

Insurance Fraud Taskforce:

interim report

March 2015

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Taskforce members



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Foreword

Insurance fraud is a significant problem which has a great cost to consumers and industry.

It has been estimated that fraud adds an extra £50 to every household's annual insurance bill. It's vital that consumers are able to access affordable insurance because it gives people the peace of mind to know that if things go wrong that they won't be left to struggle. Honest consumers are currently paying a high price for the actions of those who defraud insurance companies by creating fictional claims or deliberately lying on their application forms.

The insurance industry, which contributes £25 billion to the national output, estimates that it is facing £1.3 billion of detected fraud, with a further £2.1 billion undetected. This isn't right and it certainly isn't the case that this is a victimless crime. Fraud should no longer be a cost of business but rather a threat which has been extinguished. The UK is already an attractive place for insurers to do business, with a skilled workforce and a great network in London and beyond. I want us to be able to send out a message that the UK has a thriving insurance industry because it is best-in-class for tackling fraud.

This government takes insurance fraud very seriously. We have created a significant reform programme to control the costs of civil litigation which will help tackle fraudulent personal injury claims, including implementing Lord Justice Jackson's recommendations through provisions contained in the Legal Aid, Sentencing and Punishment of Offenders Act on 1 April 2013. The current focus of this programme is spurious whiplash claims and we are implementing a number of reforms to address these.

Despite all of this, and the efforts of industry, the problem of insurance fraud is still too big to be ignored and is not limited to personal injury claims.

In order to get to the root of this problem the government has established the Insurance Fraud Taskforce. The Taskforce has a strong chairman in David Hertzell and its membership represents industry, regulators and consumers. I'm confident that it will be able to recommend solutions which will make great inroads towards tackling this problem.



Andrea Leadsom
Economic Secretary to the Treasury

1 Introduction

David Hertzell, Taskforce Chair

1.1 Insurance fraud impacts on honest consumers and is a huge cost for society, so I am delighted to have been asked by Ministers from HM Treasury and the Ministry of Justice to chair the Insurance Fraud Taskforce. The group has been 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. The Taskforce will provide recommendations by the end of 2015.

1.2 I am pleased to be able to set out in this interim report the Taskforce's initial thinking on this problem. There will be no easy solutions, but it is heartening to see that parties from a range of sectors have thrown their support behind the challenge.

1.3 The report includes a number of questions for consideration, and the Taskforce welcomes views from interested parties to help it formulate its recommendations.

Taskforce members

- the Association of British Insurers (ABI)
- Citizens Advice
- the British Insurance Brokers' Association (BIBA)
- the Financial Services Consumer Panel
- the Insurance Fraud Bureau (IFB)
- the Financial Ombudsman Service

Statement of support from Taskforce members

"Insurance fraud is a cost to both businesses and consumers and therefore it is in everyone's interest to tackle this serious problem. We are pleased that the government has launched the Insurance Fraud Taskforce and will support its work."

1.4 HM Treasury and Ministry of Justice officials support the Taskforce and attend its meetings.

1.5 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, claims management industry, police, regulators and consumer representation bodies.¹

1.6 The terms of reference for the Taskforce are included at Annex A.

¹ The Taskforce intends to engage with all stakeholders who have an interest in its work and the wider stakeholder group will continue to expand as the work develops. Those who had previously expressed an interest in the work were invited to a roundtable event on 24 February 2015; not all were able to attend but 23 organisations were present: Motor Accident Solicitors Society (MASS), Association of Personal Injury Lawyers (APIL), National Accident Helpline, Forum of Insurance Lawyers (FOIL), Which?, Chartered Insurance Institute, Ministry of Justice Claims Management Regulation Unit, Financial Conduct Authority, Money Advice Service, City of London Police, BLM, DWF, Enterprise Rent-A-Car, Credit Hire Organisation, Alarm UK, Lorega, Lloyd's, Aviva, LV=, RSA, AXA UK, Endsleigh, AA. A summary note of this roundtable will be published on GOV.UK.

2 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, as well as the profiles of individuals and organisations who commit insurance fraud in its various forms. The Taskforce will consider both claims fraud and application fraud.

