, and other sanctions, from other regulators.

3.26 The SRA argues that it is constrained in its enforcement capabilities because of the high burden of proof that is required to 'prosecute' solicitors suspected of serious misconduct. It is able to make its own enforcement decisions (such as issuing a financial penalty up to £2,000) against the civil standard of proof – that is, on the balance of probabilities. However if it wants to enforce serious sanctions such as suspending or 'striking off' a solicitor, or imposing a substantial fine (above £2,000), it must 'prosecute' the case before the independent Solicitors Disciplinary Tribunal (SDT) which uses the criminal standard of proof, requiring that the case must be proven beyond all reasonable doubt. In considering these issues in another professional services area (health), the Law Commission commented (on requiring the criminal standard of proof) that "*It is not acceptable that a registrant who is more likely than not to be a danger to the public should be allowed to continue practising because a panel is not certain that he or she is such a danger,*"¹⁶ The Taskforce agrees that this high burden of proof is disproportionate, especially when compared to fines other regulators have issued during the period of this review, and may limit the deterrent message that such powers send out. The Taskforce considers that there is no rational justification for this discrepancy, and it may even prevent settlement by fines agreed above £2,000. The SRA suspects that larger firms would prefer to settle cases by agreed fines in the way that has become familiar in other regulated sectors, rather than face lengthy and expensive litigation in the SDT.

3.27 Examples of enforcement action include

- in November 2013 a solicitor was struck off and ordered to pay costs of £100,000 when referrals to an ATE insurer and a medical expert had not been made in good

¹⁵ SRA Code of Conduct IB(1.25) to IB(1.28)

¹⁶ Para 9.61 http://www.lawcom.gov.uk/wp-content/uploads/2015/03/lc345_regulation_of_healthcare_professionals.pdf

faith. The solicitor had directed clients to a particular ATE insurer and had been paid by a medical expert for referrals without passing on the money to their clients (or obtained their agreement to keep it) as they were required to do. It was also found that the solicitor was aware that the medical expert had been preparing medical reports based on telephone interviews with clients, rather than a medical examination

- in November 2015, a solicitor was fined £2,000, the maximum fine that the SRA can levy itself, with £600 costs for breaching the referral fee in LASPO and not having an effective system to supervise and monitor the referrals, as well as the actions of a man who worked for her
- the SRA is bringing several cases arising out of solicitors' involvement in the Axiom Legal Financing Fund collapse in the Cayman Islands which led to multi-million pound losses. In the first case a solicitor was found guilty of numerous allegations including improperly accepting and using £4.8m from Axiom when he was on notice of a serious risk that the investment fund manager was acting improperly and so he unreasonably risked his firm being a party to transactions defrauding Axiom. He was found dishonest, struck off and ordered to pay costs, within an interim payment of £115,000

Nuisance calls

3.28 Much work has already been done to tackle nuisance calls. The Taskforce will seek to build on progress made rather than duplicate existing work.

3.29 The government's Nuisance Calls Action Plan¹⁷ published in March 2014 recognises that tackling this complex problem is a shared responsibility between government, regulators, industry and consumer groups, requiring a multi-faceted response. The plan set out a range of legislative and non-legislative options for reform to reduce the volume of nuisance calls and the associated harm to consumers. Recent actions include:

- lowering the legal threshold at which the ICO may impose a monetary penalty on organisations breaching the Privacy and Electronic Communications (EC Directive) Regulations 2003 (PECRs)
- making it easier for the ICO to share information more effectively with Ofcom in relation to nuisance calls through an amendment to the Communications Act 2003

3.30 The government also announced at March Budget 2015 a £3.5 million package to help stop nuisance calls and is exploring options to provide call blocking devices to people identified as being at higher risk of financial damage and personal distress as a result of nuisance calls.

3.31 Furthermore the government will consult shortly on bringing forward secondary legislation to amend PECRs to require all direct marketing callers to provide valid Calling Line Identification (CLI), so that consumers can determine who is calling them and therefore allow any unwanted calls to be more easily identified and reported to the regulator.

3.32 The regulation of nuisance calls involves multiple regulators. Stakeholders overwhelmingly agreed that there is no coherent strategy to deal with nuisance calls that combines the different regulators. Some also argued for regulators to have stronger powers to deter criminals who trade in unlawfully obtained personal data.

¹⁷ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/299140/Action_Plan.pdf

The Information Commissioner's Office (ICO)

3.33 The ICO is responsible for PECRs and regulates unsolicited direct marketing calls which originate from the UK or are made from abroad on behalf of UK companies. It collaborates with foreign regulators and is developing information sharing schemes with them.

3.34 The ICO has a variety of powers providing a strong deterrent or punishment for those who do not abide by the principles for processing and disclosing personal data. Since 2011 the ICO has had the power to issue monetary penalty notices up to £500,000 for serious breaches of the PECRs. The government removed the legal threshold at which enforcement action can be taken meaning that the ICO no longer has to prove substantial damage or substantial distress by a company before action can be taken.¹⁸ Since the removal of the legal threshold at which enforcement action can be taken, the ICO has issued several large fines

- CMC fined £80,000 for nuisance calls including 470 to one household alone¹⁹
- one of the country's biggest CMCs fined £90,000 for nuisance calls²⁰
- a company was fined £75,000 for making live unsolicited marketing calls to members of the public
- a Swansea-based lead generation company was served a civil monetary penalty of £200,000 in October 2015 for sending thousands of unsolicited marketing text messages. A marketing campaign run by the company in April 2015 prompted 6,758 complaints in just one month
- during the month to the end of October 2015, the ICO had 83 cases under investigation; held one compliance meeting and issued 38 third party information notices

Office of Communications (Ofcom)

3.35 Ofcom is the communications regulator in the UK. It regulates abandoned and silent calls through its Persistent Misuse of Electronic Communications Networks and Services Powers in the Communications Act 2003. The maximum penalty that can be issued by Ofcom under these provisions is £2 million.

Telephone Preference Service (TPS)

3.36 The TPS was set up under the PECRs and is designed to protect consumers from unsolicited marketing calls. Callers from within the UK or from outside calling on behalf of UK companies are legally required not to call a number that is registered with the TPS or those consumers that have previously notified the caller that they do not wish to receive such calls. However if consumers consent to sharing data, for example ticking/ not ticking a box on a form this can override the protections afforded by TPS. Many stakeholders doubted that direct marketing companies were aware of these rules and suspected that even if they were they were often flouted. The TPS is regulated by the ICO.

3.37 Stakeholders highlighted that the TPS is not always effective, callers do not always check the TPS register and only a small proportion of individuals and companies have signed up.

¹⁸ Accessed November 2015; <https://www.gov.uk/government/news/government-cracks-down-on-nuisance-calling-companies>

¹⁹ Accessed November 2015; <https://ico.org.uk/about-the-ico/news-and-events/news-and-blogs/2015/04/personal-injury-claims-company-fined-80-000-by-the-ico-for-unsolicited-nuisance-calls/>

²⁰ Accessed November 2015; http://www.theargus.co.uk/news/13949401.Brighton_based_company_fined___90k_for_breaching_cold_calling_rules/

Claims management companies (CMCs)

Claims Management Regulation (CMR) Unit

3.38 The activities of CMCs in the UK are subject to regulation by the CMR which sits in the Ministry of Justice. The CMR is responsible for ensuring CMCs that contact consumers to offer claims services in relation to financial mis-selling and injury claims do so legally and in compliance with the conduct requirements imposed on them. Existing regulations already prohibit CMCs from cold-calling in person, sending unsolicited text messages to consumers without consent, and contacting anyone registered on the TPS.

3.39 A range of informal or formal enforcement tools are available by law to the CMR under the Compensation Act 2006. This action can range from written advice, warnings and undertakings – when a CMC has committed less serious breaches and is willing and able to comply – through to the variation, suspension or cancellation of authorisation where stronger action is required to address serious breaches.

3.40 In December 2014 the CMR reinforced its enforcement tools with a new power to impose financial penalties on CMCs for rule breaches, including using information gathered by unlawful unsolicited marketing. So far 4 CMCs have been fined over £1.6 million for unlawful unsolicited marketing and coercing clients into signing contracts, without giving them enough time to understand the terms and conditions before taking unauthorised payments. A CMC was fined £850,000 in December 2015 for making millions of nuisance calls in relation to NIHL claims. To date this has been the CMR's largest fine.²¹

3.41 In addition to expanding its enforcement powers, the MoJ gave consumers a new avenue of redress in January 2015 by extending the Legal Ombudsman's jurisdiction to deal with complaints about poor service from CMCs. The Legal Ombudsman now has powers to order compensation, make CMCs reimburse costs, apologise, put things right or to provide other forms of suitable redress, and a power was created for the CMR and the Legal Ombudsman to share information.

