

# **Insurance Fraud Taskforce Interim Report**



**A response by the Association of Personal Injury Lawyers**

**May 2015**

The Association of Personal Injury Lawyers (APIL) is a not-for-profit organisation with a 25-year history of working to help injured people gain access to justice they need and deserve. We have around 3,800 members, committed to supporting the association's aims and all of whom sign up to APIL's code of conduct and consumer charter. Membership comprises mostly solicitors, along with barristers, legal executives and academics.

APIL has a long history of liaison with other stakeholders, consumer representatives, Governments and devolved assemblies across the UK with a view to achieving the association's aims, which are:

- To promote full and just compensation for all types of personal injury;
- To promote and develop expertise in the practice of personal injury law;
- To promote wider redress for personal injury in the legal system;
- To campaign for improvements in personal injury law;
- To promote safety and alert the public to hazards wherever they arise;
- To provide a communication network for members.

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## **Introduction**

APIL welcomes the opportunity to respond to the Insurance Fraud Taskforce interim report. We are disappointed that the taskforce to date, and therefore the report, is biased and unrepresentative, with two insurer organisations present on the panel, but no one representing claimant lawyers. Claimant lawyers are the “gatekeepers” of the personal injury claims process, and a collaborative approach between claimant, defendant and consumer representatives would help to tackle fraud effectively. When looking at the issue of fraud, it is important that behaviours on “both sides of the fence” i.e. claimants and insurer, are examined. We are also concerned that the statistics mentioned in the report are unreliable, as it is unclear how the figures for “undetected fraud” were calculated. The statistics in the foreword and annex B also appear to contradict statistics in an earlier report produced by the National Fraud Authority.

## **Executive Summary**

- APIL is concerned that the report and taskforce itself are not balanced. Both claimant and defendant representatives should have been involved throughout the process in order to effectively tackle fraudulent behaviour. We accept that going forward, our president Jonathan Wheeler has been invited to participate in the taskforce’s work as part of the ‘personal injury expert group’. That invitation is welcome, but at the time of writing, the group has yet to meet. This does not, therefore, alter our critique of the interim report as this has been prepared without the input of claimant lawyers.
- It is unclear how the figures for “undetected fraud” have been calculated, and we require clarification on this. It is important that any fraud statistics are accurate, so the scale of the problem can be measured and steps can be taken to properly address the issue. If fraud statistics are misrepresented, and any person who claims for a lower value injury, in particular whiplash, is portrayed as being a fraudster, this intimidates genuine claimants and prevents them from accessing justice. It also steers efforts away from tackling those who really commit fraud.
- The banning of pre-medical offers and third party capture would help to reduce fraudulent practices. These practices have the potential to create an environment of “easy money”, allowing fraudulent cases to be settled without the necessary checks and balances that medical examination provides.
- We fail to see how most of the reforms already in place, as set out in the report, would actually tackle the problem of fraud. Most of the reforms referred to in the report (page 12 and 13) are aimed at saving the insurance industry money, rather than tackling fraud – the rationale behind the reform of CFAs, for example, was to reduce the costs of civil litigation. We also suggest that if the insurance industry is saving money via the reforms, this should be passed on to the consumer – insurance premiums are beginning to increase once more, despite the costs-saving reforms that have already been put in place at the expense of access to justice for individuals.
- We fail to understand how increasing the small claims court limit could result in significant savings in costs and make it easier for defendants to challenge unnecessary and exaggerated claims. If the small claims limit is increased, people will be unable to afford to instruct a solicitor to help with their claim and the “gatekeepers”, i.e. claimant lawyers, will be removed from the process. There will be no data sharing, and an

unscrupulous claimant will not be deterred or prevented from bringing a fraudulent or exaggerated claim.

- Insurers should be willing to share more data with claimant representatives. The data sharing agreement through CUE PI is a step in the right direction, but does not go far enough. There should be independent scrutiny of the data that the insurers collect and share.
- Fraudulent behaviour occurs on “both sides of the fence” – it is not solely a claimant issue. Insurer to insurer behaviours should also be examined by the taskforce.
- The timetable for the report and final report is unrealistic and rushed.