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.

Scale and impact of insurance fraud

2.2 Measuring the scale of insurance fraud is not simple. A large proportion 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 intentional deception or 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 (see Annex B) and estimates that the size of detected insurance fraud was £1.3 billion in 2013.¹ Meanwhile, it has been estimated that the level of annual undetected insurance fraud is in the region of £2.1 billion.²

2.5 The ABI has also considered the impact of fraud on consumers, and estimated that insurance fraud adds an extra £50 to every household's annual insurance bill.³ This is because the costs of fraud are ultimately covered by consumers through their premium payments.

2.6 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.

2.7 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
- blocking courts: fraudulent claims taken through the courts can delay justice for honest claimants

¹ Accessed February 2015; <https://www.abi.org.uk/News/News-releases/2014/05/Insurance-cheats-feel-the-heat-value-of-fraudulent-claims-uncovered-by-insurers-hits-record-level>

² National Fraud Authority, Annual Fraud Indicator, 2013

³ Accessed February 2015; <https://www.abi.org.uk/Insurance-and-savings/Topics-and-issues/Fraud>

- jeopardising road safety: orchestrated road collisions pose a danger to innocent motorists and add to the cost of the emergency services
- impacting the NHS: recent research suggests GPs spend a significant amount of time seeing patients they suspect are inventing or exaggerating an injury in order to claim compensation⁴

Questions for consideration: mapping the problem – scale and impact of insurance fraud

Q1) What data sources should the Taskforce use when considering the scale of insurance fraud?

Q2) How does the scale of insurance fraud in the UK compare with other developed countries?

Q3) In addition to the financial cost of fraud, what is the wider impact on consumers and society?

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

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

Profiling fraudsters

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.

2.9 The highest profile insurance fraud is committed by organised gangs who are often behind ‘cash for crash’ scams 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 benefit fraud.

2.10 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’.

2.11 Not all insurance fraud is pre-meditated and some of it is opportunistic. Opportunists will generally be otherwise law-abiding citizens who commit insurance fraud when 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.⁵ 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.

2.12 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.

⁴ Accessed February 2015; <http://www.lv.com/about-us/press/article/whiplash-fraudsters-waste-one-million-nhs-hours>

⁵ Gill & Randall, Insurance Fraudsters, 2015

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

2.14 The Taskforce will also recognise that the majority of consumers are honest and their insurance applications and claims are legitimate. Those who make genuine mistakes are not fraudsters and the Taskforce will not seek to criminalise them. The work will only target genuine insurance fraud.

Current counter-fraud initiatives

3

Insurance industry initiatives

3.1 Fraud is an expensive problem for insurers and the industry estimates it spends in excess of £200m per year tackling it.¹ The Taskforce is mindful that there should be no duplication 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 data sharing and intelligence, is outlined here.

3.2 A key step taken by the industry was the establishment of the Insurance Fraud Bureau (IFB) in 2006. It is a not-for-profit organisation funded by the insurance industry, specifically focused on detecting and preventing organised insurance fraud.

3.3 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.

3.4 The IFB's five-year strategy (2015-19) 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 lawyers, investigators, loss adjusters and others.

3.5 Another important initiative is the industry-funded Insurance Fraud Enforcement Department (IFED) of the City of London Police established in 2012. As of February 2015, IFED had made 645 arrests and secured 193 police cautions and 114 convictions at court. At any given time, IFED has between £20-£35m of fraud under investigation.

3.6 To support the work of the sector in combatting fraud, the industry has established a number of data sources, outlined below.² These 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 sources include:

- **Insurance Fraud Register (IFR)** – a register of known insurance fraudsters across all insurance product lines. The consequences of appearing on the register can mean that fraudsters may find it harder to obtain insurance and will pay higher premiums. They may also find it harder to obtain other financial services, including mortgages and loans. 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.
- **Claims and Underwriting Exchange (CUE)** – a central database of motor, home and personal injury/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

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 £200m. This previous estimate was referenced in: ABI, No Hiding Place: Insurance Exposed, 2012

² Other than the Insurance Fraud Register, these data sources listed are all under the management of the Motor Insurers' Bureau (MIB).