3.42 Since April 2013, the CMR has overseen reforms to the regulatory regime including

- banning CMCs from offering financial rewards or similar benefits to potential claimants as an inducement to make a claim **(April 2013)**
- banning the payment or receipt of referral fees between CMCs, solicitors, insurers and others for profitable PI claims **(April 2013)**
- naming online CMCs under investigation and subject to enforcement action, as part of ongoing work to raise industry standards and ensure consumers and businesses are better informed **(June 2013)**
- tightening the Conduct Rules for CMCs to better protect consumers. This included banning verbal contracts and requiring CMCs to obtain signed contracts before taking a fee **(July 2013)**
- appointing the first 2 non-executive board members to the executive-led CMR Board to provide a greater element of external challenge and help ensure continuous improvement **(May 2014)**
- strengthening further the Conduct Rules for CMCs to help tackle abuses in the financial claims sector. Key changes were made around ensuring claims are properly

²¹ Accessed December 2015; <https://www.gov.uk/government/news/company-fined-850000-for-millions-of-nuisance-calls>

substantiated before being pursued and any data received through telemarketing is legally obtained (**October 2014**)

- reinforcing the CMR's enforcement tools with a new power to fine CMCs hundreds of thousands of pounds for rule breaches (**December 2014**)

3.43 The Taskforce also endorses the work that the CMR has undertaken to publish information about its enforcement action in their communications.

Behavioural economics

3.44 Insurance fraud is not just a law enforcement problem but is informed by a number of behavioural factors.²² The Taskforce spoke with stakeholders working in the field of behavioural economics, a method of economic analysis that intersects with psychology, in order to gain insights into the complex drivers of consumer behaviour. These included academics such as Professor James Davey, the FCA and the Behavioural Insights Team (BIT).

3.45 Academics have found that those who commit fraud often feel able to justify their crime by considering it a victimless crime.²³ This is reinforced by the negative public views of the insurance industry, with news stories of bad customer experiences given prominence in the media.²⁴ In addition some consumers take the view that lack of trust is now widespread throughout society, and that they would be foolish to be honest when the chances of being caught are low.²⁵ This is supported by academic research which suggests that fraud has a moral cost.²⁶

3.46 However the chances of being caught and the consequences can be underestimated, as found in recent research into opportunistic fraud. Gill and Randall found that the consequences for insurance fraudsters are not limited to incarceration but include difficulty accessing other financial services such as mortgages and loans; breakdowns in family relationships; and poor future job prospects.²⁷

3.47 On a more positive note there is research which shows that the layout and content of documentation or websites, and the way in which relations with customers are conducted can influence the way in which customers behave. In particular customers can be persuaded to be more open and honest than they might otherwise have intended. The Taskforce appreciates that behavioural economics will not deter planned criminal activity. However it may be possible to discourage opportunistic fraud.

3.48 There are a number of areas of the application and claims process where behavioural principles have and could be deployed to tackle insurance fraud:

- **contract design:** consumers are more likely to be engaged if communications are be tailored to increase readability.²⁸ An 'honesty pledge' could be used including information about how insurance fraud increases premiums for other people and how others in similar situations do not commit fraud.²⁹ Research suggests that

²² 'Occasional Paper No. 1: Applying behavioural economics at the Financial Conduct Authority', FCA, April 2013.

²³ 'Insurance Fraud: Issues and Challenges', Stijn Viaene and Guido Dedene, April 2004.

²⁴ Lithium Technologies Customer Experience Survey 2015

²⁵ 'Insurance Fraud: Issues and Challenges', Stijn Viaene and Guido Dedene, April 2004.

²⁶ 'Fraudulent Claims and Nitpicky Insurers', Jean-Marc Bourgeon and Pierre Picard, 2014.

²⁷ 'Insurance Fraudsters: A study for the ABI', Martin Gill and Amy Randall, Feb 2015.

²⁸ 'OP No. 2: Encouraging consumers to claim redress: evidence from a field trial', FCA, April 2013.

²⁹ 'A Room with a Viewpoint: Using Social Norms to Motivate Environmental Conservation in Hotels', Noah Goldstein, Robert, Cialdini, and Vidas Griskevicius, August 2008.

where contracts are perceived to be 'fair', honesty is encouraged. Where contracts were perceived to be fair, significantly fewer fictitious claims were filed³⁰

- **direct communications:** consumers are able to take action easily and quickly when they receive information at a time that is useful to them, for example if they are suspected of fraud³¹

3.49 marketing campaigns: a wide variety of research shows that the behaviour of others in the social environment shapes individuals' interpretations of, and responses to, the situation; and people often evaluate themselves by comparing themselves to others with whom they share similar personal characteristics (e.g. age, personality, gender, attitudes).³² For example communications could appeal to social norms to deter opportunistic fraud, employing descriptive language, referring to how most people behave in a situation such as "*the majority of policyholders are honest*"; and provincial norms, evocating their immediate surroundings, such as "*join your fellow policyholders in helping to reduce premiums*"

³⁰ 'Contract design and insurance fraud: An experimental investigation', Frauke Lammers and Jörg Schiller, 2010. (Accessed November 2015; <http://nbnresolving.de/urn:nbn:de:bsz:100-opus-4879>)

³¹ 'Occasional Paper No. 10: Message received? The impact of annual summaries, text alerts and mobile apps on consumer banking behaviour', FCA, March 2015.

³² 'A Room with a Viewpoint: Using Social Norms to Motivate Environmental Conservation in Hotels', Noah J. Goldstein, Robert B. Cialdini and Vidas Griskevicius, October 2008.

4 Recommendations

4.1 Insurance fraud comes in all shapes and sizes. Accordingly there is no ‘one size fits all’ solution. These recommendations are designed to tackle different types of fraud, including organised, premeditated and opportunistic fraud at the claims stage; and application fraud when a policy is purchased. As well as these specific recommendations, the Taskforce has made a number of recommendations which cut across all fraud types.

Cross Cutting Recommendations

Improve consumer trust in the insurance sector

4.2 The Taskforce recognises that 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.

4.3 This perception is sustained for a variety of reasons, including poor understanding by some consumers of how insurance works. Particular issues raised by stakeholders included complex documentation, confusion as to how a policy works and misunderstood claims processes. This can make the process of engaging with insurers confusing. For example application and claims forms are not straightforward for many consumers. This can also lead to consumers making honest mistakes which, although are not fraud, may be mislabelled as such by industry fraud departments.

4.4 Where it exists, poor customer service can also undermine trust in insurance companies, particularly as insurance also suffers “bad press”. Media reports are, understandably, more likely to focus on negative stories rather than instances where insurers have offered excellent customer service or day-to-day claims handling. This can give a distorted overall image of insurers to the general public.

4.5 Insurers have also been criticised for practices relating to annual renewals, an issue which has recently been highlighted by the FCA¹ as well as stakeholders. This can result in consumers defaulting to renew products that are not good value or have become unsuitable for their changing needs. Often consumers who negotiate with their insurer at the point of renewal secure a cheaper premium. This can frustrate consumers, who may believe that the cheapest prices should be given to existing customers, undermining trust in the industry. It can also contribute to the perception it is necessary to negotiate with insurers at other stages of the process, including the claims stage. This can lead to consumers providing overly optimistic valuations or exaggerating claims in expectation that insurers will try to haggle down the settlement. Many consumers do not recognise that this behaviour is dishonest, despite being at risk of submitting fraudulent claims.

4.6 Academic research in the fields of behavioural science and consumer psychology has found that those who commit fraud often feel able to justify the action by considering it a victimless crime. The incorrect perception that this crime is victimless is reinforced by the negative public views of the insurance industry, with news stories of bad customer experiences given prominence in the media, and can fuel the false perception that consumers should be entitled to

¹ FCA Occasional Paper No.12: Encouraging consumers to act at renewal (Accessed December 2015; <https://www.fca.org.uk/static/fca/article-type/occasional%20papers/occasional-paper-12.pdf>)

receive a refund of their premiums. Several stakeholders suggested that consumers generally find exaggeration of a genuine claim to be more morally acceptable than out-and-out fabrication of a claim.

4.7 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.

4.8 Stakeholders suggested a variety of ways to improve levels of consumer trust and engagement. The Taskforce considers the most effective way to improve overall levels of trust in the insurance sector is to improve communications with consumers and to make greater use of principles of behavioural economics when designing the customer journey (see 3.48 for examples). All communications should be grounded in the FCA's Principles for Treating Customers Fairly (TCF).

4.9 Clear, well communicated information is vital to ensuring that consumers feel they can trust insurers. The Taskforce recognises that it can be difficult to present information on insurance products in a simple and straightforward way. By watering down legal language insurers run the risk of losing meaning which would not be in customers' best interests. However the Taskforce considers industry can do more through its communications with consumers, for example to manage customer expectations better at the purchasing stage, to ensure they understand what the policy covers and any exclusions when they take out a policy. The CII's 'Made Simple' campaign is a positive industry step towards giving consumers the information they need to better understand the day-to-day insurance policies they buy.

