Access to Justice (A2J) response to Insurance Fraud Taskforce

Introduction

Access to Justice is an incorporated ad hoc body, which coordinates action to protect access to justice for people injured through no fault of their own. It is not a formal membership organisation and participation is open to organisations, representative bodies, law firms and other businesses that support injured people. This includes support groups and charities, consumer organisations with a particular interest in legal services, solicitors' firms and barristers, claims management companies, after the event insurers, trade unions and other membership organisations and representative bodies. - See more at: http://accesstojusticeactiongroup.co.uk/

In this response, we comment on the recommendations of the Government's Insurance Fraud Taskforce, insofar as they relate to injured people. As an organisation that approaches the issue from the viewpoint of injured people, and their right to recompense for losses and injuries, we are concerned that the Taskforce composed representation almost exclusively from the insurance industry and Government, with no direct representation from those who represent injured people.

Fraudulent motor insurance claims are wrong and increase the hurdles that the overwhelming majority of genuinely injured people face. Responsible lawyers and claims management companies employ robust anti-fraud measures, and do not wish to pursue claims on behalf of anyone whom they believe to be a fraudster.

We welcome initiatives which:

- encourage data sharing;
- encourage the co-ordination of best practice between insurers, defendant and claimant law firms;
- take a more robust approach to defending claims;
- toughen sanctions (criminal or regulatory) against dishonest solicitors and owners of CMCs;
- improve communications between insurers and regulators; and
- clamp down on nuisance callers

Access to Justice also considers the Taskforce report should have done more to encourage insurers to share data with law firms, rather than as seems to be the case, the Taskforce report being more about insurers sharing data just with each other.

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Although proven fraud is rare, many insurers nevertheless settle claims, which they define as suspected fraud. This includes cases where a settlement is offered before a medical examination has even taken place.

To reduce levels of actual fraud, cut the cost of motor insurance premiums and ensure genuine claimants can continue to get the support and compensation they deserve, in addition to the comments we make above and on the Taskforce recommendations, we also recommend that insurers should annually transparently publish the statistical and financial data showing the extent of any linkage between the incidence of fraud and the pricing of premiums.

Access to Justice 's comments on the Taskforce recommendations:

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 customers

We agree with this recommendation.

Recommendation 2: To ensure anti-fraud messaging is targeted and hardhitting:

- 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

We agree that a communications strategy is important: but whilst highlighting the consequences of fraud, it should also not deter genuine claimants who may be frightened off from pursuing a legitimate claim, if the strategy is not a balanced one. The data supporting any behavioural economics research should be made available as well as the publication of the research report.

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

One of the most contentious issues in the debate over combating fraud is to define what is and is not, 'fraud'. The insurance industry, for its own interests, spreads the net as widely as it can by including 'suspected fraud' in its statistics, even if unproven and the claim is settled by them.

'Fraud' should be defined on a basis agreed with those representing injured people. Actual fraud should be limited to those cases where there is a conviction, police caution, or a judge has so ruled when adjudicating on a claim in court. Suspected fraud should not be included if the claim is settled. A clear and agreed definition should be used to establish a clear baseline of the true extent of fraud.

It is already compulsory for a solicitor to do an ASKCUE check, but this database is only as good as the information stored on it. It should also be mandatory for insurers to upload relevant information weekly.

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

We agree with this recommendation

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.

In agreeing with this recommendation, we suggest any such guidance should be produced in partnership with claimant representatives, including an agreed definition of fraud as we suggest in our response to recommendation 3 above.

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

We agree with this recommendation.

Recommendation 7: The ABI should consider how it resources its counter fraud activity and whether more priority should be given to this task.

We agree with this recommendation.

Recommendation 8: The ABI should discourage the inappropriate use of premedical offers

This is an extremely important issue, and the recommendation does not go nearly far enough.

Pre-medical offers are a major driver for fraud and must be more than discouraged: they should be banned. This is a proposal that has been repeatedly made since the anti fraud debate began which years ago, and in relation to which no good explanation has been given by the insurance industry as to why this should not be the case.

One of the key checks in eliminating fraud is to establish what medical advice the injured person sought; and a subsequent examination is also a vital part of the verification process. This proposal also would help to tackle the equally serious issue of under settlement, which is to the detriment of the claimant.

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.

We agree to this recommendation. This is an important counter fraud measure. The insurers cannot have it both ways. Any claim that is settled should be discounted from any fraud statistics: see our comments on recommendation 3 above.

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 5 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

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- 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 accident.

Access to Justice has serious concerns about these recommendations, which could cause serious injustice to those who claim late for legitimate reasons, for example finding that they did not recover from their symptoms as well as they expected to do.