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. The ABI, the IFB, and the Motor Insurers' Bureau (MIB) are also working with lawyers' representatives (the Law Society, the Motor Accident Solicitors Society and the Association of Personal Injury Lawyers) to finalise the arrangements for the 'askCUEPI' system. Under the 2015 Civil Procedure Rules changes, claimant lawyers will be required to undertake a search using askCUEPI before filing a soft tissue 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 customer and vehicle.
- **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.
- **MyLicence** – a joint initiative between the insurance industry, the Driver Vehicle and Licensing Authority (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 will be enhanced in early 2015 to give insurance providers access to a "No Claims Discount" database.

3.7 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.

Questions for consideration: current counter-fraud initiatives – insurance industry initiatives

Q6) How could existing industry initiatives be used more effectively?

Q7) Is there anything that could be done to build on existing industry initiatives?

Government reforms

3.8 Since 2010, the government has introduced a number of measures aimed at controlling the costs of civil litigation, which had become unsustainably high. These reforms implement and build on Lord Justice Jackson's recommendations³ and, more recently, have focused on whiplash given that the number of whiplash claims had increased substantially at a time when motor accidents were falling.

3.9 These reforms include (with date of commencement):

- reforming 'no win, no fee' conditional fee agreements (CFAs) so lawyers can no longer double their fees if they win, at the expense of defendants and their insurers (April 2013)

³ Accessed February 2015; <http://www.judiciary.gov.uk/publications/review-of-civil-litigation-costs-final-report/>

- banning 'referral fees' paid between lawyers, insurers, claims firms and others for personal injury claims (April 2013)
- reducing lawyers' 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)
- introducing tougher rules for claims managements companies (CMCs) to ensure that claims are properly substantiated before being pursued and any data they receive through telemarketing is legally obtained (October 2014)
- enabling the fining of CMCs which breach Claims Management Regulation rules (December 2014)
- adding a provision which allows courts to strike out claims where there has been fundamental dishonesty by the claimant in personal injury cases (in Criminal Justice and Courts Act 2015)
- banning legal services providers from offering inducements to potential personal injury clients (in Criminal Justice and Courts Act 2015)
- introducing a fixed fee of £180 for an initial whiplash report (October 2014)
- banning experts who provide treatment to an injured claimant from writing the medical report in whiplash claims (October 2014)
- requiring that medical reports for whiplash claims will have to be verified by a medical professional who has been randomly allocated to the case through the MedCo IT portal (from April 2015)
- introducing a robust accreditation scheme for medical professionals registered with MedCo, so that all claims are backed by independent evidence from trusted professionals (from January 2016)

3.10 As many of the above reforms were introduced recently and some are not yet in force, their effect, including any unforeseen consequences, may not yet be apparent.

3.11 In addition to the reforms above, the Independent Sentencing Council issued new guidelines on fraud in May 2014; these came into force on 1 October 2014.

3.12 The government also consulted on the issue of raising the small claims limit for personal injury claims with a view to providing a simple low cost route for the settlement of relatively straightforward personal injury claims. Such a change could result in significant savings in costs and make it easier for defendants to challenge unnecessary and exaggerated claims. In October 2014 the government published its response to the consultation,⁴ stating that "while the government believes that an increase [from £1,000] in the Small Claims limit in this sector would provide additional benefits, it regards it as sensible and pragmatic to consider the combined impact of earlier reforms before embarking on any further change now." That remains the government's position.

⁴ Reducing the number and costs of whiplash claims: A government response to consultation on arrangements concerning whiplash injuries in England and Wales, 2014

Questions for consideration: current counter-fraud initiatives – government reforms

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

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

4 Taskforce areas of interest

4.1 It is clear that insurance fraud is a broad and complicated issue. In order to keep the work of the Taskforce focused and manageable, the group has narrowed down the topics on which it wishes to concentrate.

4.2 Four broad topics have been identified.

The encouragement of fraudulent claims

4.3 The process of making third-party personal injury claims has become increasingly complex and opaque, as more organisations have entered a very lucrative market in which an accident has developed from being a misfortune to a business opportunity. Individuals involved in an accident may approach their insurer or a lawyer, or be encouraged to make claims by claims management companies or other intermediaries. The claims management industry has developed significantly over recent years.