4.10 In June 2015 the FCA published a discussion paper on 'Smarter Consumer Communications'² to signal its appetite to explore opportunities and initiate change in how firms communicate key information to consumers in order to help them make informed decisions. This was followed by a consultation paper in October.³ The FCA are consulting to remove a number of disclosure requirements which it identified as not being effective in terms of informing consumers about a product or service, and to reduce the regulatory burden on firms.

4.11 It is also important that consumers understand what is labelled as insurance fraud. As discussed above, many consumers may not be aware that they are acting dishonestly, or indeed be aware of the potential consequences. The Taskforce notes industry efforts to date to improve consumer information and increase consumer awareness of fraud, such as the "Get a Real Deal" campaign but consider there is more work to do noting that raising awareness requires sustained effort by all interested parties. This communications effort should include promoting the IFB's 'Cheatline' tip-off service, whose success depends in part on consumers being aware that the service exists.

4.12 The Taskforce also applauds the success of 'Claimed and Shamed' – the BBC TV series that captures fraudulent claims on camera – in raising the profile of insurance fraud and acting as a deterrent.

² DP15/5: Smarter consumer communications (Accessed December 2015; www.fca.org.uk/static/channel-page/dp-smarter-comms/dp-smarter-comms-index.html)

³ CP15/32: Smarter Consumer Communications: Removing certain ineffective requirements in our Handbook (accessed December 2015; www.fca.org.uk/news/cp15-32-smarter-consumer-communications)

Recommendation 1: To 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 customers⁴*

Recommendation 2: To ensure 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. This should include increased promotion of IFB's 'Cheatline', highlighting the impact of fraud on honest policyholders, use of the media and trusted intermediaries and communication channels outside of 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

Improve the data available in fraud databases and data sharing schemes

4.13 Historically insurers fought fraud in isolation using small investigation teams and their own limited data to prevent repeat fraudsters. As described in Chapter 3, the industry has increasingly recognised the 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.

4.14 The Taskforce recognises the potential of data sharing schemes and databases such as MyLicence, the MID and CUE, in tackling insurance fraud. However stakeholders suggested that inconsistent, incomplete and/or inaccurate data undermines their effectiveness. Better quantity and quality of data would make fraud easier to detect at every stage of the process, from application to claim. Improved data would also bring benefits for consumers. Making trusted data available at the point of quote would allow customers to rely on objective claims data rather than their memory, streamlining the process and reducing the risk of inadvertent errors which can lead to honest customers being labelled unfairly as fraudsters.

4.15 The Working Group concludes in its report that inaccurate claims records were the most significant obstacle to automated checking of CUE at the point of quote. Given the widespread benefits the Taskforce has concluded that industry should strive to improve the quality and quantity of data in fraud databases. This can be achieved in part by the further adoption of common fraud definitions which will improve the consistency of data records. The Taskforce also recommends that the public should be permitted access to CUE free of charge and have the ability to challenge inaccurate records. While consumers can already access their records by

⁴ Accessed January 2016; <https://www.abi.org.uk/News/News-releases/2016/01/ABI-and-BIBA-launch-industry-Code-of-Good-Practice-to-help-vulnerable-customers>

submitting a subject access request to 'CUE' and 'ask MID', many are deterred by the small fee charged and the fact that the process is not straightforward.

4.16 As well as improving accuracy of claims histories, this important step could improve trust between consumers and insurers and increased publicity could deter opportunistic fraudulent claims. Consumers seeking to change their records would need to prove their case and an oversight and appeal mechanism would need to be created and advertised.

4.17 In its report, the Working Group notes that there is strong anecdotal evidence that insurance fraudsters understand and seek to exploit weaknesses in existing databases. In particular records cannot be robustly identified so fraudsters can conceal or manipulate their identity to avoid detection. This suggests that while databases may be useful in combatting opportunistic and accidental fraud, they may be less effective in tackling deliberate and committed fraudsters.

4.18 The Working Group suggests that these identification problems are the result of inadequate processes, noting in particular that solicitors are not required to identify their clients. In response the Working Group suggests that insurers and solicitors should conduct checks similar to those required for money laundering. Greater use of unique identifiers such as National Insurance (NI) numbers, Driving Licence Numbers (DLN) and Ordnance Survey (OS) National Grid references could also make it more difficult for identities to be concealed and could be cross referenced with other data provided by customers to validate their authenticity. This could assist insurers in validating genuine claimants and speed up delivery of compensation to genuine consumers, as well assisting DWP in identifying possibly fraudulent use of NI numbers. Issues and concerns regarding privacy and data protection laws has prevented the Taskforce reaching a firm conclusion regarding the use of NI numbers or DLNs, though greater use of publically available OS references may merit further investigation by insurers.

4.19 Investing in the systems to utilise data sets inevitably carries a cost for insurers. The Taskforce has been told that many in the industry under-use commercially available and urges insurers to consider what more they can do to ensure data is used to its full potential. By using the data more intelligently, insurers are able detect and prevent fraud at application and claim stage, make better use of limited resources and have a greater chance of catching those involved in organised networks.

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.*

increasing membership of existing anti-fraud scheme and databases including MyLicence and CUE

Ensure data is shared appropriately

4.20 Organised fraud often exists across sectors and the Taskforce recognises that to solve the problem of fraud, insurers cannot act alone. Insurers must collaborate and share data with other sectors including claimant solicitors, wider financial services and the public sector, especially government departments, such as DWP and HMRC, given links between organised crime and benefits fraud and tax evasion.

4.21 The ABI have already agreed to share PI data from CUE with claimant solicitors through askCUE PI to validate information provided to solicitors by potential clients. The Taskforce endorses this initiative. Meanwhile, the government is considering establishing the Counter Fraud Checking Service (CFCS), a proposed database of known fraudsters to make possible public-private sector sharing of data that would help prevent fraud, by sharing information on known fraudsters with banks and insurance companies in a way that complies with data protection legislation. The database should provide new opportunities to share data among the wider financial services sector which should be explored by insurers and the ABI in due course.

4.22 The Specified Anti-Fraud Organisations (SAFO) status, designated by the Home Office under the Serious Crime Act, is a positive step towards enabling SAFO organisations to share anti-fraud data, especially with the public sector. However a number of industry stakeholders stated that some government departments, such as DWP and HMRC, could do better in reciprocating data sharing. Although the Taskforce recognises that HMRC have a statutory duty of confidentiality set out in legislation, it should look at routes for more effective data sharing, for example in areas such as law enforcement.

4.23 With regards to privacy laws and concerns, the Taskforce recognises that data sharing practices should respect the sensitive nature of consumers' personal data. Collection and analysis of personal data must only take place within a secure framework within which individuals are protected, in a way that is proportionate and as transparent as possible. For this reason data protection laws including the Data Protection Act 1998 and European legislation⁵ need to be understood and used, rather than feared or blamed; and checks and balances need to be made clear, otherwise there is a danger that the industry will create information systems that consumers fear, do not understand and, over which people feel they have insufficient control.

4.24 Throughout the review it became clear that a number of organisations were wary of sharing anti-fraud data and did not fully understand what was permitted within current data protection laws. The regulatory landscape continues to change with the introduction of the new EU legislation in this area. This has inhibited effective anti-fraud data sharing practices, with firms uncertain of what data they can share with regulators, including the SRA. An effective and proportionate approach to privacy should recognise that legitimate data sharing for fraud prevention and detection purposes is in the public interest.

4.25 The Taskforce agreed that a coordinated effort at providing guidance on UK and EU data protection laws would ease concerns about breaches and improve data sharing practices.

Recommendation 4: *In light of forthcoming EU regulations,⁶ the ICO should provide the insurance industry and others with clear guidance on data sharing practices in relation to insurance fraud*

⁵ Privacy and Electronic Communications (EC Directive) Regulations 2003 (PECRs)

⁶ General Data Protection Regulation (GDPR)

Coordinate and share best practice

4.26 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. While the Taskforce does not want to dampen the incentive for firms to take an innovative approach to tackling fraud, it considers that individual action is not enough and, as an industry wide problem, fraud requires coordinated action to combat effectively. Individual firms' efforts could be made much more effective by sharing best practice on anti-fraud measures.

4.27 The industry already has a mechanism by which it identifies its key threats on an annual basis and the Taskforce recommends that as part of that process, it agrees the key areas for each forthcoming year where such guidance should be issued. As a first step, the cross-sector Good Practice Guide on application fraud is being reviewed and will be published in 2016.