## **General comments**

### *The taskforce is unrepresentative of the industries involved*

The taskforce, as it currently stands, is biased – with no claimant lawyer representatives, but the ABI and BIBA representing the insurance industry. As explained throughout our response below, fraud is serious and in order to effectively tackle the issue, there needs to be a collaborative approach from all parties involved in the claims process. At the very least, the minutes of the meetings from the taskforce discussions must be extensive and accurate, to ensure that other parties who are not present at the meetings can contribute to the on-going discussion.

### *The scale of fraud must be accurately and independently calculated*

It is imperative that the scale of fraud is accurately measured, and that the insurance industry is not permitted to use inaccurate or misleading fraud statistics to create an environment of hostility towards those who have genuine injuries as a result of an accident. For example, the focus of Aviva’s recent report entitled the Road to Reform 2015, is that whiplash is an “easy target for fraudsters”, with the CEO Maurice Tulloch stating that “we are now witnessing a resurgence in the number and cost of whiplash and soft tissue injury claims despite some very positive developments such as the LASPO Act.” In fact, recently released CRU stats indicate that whiplash claims have, in fact, fallen by 8 per cent within the last year, and have fallen by over a third since 2010/2011. That there has been a resurgence of whiplash claims is simply untrue. We agree that steps must be taken to eradicate fraud, but those who have genuine claims should not be stigmatised, and the scale of the issue must be accurately calculated and represented.

## **Specific comments on the report**

### Foreword

We require clarification as to how undetected fraud is calculated. The figures for undetected fraud are referred to in the foreword: “the insurance industry...estimates that it is facing £1.3 billion of detected fraud, with a further £2.1 billion undetected”, and again at Annex B, but nowhere is there an explanation as to how this “undetected” fraud figure has been calculated.

Not only is the figure not explained, but it is in contradiction with earlier reports on fraud by the National Fraud Authority Annual Fraud Indicator. The Annual Fraud Indicator is

referenced at paragraph 2.4 of the taskforce's interim report. The Indicator states that "(b)ased on figures provided by the Association of British Insurers and the Insurance Fraud Bureau, insurance fraud is estimated to cost £2.1 billion per year. This estimate breaks down into £1.7 billion in hidden fraud loss, £392 million in organised "Cash for Crash" fraud, and £39 million in identified insurance fraud." Therefore the figure of £2.1 billion of undetected fraud in the taskforce report is inconsistent with the National Fraud Authority Annual Fraud indicator, which suggests that the £2.1 billion figure includes £400 million of detected fraud.

We would be interested to know how many ABI members provide data, and to what level. At paragraph 5.10 of the taskforce report, it is stated that the ABI collects information from its members relating to cases of suspected insurance fraud. This includes where a handler, having an actual suspicion of fraud challenges the applicant to clarify key information/provide additional information etc, and the applicant subsequently formally withdraws the application. It is questionable whether someone withdrawing a claim can be seen as a fraud indicator on its own, there may be other explanations as to why a claimant withdraws a claim.

It is, therefore, extremely unclear how the "undetected fraud" figure was generated, and what data was relied on to arrive at this figure. Fraud is extremely serious and steps should be taken to eradicate it. In order to do so, however, the extent of the issue must be accurately represented.

#### Mapping the problem

#### ***Q4 What particular evidence should the Taskforce take into account when determining the nature of insurance fraud?***

The taskforce must take evidence from both claimant and defendant representatives to ensure that they have a full understanding of the issues. Further, the statistics on fraud which have been provided by the ABI for this report are inconsistent with earlier statistics released by the National Fraud Authority. We require clarification as to how the £2.1 billion undetected fraud figure has been calculated.

#### ***Q5 What trends in insurance fraud should the Taskforce be aware of?***

The taskforce should be aware of the practice of pre-medical offers<sup>1</sup>, third party capture, and also certain insurer to insurer behaviours.