4.4 Claims managers and other intermediaries can 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 practice and regulation in this area.

4.5 These concerns include the practice of encouraging claims ('claims farming') where there is no evidence that an injury has been caused. One well-documented route for fraudulent claims farming is nuisance calls whereby consumers are cold-called by organisations which hold their data without the consumer's knowledge and pressure them to make a claim. 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.

4.6 The activities of UK CMCs are subject to regulation by the Ministry of Justice's Claims Management Regulation Unit, although the overall regulation of marketing communications is the responsibility of the Information Commissioner's Office and Ofcom. Existing regulations already prohibit CMCs from cold-calling in person, sending unsolicited text messages to consumers without consent, and contacting anyone registered on the Telephone Preference Service (TPS). However, the Taskforce understands that a number of these nuisance calls are thought to be from unregulated companies outside of the UK which makes this activity more difficult to police.

4.7 While it is thought that a significant number of nuisance calls may be from overseas, the data for these calls originates from the UK and the Taskforce is interested in how this is obtained. The Taskforce understands that this data is sometimes stolen but can also originate from organisations which obtain consumer consent and pass on data in exchange for referral fees. Consumers are often unaware that they have given this consent, having done so for example by ticking a box on a form.

4.8 Much work has already been done on nuisance calls and the Department for Culture, Media and Sport (DCMS) has published a joint Action Plan involving all relevant regulators, including the Information Commissioner's Office, Ofcom and the Claims Management Regulator. As part of the Action Plan the Which? nuisance calls taskforce was launched and this made further recommendations in December 2014. The Insurance Fraud Taskforce will seek to build on progress made rather than duplicate existing work.

4.9 There are various other ways in which fraudulent claims may be encouraged and there are some concerns that certain claims adverts might legitimise the idea that accidents should be greatly exaggerated in order to receive a financial benefit.

4.10 While the government is already taking action, the Taskforce is interested in further steps which could prevent the encouragement of fraudulent claims without deterring those seeking to recover legitimate losses.

Questions for consideration: Taskforce areas of interest – encouragement of fraudulent claims

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

Q11) What forms of communications encourage fraudulent claims?

Q12) Are any changes needed to the regulation of those involved in the claims process?

Q13) How might coordinated regulatory action against the encouragement of fraudulent claims across different jurisdictions be achieved?

Drivers of policyholder behaviour

4.11 The Taskforce believes it is important that the insurance market functions well for honest consumers. Consumers do not always find the application or claims process intuitive and can make mistakes; innocent mistakes do not constitute fraud and so the Taskforce will not target these individuals.

4.12 However, some policyholders do commit insurance fraud and it appears this is driven either by confusion or by the perception that insurance is “fair game” for fraud.¹

4.13 On the one hand, there can be a fundamental misunderstanding of insurance among some consumers, who do not realise it is designed to cover the risk of an event occurring and instead believe that they deserve a refund of premiums paid where no claim has been made. It is in this context that consumers generally find exaggeration of a genuine claim to be more morally acceptable than out-and-out fabrication of a claim. 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.² This misunderstanding can be compounded for those customers who have a general lack of engagement with insurance.

4.14 On the other hand, academics have found that those who commit fraud often feel able to justify the action by considering it a victimless crime.³ 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. In addition, some consumers take the view that corruption is now widespread throughout society and that they would be foolish to be honest when the chances of being caught are low.⁴ The chances of being caught and the consequences can be underestimated, as found in recent research into opportunistic fraud. Gill

¹ Baldock, Trends & issues in crime and criminal justice – no. 66 Insurance Fraud, Australian Institute of Criminology, 1997

² 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

³ Viaene and Dedene, Insurance fraud: issues and challenges, The Geneva Papers on Risk and Insurance, vol 29 no. 2, 2014

⁴ Viaene and Dedene, Insurance fraud: issues and challenges, The Geneva Papers on Risk and Insurance, vol 29 no. 2, 2014