4.28 Throughout the review, the Taskforce has identified positive practices to tackle fraud (see 3.7 for examples). A key example of good practice identified by stakeholders to tackle fraud is assigning board level ownership of the issue of insurance fraud. As discussed in Chapter 5 different departments of insurers can sometimes have competing objectives and without effective oversight and direction, their activities can be counterproductive. For example incentives to increase sales may not be properly coordinated with claims and fraud departments. By assigning Board level ownership and ensuring responsibility rests with the most senior decision-makers, firms are better placed to manage potential conflicts of interest between departments and to establish a culture and strategy for tackling fraud. It is for individuals firms to decide their own governance structures, but in practical terms the Taskforce considers that fraud would appear on the risk register and be a standing item at Board meetings.

4.29 The Taskforce is aware that the FCA are proposing amendments to the FCA Handbook⁷ that will amend the reporting requirements and submission methods for some firms. For the first time, many firms will be required to complete a financial crime return⁸ including questions on resources to tackle financial crime, suspicious activity reports and prevalent fraud typologies. The Taskforce endorses these changes and suggests that in the future the FCA should consider whether fraud should be given greater weight in financial crime returns.

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

⁷ FCA CP15/42: Quarterly Consultation Paper No. 11

⁸ Appendix 6: 16 Annex 42AR

Take a more robust approach to defending claims

4.30 The Taskforce recognises that some insurer behaviours and practices may fuel a perception that insurance fraud is relatively low risk. For example for some minor whiplash claims, insurers find that once court proceedings are started it is cheaper to settle the claim even if the circumstances and lack of evidence suggest it may be potentially fraudulent. Many insurers also settle PI claims before they ever reach court and without seeing supporting medical evidence, also with the aim of reducing costs. This is known as a pre-medical offer. On a case-by-case basis, these can be viewed as rational commercial decisions, but systematically settling claims in these ways can encourage the view that insurance fraud is “easy money”, undermining anti-fraud activity elsewhere in the organisation.

4.31 In some circumstances these issues can be exacerbated by short term incentives that encourage claims staff to expedite payment at the lowest cost in order to improve the customer journey, but potentially undermine counter fraud activity elsewhere in the firm. Firms should ensure that incentives and objectives between departments are aligned, including where necessary through their internal accounting procedures. Recommendation 6 should go some way toward tackling these issues.

4.32 Some members of the Taskforce and many stakeholders suggested that unless the medical evidence process is reliable, there is no incentive for insurers to wait for medical evidence before making an offer of settlement. In the past this has been a particular problem for minor whiplash injuries, where insurers have not had confidence in medical diagnoses. The Taskforce notes the substantial work undertaken by MoJ to reform in this area with the establishment of MedCo and accreditation of MROs which has made the medical evidence process much more robust. In this context, the Taskforce considers there is a strong case for insurers to reduce the number of pre-medical offers.

4.33 Some insurers have taken the decision to defend all court proceedings where they suspect the claim is fraudulent. They balance the short-term additional costs against the longer-term benefits of discouraging fraudulent claims. Some obtain ‘fundamental dishonesty’⁹ decisions meaning that the claimant has to pay the defendant’s costs.¹⁰ This sends a clear warning to those considering submitting exaggerated and fraudulent whiplash claims.

Recommendation 8: The ABI should discourage the inappropriate use of pre-medical offers

Recommendation 9. The insurance industry as a whole should consider following the established good practice of some insurers in defending court proceedings where they believe the claim is fraudulent

Consider legal changes to reduce exaggerated or fraudulent late claims

4.34 A significant number of minor PI 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

⁹ Criminal Justice and Courts Act 2015

¹⁰ Accessed November 2015; <http://www.aviva.com/media/news/item/uk-aviva-reaches-milestone-in-fight-against-dishonest-whiplash-claims-17361/>

fraudulent. Difficulties in establishing the veracity of such claims mean it is difficult to produce statistics on how many are in fact bogus.

4.35 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 Taskforce therefore considers that further work needs to be undertaken ensure that any late exaggerated or fraudulent claims not addressed by whiplash reform are discouraged.

Recommendation 10: The government should review how fraudulent late claims can be discouraged 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 (SCT)*
- *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*

introducing a rebuttable evidential presumption that no injury was suffered where claims are lodged after a specified period of time has elapsed since the alleged accident¹¹

Be responsive to emerging fraud risks

4.36 Fraud is constantly evolving as criminals and opportunists find new ways to cheat the system. To some extent there is a latent “demand” to commit fraud and the Taskforce accepts that pressure on certain types will inevitably mean that others expand or emerge. With substantial reforms to whiplash on the horizon, which has been a very substantial source for fraud, there is a risk that fraudsters move further into other areas.

4.37 One particular area for concern for the Taskforce which was also raised by several stakeholders, is the potential for fraud linked to rehabilitation. There is a risk that removing the right to general damages for minor whiplash injuries, may push fraud to other parts of the claims chain, for example fraudulent rehabilitation providers who may inflate invoices or add on treatment such as physiotherapy as part of a claim where it is not needed.

4.38 The Taskforce is aware of similar problems in the USA but concluded that there was not sufficient evidence in the UK to make a specific recommendation. Instead the Taskforce recommends that the scale of the problem must first be established before deciding what further measures are needed whilst accepting that the US experience is a warning. The Taskforce also notes that MedCo has only recently been established and considers that it may not be appropriate expand its remit at this early stage.

4.39 Arson was also highlighted as a possible source of fraud. Although there is much activity on risk management and prevention by the insurance industry, and some examples of successful enforcement¹², there are complexities in calculating the cost of arson fraud to society. The Taskforce recognises that the scale of the problem must first be established before deciding what further measures are needed.

¹¹ For example if a soft tissue injury claim was made over 1 year from when the accident occurred it is to be presumed that no injury was suffered unless the claimant can provide contemporary evidence such as GP notes or A&E visit, or time off work

¹² Such as by Norfolk Constabulary in August 2014 and Merseyside Police setting up a specialist team to target arson fraud in 2009

4.40 The Taskforce believes it is of utmost importance that insurers remain alive to emerging fraud risks.

Recommendation 11: The insurance industry should remain vigilant to emerging fraud and should coordinate its engagement with government through the ABI

Claims Fraud

4.41 Recommendations aimed at tackling claims fraud have been grouped under two broad headings: premeditated and opportunistic fraud.

Premeditated fraud

Improve cross cross-industry coordination

4.42 For the purpose of this report, premeditated fraud is that which is planned in advance by people with a specific objective of submitting or encouraging false claims. Often such fraud is planned, coordinated and/or conducted by people working together on a continuing basis. The most high profile example of premeditated fraud is 'crash for cash' scams which remain a serious problem for the insurance industry and are a major contributor to the overall scale of insurance fraud.

4.43 Many of the recommendations in the previous section aimed at improving data quality and sharing should bring substantial benefits to individual firms in their efforts to identify and prevent all types of fraud. But the organised and planned nature of premeditated fraud, which in some cases involve serious organised criminals, means tackling it effectively requires a cross industry coordination.

4.44 The Taskforce supports the insurance industry in their continued investment in industry initiatives, such as IFED, IFR and IFB. Most recently the Taskforce welcomed the news that the insurance industry agreed in November 2015 to support the future IFB strategy.

4.45 The IFB leads the industry's collective fight against organised insurance fraud, working closely with IFED. Stakeholders overwhelmingly agreed that there is strong technical fraud expertise in the industry and a common interest in disrupting fraud. Reflecting this important coordination role, many stakeholders suggested that the IFB should act as a central data hub, facilitating access to the wide range of available data sets.

4.46 A well-run central hub would respect the sensitive nature of data and allow access to appropriate data for insurers and other industry stakeholders. The IFB would need to build and maintain any infrastructure that was needed and would be responsible for determining and expanding membership. Once established, the system could be relatively self-servicing as it would not require the IFB to hold every piece of information, but rather act as a portal to other data sets. The Taskforce recognises that many of the data sets are commercial operations and as such, providing access to IFB in this way may not be straightforward. However in view of the strong body of support from stakeholders and members, the Taskforce considers that the IFB should establish itself in this role as a central data hub.

4.47 As with individual insurers, the IFB could be more effective if provided access to more comprehensive data. This is distinct from its role as a data hub, in that the IFB needs access to data for its own proprietary fraud detection and prevention work. At present, the IFB does not have access to Claims Portal data which is a rich source of information including details on the

claimant and their injuries, vehicle damage, rehabilitation provision and a description of the accident. Importantly, claims notification forms are completed by claimant representatives and so could help identify and catch the minority which are professional enablers and other organised criminals.

4.48 The insurance industry has invested significantly to establish IFED and continued investment will enable it to continue to lead and drive the national police response to insurance fraud, bring more criminals to justice and challenge the public perception that insurance fraud is a victimless crime. In turn, IFED has engaged with regional forces – in particular through coordinated ‘days of action’ activity – and re-energised regional forces efforts to combat insurance fraud. The Taskforce considers that regional forces should continue to prioritise combatting fraud and note that police funding will need to be available.