We note that the Government already plan to go beyond the first of these recommendations anyway, by generally extending the small claims track limit, with which proposals we do not concur, and in relation to which we will give our detailed comments when the consultation paper on the scheme is published.

We agree that one option would be to impose a costs penalty for late notified claims, but we would suggest that 6 months is far too short and would exclude far too many legitimate cases. We would propose that any such sanction should apply only after 12 months: beyond that date, the risk of fraud could be argued to be greater. Moreover, any shorter period would run the risk of being seen as disproportionate under Article 6 of ECHR by interfering with the right to a fair hearing.

With such a system, exemptions would also be needed to accommodate legitimate reasons for a late claim, such as a late onset condition; or a claim on behalf of a minor, so as also to avoid infringing Article 6.

We do not support a system of 'predictable damages' for soft tissue injuries: there is no reason why they cannot be assessed within the relatively narrow parameter bands already set by the JSB guidelines, which are based upon case law.

We do not agree with shifting the burden of proof: it is already the law that any injury has to be proved by the claimant. Any delay in claiming is in itself evidential as to the extent of any injury and it remains for the claimant to prove the claim on the balance of probabilities.

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

We agree with this recommendation.

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.

We agree with this recommendation.

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

We agree with this recommendation.

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

We accept that current levels of fines may not be proportionate as a deterrent, but we consider that any review of SRA powers should distinguish between misconduct due to fraud and corruption as opposed to negligent behaviour by the solicitor concerned.

The Solicitors' Disciplinary Tribunal has a high 'conviction' rate and therefore needs no review of its standard of proof. If there is to be a review, then the criminal standard should continue to apply to conduct that is alleged to be criminal as opposed to negligent.

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

We agree with this recommendation in principle but would add that this is already the case. Detection of and enforcement against fraudulent activity is already part of the SRA's regulatory role. The Solicitors' Disciplinary Tribunal already 'names and shames' solicitors against whom it makes an adverse finding.

Client identification checks are already made at medical examinations for a personal injury claim under the Medco system: another reason to ban premedical offers (see comments on recommendation 8 above).

Referral fees are banned and the ban should be properly enforced as to fail to do otherwise is to continue to allow market distortion.

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.

We agree with this recommendation.

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.

The intention behind this recommendation is that the information as to the source of referral will go direct to the insurers rather than the IFB, suggesting that it is not concerned about fraud prevention.

We do not agree with this recommendation, as it is anti competitive and would not work, as it requires disclosure of commercially sensitive information. The information may also give a commercial advantage to insurers, not linked to any issues about fraud prevention.

Solicitors who are breaking the referral fee ban or otherwise using doubtful referral sources would not self-report on a CNF anyway.

If the insurers are concerned about a particular referral source, then they should publicise those concerns to warn solicitors that the referrer may not be operating legitimately.

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.

We agree with this recommendation. Such contact should be strictly circumscribed to avoid illegitimate contact behind the solicitors' back, for example to persuade the claimant to under settle.

We recommend adopting the approach taken by the Portal behaviour committee

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.

We agree with this recommendation. We recommend the standard letter produced by the Portal behaviour committee.

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

We agree with this recommendation. However, the biggest problem concerns CMC organisations, especially small ones, that do not register and are effectively unregulated as they are difficult for the regulator to identify and act against. A major concern arises from those CMCs that operate offshore outside the jurisdiction.

The owners of CMCs should not be able to hide behind 'the corporate veil', but like solicitors, face personal sanctions for misconduct.

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.

We agree with this recommendation but more needs to be done. The Government should take powers to require telecoms undertakings to discontinue telephone lines used for unlawful marketing and for return calls in response to an unlawful approach; and to ban CMC businesses who have been found to make unlawful unsolicited calls from subscribing to new lines.

If an individual is asked to agree to their data being used for marketing purposes, their opt-in should be much more clearly requested; and if given, should only be valid for six months. After this point, a renewed opt-in should be sought before the individual is contacted.

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

We agree this recommendation but believe its prospects of success are limited in that such activities are not universally unlawful. We repeat our comments under recommendation 21, to cut phone lines and on opt-ins; we agree more needs to be done to ensure consumers are aware of the consequences of opting-in.

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.

We agree with this recommendation, but point out this work is already in hand through the CJC

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.

We agree with this recommendation.

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.

We agree with this recommendation.

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.

We agree the principle of a continuous review, but cannot support these legacy arrangements, as they would build on what is an already unbalanced set of recommendations. We repeat our concern that the Taskforce did not have claimant organisation representation on it. If fraud is to be tackled effectively, it can only be done with the full involvement of claimant representatives, who are best placed to eliminate fraudulent claims, if given the support and information they need from the insurance industry to do so.