& Randall found that the consequences for insurance fraudsters are not limited to incarceration but include breakdowns in family relationships and poor future job prospects.⁵

4.15 Behavioural economics suggests that there are many complex drivers of consumer behaviour⁶ and the Taskforce intends to explore ways to reduce opportunistic fraud and tackle the perception that insurance fraud is victimless, without consequences, or even justifiable. It may be that dealing with the perception that insurance fraud is victimless could be as effective as a preventative remedy. Academic research suggests that fraud has a moral cost⁷ and that informal sanctions, such as peer pressure, can be more effective than formal sanctions.⁸

4.16 The Taskforce believes that the insurance industry has an important role to play in influencing policyholder behaviour. For example, it could raise consumer awareness of fraud through messaging around the impact it has on consumers or by giving a greater profile to the IFB Cheatline. The Taskforce notes industry efforts to date to increase consumer awareness of fraud.⁹ It understands that the insurance industry has agreed to consider how it may evolve its approach to consumer awareness and education, and identify a set of objectives that would set its future fraud communications agenda. The Taskforce looks forward to a progress update from the ABI on this work by Q2 2015.

4.17 Alongside this industry work, the Taskforce will further consider the wider area of policyholder behaviour.

Questions for consideration: Taskforce areas of interest – drivers of policyholder behaviour

Q14) How could engagement with consumers and consumer education be improved to reduce insurance fraud?

Q15) How might communications be used to discourage dishonest claims and should these communications emphasise the effect of fraud on honest policyholders?

Q16) How common is the perception that insurance fraud is a victimless crime?

Q17) Do the actions of any party involved in the underwriting or claims process encourage the perception that insurance fraud is justifiable?

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

Fraud deterrents in the claims process

4.18 The Taskforce is interested in the adequacy of deterrents for making spurious claims, both whether the courts have sufficient powers to deal with such cases, and whether the legal process adequately supports full investigation of claims. The Taskforce has been informed under the current legal process it is sometimes and easier and cheaper to settle a potentially fraudulent claim.

4.19 The Taskforce is aware that new Independent Sentencing Council guidelines came into force on 1 October 2014 which have tightened existing guidelines and have sought to promote greater transparency and consistency in sentencing. Despite this, there is still anecdotal concern

⁵ Gill & Randall, Insurance Fraudsters, 2015

⁶ FCA, Applying behavioural economics at the Financial Conduct Authority, 2013

⁷ Bourgeon and Picard, Fraudulent Claims and Nitpicky Insurers, American Economic Review, vol.104, 2014

⁸ Richards, Deterring insurance: a critical and criminological analysis of the English and Scottish Law Commissions' current proposals or reform, Insurance Law Journal, 2013

⁹ For example, through various campaigns such as 'Get a Real Deal' (November 2013)

about the seriousness with which insurance fraud is treated within the criminal justice system – either in prosecutions brought or sentences passed.

4.20 The Taskforce will consider whether the current legal structure encourages farming of fraudulent low-value claims and if there is evidence that existing deterrents are not strong enough. If evidence is found then the Taskforce will look at potential recommendations to address this. When assessing possible recommendations, the Taskforce will take into account any impact that these might have on access to justice and the customer experience for innocent consumers.

Questions for consideration: Taskforce areas of interest – fraud deterrents in the claims process

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

Q20) How effective are current legal deterrents at preventing insurance claims fraud?

Q21) Is there any evidence that insurance fraud is not treated with sufficient seriousness within the criminal justice system?

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

Role of fraud data

4.21 Historically, insurers fought fraud in isolation using small investigation teams and their own limited data to prevent repeat fraudsters. As described above, the industry has increasingly recognised the importance of collaboration and sharing data on fraud to tackle this dynamic problem. When insurers have more data available they are 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.

4.22 There is still capacity for fraud data to take a bigger role in preventing insurance fraud. The Taskforce has been told that many in the industry under-utilise available commercial software and could make an investment in this in order to reap the rewards. Current data initiatives could also be expanded beyond insurers to others involved in the claims process, although this would come at a cost and funding of this would need to be acceptable to all parties. The Taskforce understands that insurers are already exploring data sharing with third parties and claimant lawyers will have access shortly to information from the CUE personal injury database.