Recommendation 12: The insurance industry should support the development work needed to evolve the IFB into a holistic intelligence hub and ensure timely contribution to the evolved dataset

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

Tougher action against dishonest solicitors

4.49 The SRA has a key role in tackling premeditated fraud. Although the vast majority of claimant solicitors are honest and competent, fraudulent claims often require the involvement of a solicitor. Fraudulent claims can be enabled either through incompetence, or by deliberate and dishonest behaviour. It is alleged that there are even some cases where law firms are set up by criminal gangs to assist them in their scams. With responsibility for upholding the integrity of the legal profession, and ensuring solicitors comply with the law, the SRA clearly has a duty to tackle solicitors acting as professional enablers. Yet many stakeholders criticised the regulator, saying it is not doing enough to take enforcement action against solicitors involved in fraud. One issue that stakeholders, including solicitor members of the Working Group, commonly raised is that the SRA Handbook does not stipulate what checks claimant solicitors are required to carry out for their clients in PI cases. The SRA has stated that although appropriate fraud protection and anti-money laundering checks are not stipulated, they are implicitly covered by their general principles.¹³ Another issue commonly raised was that the SRA does not enforce the ban on referral fee introduced by LASPO as effectively as it could.

4.50 The SRA has raised concerns that its enforcement and fining powers are not consistent with those of other regulators such as the FCA, CMR and ICO. For example the SRA can currently fine alternative business structures £250 million but can only fine a traditional solicitors’ partnership £2,000. Higher fines or “striking off” require a prosecution before the independent Solicitors Disciplinary Tribunal (SDT). While the SDT has unlimited fining powers, it considers cases on the basis of the criminal standard of proof, meaning the case must be proven beyond all reasonable doubt. That makes it difficult to impose high financial penalties and more importantly means that those who are dishonest on the balance of probabilities (the civil standard of proof) can continue to practice. This undermines the strength of the regulator, and means its enforcement actions may not act as a credible deterrent.

¹³ SRA Principle 1: ‘uphold the rule of law and the proper administration of justice’

4.51 The Taskforce also believes that the SRA could make greater use of its 'naming and shaming' powers which can act as a powerful deterrent. Research on insurance fraud¹⁴ and behavioural economics has demonstrated that the threat of reputational damage can be highly effective in discouraging premeditated fraud. Research also suggests that highlighting the consequences and impact of fraud on others i.e. that it is not a 'victimless crime' is also effective in deterring future fraudsters, especially opportunistic fraudsters. Examples of good practice in this area includes the communications strategies of the CMR and ICO to publicise large fines against nuisance callers in the mainstream media.

4.52 The Taskforce recognises that the SRA has a difficult task. Firms operating a corrupt or fraudulent business model make up only a small minority of the 130,000 individuals and 10,000 firms that the SRA supervises. The SRA has limited resources and such firms may not be obvious to SRA as part of its normal supervisory activity. Insurers have access to intelligence and data which, if shared with the SRA, would make them much more effective in identifying and challenging fraudulent firms. Discussions are already underway between insurers and the SRA regarding how to share information about law firms suspected of insurance fraud.

4.53 Given the IFB's unique position in the market and access to information, the Taskforce believes it is well placed to coordinate the exchange of data, by acting as intermediary between insurers and SRA. This will ensure the information is used intelligently and the SRA is put in the strongest possible position to take action against dishonest solicitors.

4.54 Several stakeholders suggested that small changes to claims notification forms (CNFs), could potentially make it easier for the SRA and insurers to identify fraudulent claims. At present, the forms, which solicitors submit to the Claims Portal for low value PI claims, do not require solicitors to disclose details of the referral source. Requiring firms to disclose referral sources would allow insurers to identify those from 'claims farmers' and other questionable sources and scrutinise the claims more closely and refer dishonest solicitors to the SRA.

Recommendation 14: The government should

- *consider strengthening the fining powers of the SRA for 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 including by

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

¹⁴ 'Insurance Fraudsters: A study for the ABI', Martin Gill and Amy Randall, Feb 2015.

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, the government should consult on introducing a mandatory requirement for referral sources to be included on CNFs and claims should only proceed where CNFs are complete. Insurers should share data with the SRA and CMR if they suspect claimant representatives of breaching the referral fee ban

Improve communication between insurers and the regulators of professionals that enable fraud

4.55 As stated above, a small number of solicitors commit premeditated fraud. One type of fraud is where a solicitor acts without genuine instructions in order to take forward a claim.

4.56 It is good practice for claimant representatives to notify defendants that they have received instructions from their client however several defendant representatives raised concerns that this does not always happen. As a result some insurers and defendant solicitors contact claimants directly to ask them whether they have instructed legal representatives, despite being unsure about whether this is permitted. The SRA has confirmed that this behaviour is permitted as long as the approach is 'appropriate' and 'proportionate'. The IFB has already done some work to combine this advice into best practice for their customers.

Recommendation 18: The ABI, in conjunction with the IFB, should produce guidance to its members setting out what forms of direct contact is acceptable with the alleged claimant if they suspect that legal representatives are acting without instruction

Recommendation 19: Claimant and defendant representatives (APIL, MASS, FOIL and ABI) should produce a standard letter in conjunction with the SRA and IFB for insurers to send to claimants directly to verify whether they have instructed a firm to represent them

Opportunistic fraud

4.57 Whereas recommendations aimed at tackling premeditated fraud focused strengthening the resources of enforcement bodies and disrupting fraud at a macro level, recommendations aimed at tackling opportunistic fraud focus on disrupting unscrupulous intermediaries that pressurise usually honest people into making fraudulent claims, such as for personal injuries that never occurred. The Taskforce also believes that opportunistic fraud will be reduced if trust between industry and consumers is increased (see Recommendations 1 and 2).

Strengthen regulation of claims management companies (CMCs)

4.58 At Summer Budget 2015, the government announced a fundamental review of the regulation of CMCs, led by Carol Brady. The Taskforce fully endorses this review, which is a necessary step towards tackling the numerous examples of poor practice which were highlighted by stakeholders. While CMCs do assist people in bringing claims who would

otherwise not be made and thereby play a positive role in facilitating access to justice, CMCs came under heavy criticism in responses to the call for evidence and in the Working Group as being responsible for encouraging unnecessary or bogus claims. The Taskforce is concerned that poor practice by some unscrupulous CMCs plays a central role in encouraging otherwise honest people to fabricate or exaggerate injuries.

4.59 As the review by Carol Brady is not yet published, the Taskforce highlights key concerns raised by stakeholders but does not seek to prescribe how such concerns may be resolved. Progress following the publication of this report and the review by Carol Brady will be a matter for the legacy vehicle proposed in Recommendation 26.

4.60 Common concerns raised by stakeholders include:

- the recent ban on referral fees has failed to take effect as lawyers continue to receive emails from CMCs offering claimant details and the SRA does not rigorously enforce compliance
- banned CMCs often re-emerge under different guises, in a practice known as “phoenixing”
- marketing companies, MROs and most credit hire companies are not currently regulated
- the CMR does not have adequate resources or powers, and an independent regulator may be better suited to the regulation of CMCs
- the Working Group would welcome better regulation of how and where CMCs obtain data, including those who operate from abroad

Recommendation 20: The government should establish a stronger regime for CMC regulation and ensure that it has adequate resources and powers to do its job effectively. In particular the regulator should

- *effectively police the referral fee ban*
- *prevent the use of "phoenix" companies*
- *consider how to deal with those organisations providing claims management services outside the regulated sector*
- *liaise with the ICO regarding the abuse of data protection rules*

maintain a robust regime to ensure those regulated are run by fit and proper persons

Clamp down on nuisance calls that encourage fraudulent claims

4.61 One tactic some CMCs and other intermediaries use to encourage opportunistic claims fraud is nuisance calls. This is termed ‘claims farming’. The strategy on nuisance calls and texts thus far has focused on their annoyance, not the economic harm they inflict on the UK economy through the encouragement of fraud.

4.62 Responsibility for regulating nuisance calls and texts falls to ICO and Ofcom. Some stakeholders argued that these regulators need stronger powers, particularly in relation to criminals who trade in unlawfully obtained personal data. Furthermore many stakeholders were unclear about how the responsibilities of the regulators overlapped. Stakeholders

overwhelmingly agreed that there does not appear to be coherent strategy that cuts across the patchwork of regulators who regulate different types of nuisance calls and texts. The Taskforce is reassured by recent enforcement activity that the ICO and Ofcom's powers are sufficient to tackle the obvious issues with nuisance calls, but does believe that better coordination between the relevant organisations would help them become more effective.