We are surprised and disappointed that the link between fraudulent behaviour and the practice of pre-medical offers is not already addressed in the taskforce's report. David Hertzell, the chairman of the taskforce, stated earlier this year that "the settling of claims without medical evidence, that is an encouragement to people to chance their arm. You can understand economically why insurers do that, but you are creating an environment where

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<sup>1</sup> We appreciate that an aim of the pre-action protocol for low value road traffic accident claims, contained at paragraph 3.2(4) of the protocol, is to ensure that offers are made only after a fixed cost medical report has been obtained and disclosed. This does not, however, go as far as to ban pre-medical offers in these cases, and in any event, pre-medical offers are not limited to these types of case. There must be a ban on these offers in any claim.

the dishonest might flourish.”<sup>2</sup> It is essential, in our view, that the practice of making pre-medical offers is ended.

The offer of a settlement before any medical evidence has been obtained means that the injury suffered by the claimant cannot be validated or accurately quantified. Pre-medical offers are sometimes made before an independent solicitor has been instructed by the claimant, or sometimes without the instructed solicitor’s knowledge. The injured person will be offered a sum without knowing whether it is reasonable or not. This practice can be seen as fraudulent against the claimant, as the injured person will be offered a sum without knowing whether it is reasonable or not and this could lead to under-settlement of the claim. It also has the potential to create an environment of “easy money”, allowing fraudulent cases to be settled without the necessary checks and balances that medical examination provides.

The examination of fraudulent practices should also extend to an analysis of direct insurers contact. APIL has long argued that this is a type of fraud on the claimant, and should be prevented. Sometimes known as “third party capture”, this happens when an insurer handles a claim for a person who has been injured by the insurer’s own policy holder. The insurer will sometimes offer a quick cash deal to the victim of the accident, which bears little relation to what the claim is actually worth, in an attempt to minimise the amount of money that the defendant insurer has to pay out. The offer is often made without evidence and without advising the injured person that they have the right to obtain legal advice – resulting in under-settlement and under-compensation.

We also believe that insurer to insurer behaviours should be examined by the taskforce. In *Fallows v Harkers Transport (A Firm)*<sup>3</sup> His Honour Judge Platt succinctly described a business model where “RSA [Royal & Sun Alliance Group] have chosen to set up a separate company which is a wholly owned subsidiary of the parent company, called RSA Accident Repairs Limited (“RSAARL”) to undertake repairs of vehicles insured by RSA. It does so either by performing the repairs at its own repair centres or by using sub-contractors.” The Judge noted that this business model “is seen on the part of RSA as perfectly legitimate and by a number of defendant insurers as involving methods of business which fall somewhere between very sharp practise and outright fraud.”

The Judge also explained that “this scheme could only be effective and profitable to RSA so long as RSA were able to conceal from other insurers what they were doing. This would seem to explain the quite extraordinary lengths to which RSA through its solicitors and RSAARL have been prepared to go in order to conceal the true position *vis-a-vis* RSAAL and its subcontractors in answer to proper requests for disclosure from defendant insurers.”

The conclusion reached by the Judge in that case was “since RSAARL is wholly owned by RSA the effect of these extra charges if they are paid by defendants is simply to boost RSA Group's profits beyond the actual cost of repair by the margins inserted by RSAARL. I can find no basis in law for saying that this is a course of action which a claimant insurer is entitled to take and I do not need to repeat the public policy arguments”

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<sup>2</sup> <http://www.postonline.co.uk/post/news/2397259/cold-calling-and-claims-regulation-on-taskforce-agenda>

<sup>3</sup> [2011] EW Misc 16

Following this decision there was a test case, *Coles v Hetherington*<sup>4</sup>, to examine this business model. The Court of Appeal in *Coles* found in favour of RSA's model, despite the third party insurers in the case stating that the model increased repair costs by 25 per cent. The Court of Appeal held that the insurer does not need to mitigate loss with regard to direct losses and the reasonableness of the repair charge is to be judged by reference to what a person in the position of the claimant could obtain on the open market (rather than the lowest price that an insurer could obtain). Permission to appeal to the Supreme Court was refused, as it was held that the insurers did not raise an arguable point of law. We believe that these practices, warrant further investigation by the insurance fraud taskforce.