4.23 The Taskforce will consider in its recommendations the key areas for expansion of data sharing, but will also take into account the impact on privacy.

Questions for consideration: Taskforce areas of interest – role of fraud data

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

Q24) What impediments are there that hinder fraud data-sharing?

Q25) What are the most effective ways to extend fraud data-sharing with the view of tackling insurance fraud?

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

Q27) What are the greatest risks to privacy in fraud data-sharing and what should be done to mitigate these?

4.24 The Taskforce will remain open to exploring other important areas of interest that may arise during the Taskforce's work.

Questions for consideration: Taskforce areas of interest

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

5 Next steps

5.1 This interim report has outlined the Taskforce's early thinking on the problem of insurance fraud. Due to the complexity of the problem the Taskforce will need to explore the issues in more depth before making final recommendations later in 2015. However, the Taskforce has considered whether there are any early steps which would benefit from being initiated at this stage rather than in the final report, and has identified an initial recommendation.

Initial recommendation

The ABI and BIBA to update industry guidance on the prevention of application fraud

5.2 This report has set out the numerous initiatives taken forward by the insurance industry to prevent fraud and the Taskforce supports the progress made by industry to date.

5.3 The Taskforce notes that innovations and technology in counter-fraud techniques have evolved since the ABI and BIBA first published guidance for insurers and insurance intermediaries on how to prevent application fraud in October 2011.¹ The Taskforce believes that an update is required so that it continues to remain fit for purpose.

5.4 The Taskforce is pleased that the ABI and BIBA have agreed to update this guidance by Q4 2015.

Considering final recommendations

5.5 The Insurance Fraud Taskforce is ensuring its work is transparent by publishing meeting minutes on GOV.UK and holding events with stakeholders. The Taskforce aims to maintain the engagement of those beyond the core membership. This report presents an opportunity for all interested parties to submit their views and share their expertise in order to help the Taskforce meet its aims.

5.6 All interested parties are encouraged to submit answers to this report's 'Questions for consideration', using the form on the Insurance Fraud Taskforce website: www.gov.uk/government/groups/insurance-fraud-taskforce

5.7 This form should be sent to insurancefraud@hmtreasury.gsi.gov.uk by 13 May 2015.

5.8 This is the best opportunity to shape the work of the Taskforce, as it will soon begin considering recommendations. However, the Insurance Fraud Taskforce mailbox will remain open until the Taskforce completes its work and the group will consult interested parties when scrutinising potential recommendations.

5.9 A final report will be produced by the end of 2015 with recommendations and justification.

¹ BIBA & ABI, Helping to reduce insurance fraud when customers apply for products – a good practice guide, 2011

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:

- the perception among some consumers that insurance is 'fair game' and that insurance fraud is a legitimate way of making some money
- the extent to which insurance fraud is encouraged (or not deterred) by existing practices of those involved in the claims process (including insurers, lawyers, claims management companies and other intermediaries)
- 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:

- the potential long-term benefits against the potential long-term costs
- whether the solution would have an adverse impact on consumers and if so, whether action could be taken to mitigate this
- whether the solution is robust or could be undermined
- 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 An interim scoping report will be published by March 2015 and a final report will be published by the end of 2015.

The ABI – calculation of fraud statistics

B

B.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 £1.3 billion in 2013.¹

B.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.

B.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.

B.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:

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.*

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;*

¹ Accessed February 2015; <https://www.abi.org.uk/News/News-releases/2014/05/Insurance-cheats-feel-the-heat-value-of-fraudulent-claims-uncovered-by-insurers-hits-record-level>

- *an insurer has terminated a contract or a non-contracted relationship/recognition with a supplier or provider;*
- *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.*

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.

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

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).*

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

HM Treasury contacts

This document can be downloaded from
www.gov.uk

If you require this information in an alternative
format or have general enquiries about
HM Treasury and its work, contact:

Correspondence Team
HM Treasury
1 Horse Guards Road
London
SW1A 2HQ

Tel: 020 7270 5000

Email: public.enquiries@hmtreasury.gsi.gov.uk