4.63 There are a number of ways in which personal data about consumers is dishonestly obtained by CMCs and other nuisance callers including theft and illicit purchases. Often data is purchased from organisations removed from the claims process who have obtained through it through legitimate means. For example consumers may give consent to sharing their data by ticking a box on an unrelated website. It is clear that many consumers are unaware of the consequences of giving consent to use of their data. Under forthcoming EU regulations¹⁵ opt-outs will no longer be an acceptable form of consent.

4.64 Currently the ICO's Direct Marketing Guidance among other things, stipulates a 6 month time limit for businesses to use personal data obtained in this way. The Taskforce believes that putting this on a statutory footing could reduce the amount of data in the system traded about consumers. This should in turn reduce the amount of nuisance calls consumers receive.

4.65 As well as making nuisance calls themselves, some CMCs purchase leads from third parties, despite this being forbidden by the referral fee ban. Some such third parties are based overseas meaning they are able to avoid regulation by UK authorities. This makes it difficult to tackle the source of the nuisance calls. Instead the Taskforce believes more needs to be done to tackle demand for nuisance tactics. More robust enforcement of the referral fee ban would cut off the economic incentive for nuisance callers and lead to a reduction in call volumes.

Recommendation 21: The government should

- *develop and deliver a coherent regulatory strategy to tackle nuisance calls that encourage fraudulent personal injury or other claims, in partnership with the CMR, IFB, ICO, ABI, Ofcom and SRA*
- *put the ICO's Direct Marketing Guidance on a statutory footing*

Recommendation 22: The ICO should

- *work with regulators operating in countries where nuisance calls are commonly sourced to tackle nuisance calls internationally*
- *coordinate a communications strategy to inform consumers what giving consent to use of their data means in practice*

Tackle fraudulent claims for noise induced hearing loss (NIHL)

4.66 Stakeholders reported that NIHL claims are one example of claims that are commonly 'farmed'.

4.67 In recent years, statistics show an increase in the number of notified NIHL claims (see Table 2.E to 2.G) and insurers have reported that a large percentage of these are rejected (as many as 85%). This suggests that many of these claims are exaggerated or fraudulent. In addition, the

¹⁵ The General Data Protection Regulation (GDPR)

costs of these claims are substantial. For every £1 paid to the claimant, over £3 was paid to their lawyer.

4.68 The government is concerned about the number and cost of NIHL claims and the Ministry of Justice has asked the Civil Justice Council (CJC) to consider the issue and make recommendations this year. The Taskforce has therefore decided that it would be not be appropriate to make specific recommendations on this topic and instead looks forward to seeing the CJC recommendations in due course.

Recommendation 23. The government should consider introducing a fixed recoverable costs regime for noise induced hearing loss (NIHL) claims

The Taskforce endorses and supports the CJC's investigation into how a fixed recoverable costs regime for NIHL cases (and perhaps other similar cases) might work, and how the handling of NIHL claims might be improved by both claimant and defendant representatives (including how evidence is obtained and presented), and recommends that this work should include consideration of quality standards and/or other thresholds for medical evidence

Application fraud

4.69 Overall responsibility for spotting and preventing fraudulent applications ultimately rests with insurers, however many consumers buy insurance through price comparison websites (aggregators) rather than direct from their insurer, where there are fewer barriers to application fraud. The Taskforce understands that this is a significant problem. As many as one-third (35%) of insured motorists believe that it is acceptable to omit or adjust data to reduce their motor insurance premiums on application.¹⁶

4.70 This means that aggregators are uniquely positioned to spot certain suspicious consumer behaviours. For example some consumers manipulate their application details to achieve a cheaper quote. In many cases this can be part of legitimate efforts to shop around, but it can also be a tell-tale sign of application fraud, for example where driving offences have been modified or omitted. The Taskforce understands that aggregators do not currently share intelligence with insurers on suspicious consumer behaviour as effectively as they could.

4.71 The Taskforce recognises that there is a balance to be struck. Aggregator efforts to tackle application fraud at the point of quote should not come at the expense of hampering shopping around which could stymie competition in the market, but aggregators should make much greater use of fraud databases such as CUE and data sharing schemes such as MyLicence. Further to the anti-fraud benefits, the Taskforce would also expect efficiency savings as aggregators would need to search such databases only once, rather than multiple searches by each quoting insurer.

4.72 The Taskforce recognises that at present there is little incentive for aggregators to use such databases and data sharing schemes as the data can be inaccurate and checking them can slow the quotation process, disadvantaging them against competitors. Furthermore aggregators do not have such strong commercial incentives as insurers to counter insurance claims. However in view of their unique position in the market the Taskforce has concluded they must play a greater role in the fight against fraud and urges constructive dialogue between insurers, the IFB and aggregators around anti-fraud data sharing. If nothing can be achieved within a reasonable time

¹⁶ Accessed November 2015; <http://www.lexisnexis.com/risk/uk/newsroom/15-11-23-motor-insurance-fraud.aspx>

the FCA should consider whether to intervene in support of their general requirement for firms to combat financial crime.

Recommendation 24: Aggregators should establish the use of existing fraud databases and data sharing schemes on a consistent basis in order to improve the industry's ability to detect fraud at the point of quote

Recommendation 25: Aggregators should proactively engage with insurers and come to a collective data sharing agreement to tackle insurance fraud in order to detect suspicious consumer behaviour at the point of quote. This initiative should be coordinated by the IFB

Legacy vehicle

4.73 Throughout the review it was noted that there is not enough dialogue between different sectors such as insurers, brokers, aggregators, regulators, solicitors and consumer organisations, regarding insurance fraud.

4.74 One of the most positive aspects of the Taskforce has been its ability to bring together broad and disparate groups of stakeholders around a common issue. This is most clearly reflected in the work of the Working Group. Historically claimant and defendant solicitors have an adversarial relationship, however working together on fraud in the personal injury space, there were many areas where agreement was made, and collaboration and challenge were key to refining their recommendations.

4.75 Taskforce recommendations will only be effective if named parties take them forward. Establishing a legacy vehicle is key to ensuring continued engagement between parties, that recommendations are implemented and that insurance fraud stays on the agenda after the publication of this report.

Recommendation 26. The government should establish a legacy vehicle to ensure that Taskforce recommendations are implemented

The legacy vehicle should continue the effective dialogue between different stakeholders regarding insurance fraud and should be made up of industry representatives similar to that of the Taskforce. It should review progress against these recommendations and fraud developments generally and should report to government once a year initially for 3 years. It should produce an annual report to government on progress and areas that need to be improved

5 Other issues

5.1 The Taskforce has made a number of general and specific recommendations (see Chapter 4) which will do make further progress in combatting insurance fraud.

5.2 However in the course of the work of the Taskforce, a number of stakeholders made broad observations on the UK legal system, which covers England and Wales, compared to other countries, such as France and Sweden, whose legal systems markedly reduce the propensity for fraudulent claims;¹ as well as insurance market behaviour and practices. On occasion the Taskforce has made recommendations which are connected to these observations. On others the Taskforce has not, either because they have been considered outside its terms of reference (see Annex A), or because it is thought that they require further thought and consultation. Many stakeholders raised concerns about elements of the legal system, in particular the way in which it works to provide compensation for personal injuries such as whiplash. The Taskforce established a Personal Injury Working Group to review insurance fraud within the current system and it has adopted some of their recommendations.

5.3 Interestingly concerns about the legal current system were not divided between those who represent claimants on one side and those who represent insurers on the other. There were some on both sides who had concerns and others who wished to retain much of the current system.

5.4 As noted earlier the Taskforce did not consider it appropriate to make recommendations about the legal system which would affect honest and dishonest policyholders alike. Such recommendations require specific consultation and would involve a stakeholder group that would include members who have not been involved with the Taskforce.

5.5 The Taskforce supports the government's proposals at Autumn Statement 2015 to increase the Small Claims Track limit for PI claims from £1,000 to £5,000. Many stakeholders raised this with the Taskforce noting that the limit had in effect been eroded by inflation since its introduction in 1991. A range of views were expressed, but most claimant solicitors opposed an increase and most insurers were supportive of an increase, with stakeholders suggesting an increase either to £5,000 or even £10,000 in line with other types of claim. The Taskforce considers that there is a delicate balance to be struck. Setting the limit at the wrong level could lead to claims being spuriously inflated to exceed the increased limit or disadvantage consumers by causing solicitors to withdraw from the PI market.

Limitation period

5.6 Some stakeholders recommended reducing the limitation period from 3 to 1 or 2 years for certain minor personal injuries such as some whiplash.

5.7 The Taskforce has some sympathy with this view, in recognition that there is a correlation between late claims and fraud. However there can be valid reasons for making claims late, so the Taskforce considers these issues are best addressed though alternative methods, such as those described in Recommendation 10 for tackling late claims.