#### Current counter-fraud initiatives

We note that at paragraph 3.1, it is stated that the insurance industry estimates that it spends in excess of £200m per year tackling fraud. We would be grateful for clarification as to how this figure has been arrived at. If accurate, it is also important to view this figure in context. In 2014, the UK general insurance industry received worldwide net premiums of £50.2 billion, and paid out on claims worth £32.1 billion<sup>5</sup>. This leaves £18.1 billion, with £1.4 billion underwriting profit, leaving £16.7 billion in commission and expenses. £200 million equates to just over one per cent of £16.7 billion.

#### ***Q6 How could existing industry initiatives be used more effectively?***

The insurance industry should be willing to share more data with claimant representatives. Whilst CUE PI is a step in the right direction, more data and information could be shared to help identify fraudsters. Claimant representatives are the "gatekeepers" of the claims process. If equipped with the correct information about the potential client, they are in a position to identify suspicious or potentially fraudulent behaviour. Yet, the amount of information that the insurance industry will share is, at present, minimal. We suggest that there should be independent scrutiny of the insurance fraud database, to ensure that the industry is storing and releasing the correct information. The current system is very opaque.

#### ***Q8 To what extent will the government's civil litigation and costs reforms address insurance fraud? Should these reforms be expanded?***

We fail to see how many of the government's reforms, set out on page 12 and 13 of the report, would address insurance fraud.

In the name of reducing costs, many of the reforms have had a devastating impact on the rights of injured people to access justice, making it harder for claimant firms to take on cases and provide the claimant with 100 per cent of the compensation that they deserve. The rationale behind the reform of "no win no fee" was to reduce legal costs in civil litigation and make costs more proportionate. Instead, the removal of recoverability for success fees and ATE premiums has meant that the injured person may no longer receive all of their damages if they win their case – leading to injustice. Fixed costs for low value claims up to £25,000 has resulted in lower levels of resources being available for solicitors to run these types of claims, therefore reducing the help available to injured people.

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<sup>4</sup> [2013] EWCA Civ 1704

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[https://www.abi.org.uk/~/\\_/media/Files/Documents/Publications/Public/2014/Key%20Facts/ABI%20Key%20Facts%202014.pdf](https://www.abi.org.uk/~/_/media/Files/Documents/Publications/Public/2014/Key%20Facts/ABI%20Key%20Facts%202014.pdf)

We also fail to see how introducing a fixed fee of £180 for an initial whiplash report will tackle fraud. When the proposals to introduce a fixed fee were first introduced, APIL stressed that any reform of the medical reporting process should deliver a more thorough examination, reviews of medical history and a detailed report, as this would help to deter fraudulent and exaggerated claims, along with ensuring an accurate valuation of the claim. APIL was concerned that a reduced fee may result in an examination and report which fails to achieve this objective.

We welcome accreditation, but we do not see how random allocation of experts will address fraud. APIL is opposed to random allocation, as the claimant should be free to select the accredited expert of their choice.

At paragraph 3.12 of the taskforce's report, it is stated that "(raising the small claims court limit for personal injury claims) could result in significant savings in costs and make it easier for defendants to challenge unnecessary and exaggerated claims". We strongly believe that if the small claims limit were raised, the opposite would, in fact, be true. If the small claims limit is increased, people would be unable to afford representation and would either take the case on themselves or may allow an unregulated claims management company to run the case for them. The "gatekeepers", i.e. claimant lawyers, will be removed from the process, and there would be no CUE PI checks or data sharing of any kind. Without a solicitor to advise them, the claimant would be at risk of under-compensation through a pre-medical offer – or could even be offered, and accept, money when they haven't in fact been injured.