Alternative business structures

5.8 Some stakeholders raised the issue of insurer owned law firms often referred to as alternative business structures. This is not a topic where the Taskforce considers it appropriate to

¹ These include shorter limitation periods, tables of predictable damages, less involvement of lawyers and time limits for medical examinations

make any recommendations. However the Taskforce does observe that it may be difficult to make a case that the current legal system operates in a prejudicial way whilst at the same time seeking to exploit it.

Devolution

5.9 Matters relating to financial services are reserved, while the legal systems in Scotland and Northern Ireland are devolved. Given time constraints, the Taskforce has not considered devolution issues in detail however it is important to note that Scotland in particular has not experienced the same high levels of whiplash as other parts of the UK. Although the Taskforce has focused on England and Wales, its recommendations may also have implications and benefits for other parts of the UK.

Market practice

5.10 It is not the role of the Taskforce to advise insurers how to run their businesses. However there were some common themes that came from stakeholders and stakeholder meetings. Some have resulted in a recommendations and are dealt with elsewhere and others are set out here by way of general comment.

Best practice

5.11 The Taskforce considers that there are a number of best practice business management issues that insurers should consider.

5.12 The Taskforce believes that in accordance with the FCA requirement to counter financial crime, fraud prevention should be a senior management concern rather than being seen as a technical issue or at best as a means of obtaining a short term competitive advantage. Proper resource in terms of people and IT investment need to be dedicated to counter fraud activity over a long term.

5.13 Incentives that may encourage fraud also need to be considered. Short term incentives to encourage claims staff to expedite payment at the lowest cost may “improve the customer journey” but will undermine counter fraud activity elsewhere. Cost should be properly accounted for internally. It makes little sense to encourage behaviour in one area and spend money in another to counter it. Should claims staff be responsible for dealing with fraudulent claims or should suspicious claims be referred to another team?

5.14 Insurers also need to look very carefully at their supplier arrangements. If these provide an incentive to “short change” the policyholder then despite any service level agreements to the contrary that is what will happen. Such behaviour will reinforce policyholder suspicion and encourage exaggeration and opportunistic fraud.

5.15 There appears to be a link between application fraud and subsequent claims fraud therefore deterring application fraud should reduce claims fraud. Insurers should ensure sales and marketing initiatives are closely coordinated with claims practices and fraud prevention. Fraudsters move quickly. They do not need to make a business case and they are often technically adept. Weaknesses will be quickly exploited. Insurers should review their distribution methods and incentives for much the same reason.

5.16 Both the FOS and the CII record that the majority of consumer and SME “disputes” relate to the policyholder’s failure to understand the policy that they have purchased. That is not entirely the fault of insurers but more could be done to improve the clarity of documentation

and the language used. The CII 'Made Simple' is a useful initiative and much good work has been done. However a lack of understanding breeds a lack of trust and an excuse for those minded to do so to commit opportunistic fraud.

5.17 The Taskforce is aware that good research has been published about consumers and behavioural economics and considers it would be worthwhile for insurers to review their documentation, sales and claims processes with consumer behaviour in mind.

5.18 Specifically some stakeholders raised the issue of dual pricing in motor insurance. Introductory offers are of course common in all areas of business. However the practice has widened to many renewal quotes where no introductory offer is involved. If the price at the start is regarded as negotiable then policyholders will regard it as likely that any claim will be too and adjust their figures accordingly.

5.19 In a similar vein the Taskforce recognises that insurance is often bought in a depersonalised way and that insurers are regarded by many policyholders as faceless large businesses. Fraud is regarded by some as a way of "getting their own back" and a victimless crime. In fact at a very basic level insurers have no money themselves but are the custodians for a fee of all their policyholders' money. Fraudsters do not take money from some remote company; they take it from their friends and neighbours. The Taskforce encourages efforts to inform policyholders about the way in which insurance works, and about fraud, but recognise that the message will always be a difficult one for the industry itself to promote as it will be seen as having a vested interest. More neutral comment is required through the media, education and by government.

5.20 The role of insurance in society is likely to increase in the future if public spending is to be restrained. To be fully effective policyholder trust and understanding needs to be enhanced and the incentives for fraud whether organised or opportunistic need to be discouraged and curtailed.

A Terms of reference

Aim of the taskforce

A.1 To investigate the causes of fraudulent behaviour and recommend solutions to reduce the level of insurance fraud in order to ultimately lower costs and protect the interests of honest consumers.

Focus

A.2 The taskforce will be expected to recommend solutions which would lead to a long-term reduction in the level of insurance fraud. It will not concentrate on specific lines of insurance but will instead consider fraud in the round. Solutions may be legislative, regulatory or industry-led.

A.3 The taskforce will focus primarily on solutions which address the following issues:

- i) the perception among some consumers that insurance is 'fair game' and that insurance fraud is a legitimate way of making some money;
- ii) the extent to which insurance fraud is encouraged (or not deterred) by existing practices of those involved in the claims process (including insurers, solicitors, claims management companies and other intermediaries); and
- iii) aspects of the current legal or regulatory framework which could be strengthened to prevent insurance fraud.

A.4 The taskforce will take the following into account when considering the merits of possible solutions;

- i) the potential long-term benefits against the potential long-term costs;
- ii) whether the solution would have an adverse impact on consumers and if so, whether action could be taken to mitigate this;
- iii) whether the solution is robust or could be undermined;
- iv) if raising barriers to fraud in certain areas will simply lead to an increase in fraud in other areas.

A.5 The overarching factor in forming any recommendation will be the impact on honest consumers.

Timeframe

A.6 The taskforce is to be established by January 2015. An interim scoping report will be produced by March 2015 and a final report will be published by the end of 2015.

List of Taskforce recommendations

B

- 1 To 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 customers¹
- 2 To ensure 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. This should include increased promotion of IFB's 'Cheatline', highlighting the impact of fraud on honest policyholders, use of the media and trusted intermediaries and communication channels outside of 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
- 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
 - increasing membership of existing anti-fraud scheme and databases including MyLicence and CUE
- 4 In light of forthcoming EU regulations,² the ICO should provide the insurance industry and others with clear guidance on data sharing practices in relation to insurance fraud
- 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
- 6 Insurers should ensure Board level ownership of counter fraud activity

¹ Accessed January 2016; <https://www.abi.org.uk/News/News-releases/2016/01/ABI-and-BIBA-launch-industry-Code-of-Good-Practice-to-help-vulnerable-customers>

² General Data Protection Regulation (GDPR)

- 7 The ABI should consider how it resurces its counter fraud activity and whether more priority should be given to this task
- 8 The ABI should discourage the inappropriate use of pre-medical offers
- 9 The insurance industry as a whole should consider following the established good practice of some insurers in defending court proceedings where they believe the claim is fraudulent
- 10 The government should review how fraudulent late claims can be discouraged 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 (SCT)
 - 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
 - introducing a rebuttable evidential presumption that no injury was suffered where claims are lodged after a specified period of time has elapsed since the alleged accident³
- 11 The insurance industry should remain vigilant to emerging fraud and should coordinate its engagement with government through the ABI
- 12 The insurance industry should support the development work needed to evolve the IFB into a holistic intelligence hub and ensure timely contribution to the evolved dataset
- 13 The Claims Portal Limited should give IFB access to Claims Portal data
- 14 The government should
 - consider strengthening the fining powers of the SRA for fraudulent or corrupt activity
 - consider reviewing the standard of proof used in cases put before the Solicitors Disciplinary Tribunal
- 15 The SRA should take a tougher approach to combatting fraud including by
 - making clear that it will give an appropriate focus to combating financial crime through its existing powers, including naming and shaming
 - considering requiring solicitors to undertake client identification checks in cases other than just those where they handle client money
 - working with the CMR Unit to enforce the referral fee ban
- 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
- 17 In implementing the whiplash reforms outlined at Autumn Statement 2015, the government should consult on introducing a mandatory requirement for referral sources to be included on CNFs and claims should only proceed where CNFs are complete.

³ For example if a soft tissue injury claim was made over 1 year from when the accident occurred it is to be presumed that no injury was suffered unless the claimant can provide contemporary evidence such as GP notes or A&E visit, or time off work

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

- 18 The ABI, in conjunction with the IFB, should produce guidance to its members setting out what forms of direct contact is acceptable with the alleged claimant if they suspect that legal representatives are acting without instruction
- 19 Claimant and defendant representatives (APIL, MASS, FOIL and ABI) should produce a standard letter in conjunction with the SRA and IFB for insurers to send to claimants directly to verify whether they have instructed a firm to represent them
- 20 The government should establish a stronger regime for CMC regulation and ensure that it has adequate resources and powers to do its job effectively. In particular the regulator should
 - effectively police the referral fee ban
 - prevent the use of "phoenix" companies
 - consider how to deal with those organisations providing claims management services outside the regulated sector
 - liaise with the ICO regarding the abuse of data protection rules
 - maintain a robust regime to ensure those regulated are run by fit and proper persons
- 21 The government should
 - develop and deliver a coherent regulatory strategy to tackle nuisance calls that encourage fraudulent personal injury or other claims, in partnership with the CMR, IFB, ICO, ABI, Ofcom and SRA
 - put the ICO's Direct Marketing Guidance on a statutory footing
- 22 The ICO should
 - work with regulators operating in countries where nuisance calls are commonly sourced to tackle nuisance calls internationally
 - coordinate a communications strategy to inform consumers what giving consent to use of their data means in practice
- 23 The government should consider introducing a fixed recoverable costs regime for noise induced hearing loss (NIHL) claims

The Taskforce endorses and supports the CJC's investigation into how a fixed recoverable costs regime for NIHL cases (and perhaps other similar cases) might work, and how the handling of NIHL claims might be improved by both claimant and defendant representatives (including how evidence is obtained and presented), and recommends that this work should include consideration of quality standards and/or other thresholds for medical evidence
- 24 Aggregators should establish the use of existing fraud databases and data sharing schemes on a consistent basis in order to improve the industry's ability to detect fraud at the point of quote

- 25 Aggregators should proactively engage with insurers and come to a collective data sharing agreement to tackle insurance fraud in order to detect suspicious consumer behaviour at the point of quote. This initiative should be coordinated by the IFB
- 26 The government should establish a legacy vehicle to ensure that Taskforce recommendations are implemented

The legacy vehicle should continue the effective dialogue between different stakeholders regarding insurance fraud and should be made up of industry representatives similar to that of the Taskforce. It should review progress against these recommendations and fraud developments generally and should report to government once a year initially for 3 years. It should produce an annual report to government on progress and areas that need to be improved.

C The ABI calculation of fraud statistics

C.1 The ABI collects information annually regarding detected fraud to provide its members and wider stakeholders with an indication of the extent of detected fraud that the industry faces at both the application and claims stage. The ABI estimates the size of detected insurance fraud was £1.32 billion in 2014.¹

C.2 Insurers are able to report on and measure cases of clear detected fraud without difficulty. However reporting on and measuring likely cases of fraud encountered by insurers presents some challenges. Accordingly, the ABI has developed a list of scenarios in which it is believed fraud is likely to be involved and asks its members to provide the numbers of cases which fall into those categories. While some of those cases may have an innocent explanation, many more cases of successful fraud go undetected.

C.3 The ABI's fraud statistics are therefore intended to provide an indication of the volume and value of fraud detected by the industry. These statistics do not include claims which involve exaggerated personal injury where the claim has been paid.

C.4 The ABI collects information from its members which falls into the following description, which is based on the Fraud Act 2006, and reflects the definition adopted in relation to the Insurance Fraud Register:

C.5 *Any party seeking to obtain a benefit under the terms of any insurance-related product, service or activity can be shown, on a balance of probabilities, through its actions, to have made or attempted to make a gain or induced or attempted to induce a loss by intentionally and dishonestly:*

- *making a false representation; and/or*
- *failing to disclose information; and/or*
- *having abused the relevant party's position.*

C.6 In addition, one or more of the following outcomes has taken place which relates to the fraudulent act:

- *an insurance policy application has been refused;*
- *an insurance policy or contract has been voided, terminated or cancelled;*
- *a claim under an insurance policy has been repudiated;*
- *a successful prosecution for fraud, the tort of deceit or contempt of court has been brought;*
- *the relevant party has formally accepted his/her guilt in relation to the fraudulent act in question including, but not limited to, accepting a police caution;*
- *an insurer has terminated a contract or a non-contracted relationship/recognition with a supplier or provider;*

¹ Accessed November 2015; <https://www.abi.org.uk/News/News-releases/2015/07/You-could-not-make-up-Savings-honest-customers-insurers-expose-3-6-million-worth-insurance-frauds>

- *an insurer has attempted to stop/recover or refused a payment made in relation to a transaction;*
- *an insurer has challenged or demonstrated that a change to standing policy data was made without the relevant customer's authority.*

C.7 *Also, the relevant party must have been notified that its claim has been repudiated, or relevant policy or contract voided, terminated, or cancelled, for reasons of fraud and/or it is in breach of the relevant terms and conditions relating to fraud within the relevant policy or contract.*

C.8 The ABI also collects information from its members relating to cases of suspected insurance fraud:

C.9 *Where a handler having an actual suspicion of fraud (e.g. manual fraud indicator(s), tip off, system generated "high risk" referral etc.) challenges the applicant/claimant by letter, telephone call or instruction of an investigator etc., to clarify key information, provide additional information or documentation etc., and the applicant/claimant subsequently:*

- *fails to co-operate or provide further documentation; and/or*
- *formally withdraws the application/claim (by phone, e-mail or letter) without a credible explanation; and/or*
- *allows all communication with the insurer to lapse despite the insurer's reasonable attempts to re-establish contact; and/or*
- *accepts (without a credible explanation) either a substantially reduced settlement offer in respect of a claim, or a substantially increased premium in respect of an application/renewal (other than in cases where there has been a careless misrepresentation).*

C.10 All other 'gone away' claims/applications arising in the course of normal business do not represent suspected fraud under this definition.

D Stakeholder engagement

Written responses to the call for evidence

1 st Central	Irwin Mitchell Solicitors LLP
Admiral and EUI	Kennedys Law
Ageas	Keoghs LLP
Allianz UK	Lloyd's Market Association (LMA)
Arson Prevention Forum	LV=
Association of British Insurers	Motor Accident Solicitors Society (MASS)
APIL	Motor Insurers' Bureau (MIB)
Aviva	National Accident Helpline
BLM Law	NFU Mutual
Browne Jacobson LLP	The Phoenix Group
Cardiff Law School, Cardiff University	QBE
Centre for Commercial Law Studies, Queen Mary University of London	Saket Trivedi
Civil Justice Council	Strata Solicitors Limited
Covéa Insurance	Thompsons Solicitors
The Credit Hire Organisation	Weightmans
DAC Beachcroft	Zurich
Direct Line Group	
DWF	
Enterprise Rent-A-Car	
esure	
Financial Services Consumer Panel	
FirstGroup	
The Forum of Insurance Solicitors	
Haven Insurance	
Home Retail Group	
Horwich Farrelly Solicitors	
Insurance Fraud Enforcement Department	

Stakeholder meetings held

1st Central

AgeUK

Arson Control Forum/ Arson Prevention Forum

Association of Personal Injury Solicitors

AXA Insurance UK plc

Carol Brady

Claims Management Regulation Unit

Claims Portal Board

Claire Milne, Visiting Senior Fellow, London School of Economics and Political Science

DAC Beachcroft

Department for Transport

Dr Janice Goldstraw-White, Independent Criminologist

Home Office

Information Commissioner's Office

LV=

MoneySuperMarket.com

Motor Insurers' Bureau

National Accident Helpline

Ofcom

Patrick Fagan, Associate Lecturer, Goldsmiths

Solicitors Regulation Authority

Synectics Solutions Ltd

Tesco

the Department for Culture, Media and Sport

TrueCall

VitalityHealth

E Glossary

Acronym	Name
ABI	Association of British Insurers
APB	Arson Prevention Bureau
APIL	Association of Personal Injury Lawyers
BIBA	British Insurance Brokers' Association
CFA	Conditional fee agreement
CFCS	Counter Fraud Checking Service
CIFAS	Credit Industry Fraud Avoidance System
CJC	Civil Justice Council
CMC	Claims management company
CMR	Claims Management Regulation Unit
CNF	Claims notification form
CPR	Civil Procedure Rules
CUE	Claims Underwriting Exchange
DVLA	Driver and Vehicle Licensing Agency
DWP	Department for Work and Pensions
FCA	Financial Conduct Authority
FOIL	Forum of Insurance Solicitors
HMRC	HM Revenue & Customs
ICO	Information Commissioner's Office
IDSL	Insurance Database Services Limited
IFB	Insurance Fraud Bureau
IFED	Insurance Fraud Enforcement Department
KADOE	Keeper At Date Of Event
LASPO	Legal Aid, Sentencing and Punishment of Offenders Act 2012
MASS	Motor Accident Solicitors Society

MIAFTR	Motor Insurance Fraud And Theft Register
MIB	Motor Insurers' Bureau
MID	Motor Insurance Database
MoJ	Ministry of Justice
NFIB	National Fraud Intelligence Bureau
NI	National Insurance
NIHL	Noise Induced Hearing Loss
OFCOM	Office of Communications
PI	Personal injury
PSLA	Pain, suffering and loss of amenity
RTA	Road traffic accident
SDT	Solicitors Disciplinary Tribunal
SRA	Solicitors Regulation Authority
TPD	Third party damage
TPR	Third party injury