***Q9 Are there any other legislative reforms or regulatory changes required to reduce third-party personal injury fraud?***

As above, a ban on pre-medical offers and third party capture would go some way to tackling fraudulent behaviour, as would further restrictions on nuisance calls. Making pre-medical offers, and nuisance calls which may encourage people to claim regardless of whether or not they have had an accident, create an environment of "easy money". It is important that any behaviour which encourages opportunistic claims is stamped out.

***Q10 What practices by those involved in the claims process (including insurers, lawyers, CMCs and other intermediaries) should the Taskforce target?***

The taskforce should, as above, target third party capture, cold calling and pre-medical offers.

There should be co-operation between regulators – particularly between the SRA and the Claims Management Regulator, to stamp out unscrupulous practices. The taskforce should look at how the regulators work together, what they share and how this might be improved.

***Q18 What more could be done to make insurance fraud socially unacceptable?***

It should be seen as unacceptable for insurers to make pre-medical offers. The practice of pre-medical offers removes the checks and balances from the system and creates an environment of easy money – as well as denying genuine claimants full and proper compensation.

We also suggest that savings from tackling fraud should be correctly calculated and evidenced, with those savings passed on to the consumer. Most of the reforms set out at



pages 12 and 13 were aimed at reducing costs for the insurance industry, which, it was said, would bring down premiums for consumers. Whilst motor insurance premiums did decline between 2013 and 2014, they have now begun to increase, in real terms<sup>6</sup>, once more. The average motor insurance premium in Q4 of 2014 was £372, which was up 5 per cent from the previous quarter<sup>7</sup>. This is despite the reforms being in place and savings being made by the insurance industry. If consumers can see the benefit of the clamp-down on fraud, they are more likely to remain honest, and fraud is more likely to be seen as socially unacceptable.

***Q19 Is there evidence that the legal system in the UK contributes to a higher level of insurance claims fraud than in other countries?***

We are not aware of any such evidence.

***Q22 What more can insurers do to challenge potential fraudsters and increase deterrents in the claims process without damaging the customer experience?***

This question demonstrates the bias placed on this report. At the heart of many of these claims will be an injured person who wants access to justice and the correct amount of compensation to put them back in the position that they were in before the accident.

***Q23 Is fraud data being adequately used, and if not, why not?***

As above, we believe that CUE PI is just a step in the right direction, and that the insurance industry should be willing to share much more information about potential claimants with claimant lawyers. If they do not agree to do so, this decision needs to be challenged. We believe that if claimant lawyers were more fully equipped with claims histories, this would be a deterrent to potential fraudsters in trying to claim. As above, claimant representatives are gatekeepers to the process. If someone was a fraudster and they knew that their claims history would be examined by their solicitor before they took on the claim, this is likely to put them off trying to bring a claim which is falsified.

***Q26 Are there any groups outside of the insurance industry with whom fraud data should be more actively shared?***

Fraud data should be more actively shared with claimant lawyers. Claimant lawyers are the “gatekeepers”, and must be adequately equipped with data to detect fraudulent claims.

***Q28 Other than the four areas of interest identified, are there other important issues which the taskforce should consider?***

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<sup>6</sup> In the first quarter of 2015, premiums fell by 2.4 per cent. The AA explained in the British Insurer Index (<http://www.theaa.com/newsroom/bipi/car-home-insurance-news-2015-q1-bipi.pdf>), however, that insurers offer price reductions at the start of the year, to build market share at a time when, with new motor registrations, more policies are sold than at other times. The AA also explained that premiums will start to rise and continue to do so over the rest of 2015.

<sup>7</sup> <https://www.abi.org.uk/News/Industry-data-updates/2015/02/ABI-average-motor-insurance-premium-tracker-Q4-2014-data>

As above, fraud is not a solely claimant problem. The remit of the taskforce must cover defendant and insurer to insurer behaviours.

We also believe that application fraud, and its effect on workplace safety, require investigation. We are concerned that when an accident occurs, employers may not report it, for fear of increasing their insurance premium. This means that accidents will be going unreported and dangerous workplace practices will not be monitored or stopped – increasing the likelihood of repeat accidents.

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