FRAUD IN THE MOTOR & DISEASE SECTORS

Modern Insurance caught up with Weightmans to discuss the current trends in Fraud. We spoke with Jeff Turton, Principal Associate, on fraudulent claims in Motor, and Paul Debney, Partner, on fraud in Disease.

Motor **FRAUD**

In 2018, the Insurance Fraud Bureau (IFB) published its Insurance Fraud Strategic Threat Assessment, which outlined what it regarded to be the most significant insurance fraud threats. It reported that, in motor insurance, the organised 'crash for cash' scams which have for so long been the bane of the industry, have been overtaken by the threat of genuine claims that involve elements of opportunistic fraud.

Whilst the layering of genuine claims with fraudulent elements is not new, we have detected a significant upturn in claims which include contrived, unnecessary or exaggerated heads of loss, especially where credit hire or ancillary expenses - such as physiotherapy charges - are claimed.

One of the challenges of tackling layering is that it can appear in almost any claim, and traditional methods of screening for fraud may not be fit for the purpose of detecting it. Plus, perhaps motivated by a historical view from some areas of the judiciary that a fabricated or exaggerated head of loss should not be fatal to an otherwise genuine claim, insurers have sometimes considered it to be commercially astute to consider compromising a claim despite the presence of a dishonest element.

In our view, the most effective way in which insurers can tackle the increase in layered claims is to develop a collective approach to detecting and delivering robust outcomes in these claims and, once done, deterring claimants or professional enablers from bringing them in the future.

Detection

It is very rare that there is a single silver bullet available to undermine a claim in full and detection must extensively utilise industry shared data, together with technology and technical expertise. This approach underpins our success, and collaboration with insurers is vital in achieving these goals. With the use of structured and unstructured data, along with social media, we have been able to identify a greater number of potentially fraudulent claims and link those involved in the perpetration of these claims with much more confidence. Natural language processing has given us the opportunity to predict the probability of fraud and is the next step in the evolution of fraud detection.

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Delivery

As we have previously reported, there are signs that the courts are now more willing to make findings of fundamental dishonesty and deploy S.57 Criminal Justice and Courts Act 2015 to dismiss genuine PI claims which contain elements of dishonesty. Just recently, the High Court has dismissed a claim in which the claimant was genuinely injured but he lied about the disposal of his car after the accident in question. Insurers should take comfort from this shift in approach and collectively send a signal to claimants and enablers by robustly defending claims where dishonesty has been detected, to trial.

Deterrent
There are various ways to make a dishonest claimant feel the pinch. One way, thanks to the QOCS fundamental exception under CPR 44.16 (and other QOCS exceptions), that insurers can do this is to hit them in the pocket. The industry should be encouraged to adopt a best practice approach to their claims handling strategies, so that all insurers are thinking about the recovery of costs, and how best to robustly enforce those costs, from the moment a dishonest claim is detected.

In addition, insurers are encouraged, in appropriate cases, to play their part in delivering the industry counter fraud message, by bringing committal proceedings and private prosecutions and by making referrals to the Insurance Fraud Enforcement Department. Whilst such action involves a cost, insurers will feel the benefit in the long-term when it is fully understood by prospective fraudsters that there are real risks to bringing dishonest claims.

Collaboration was a key reason why the industry succeeded in reducing the threat of 'crash for cash' and there can be no doubt that the challenge of layering can also be met by insurers joining forces to tackle it.

Jeff Turton
is the Principal Associate at Weightmans.

Disease **FRAUD**

Despite rapidly falling numbers, the key fraud challenges in disease claims still arise in noise induced hearing loss matters, primarily because fraud is not obvious and detection not easy. The majority of such claims are historic, and in many there is little or no direct evidence to counter the claimant's allegations. Our experience of dealing with almost 30,000 deafness claims and detailed analysis of that data has allowed us to determine exactly what red flags to look for and what verification to seek.

We have learned that claimants often try to "shave the rough edges" off their claims. By, for example: -

- Claiming that work was noisy when it simply wasn't;
- Exaggerating noise exposure at employers, for which insurance cover has been traced and reducing it (sometimes to nil) at employers where none is known;
- Conveniently forgetting that hearing protection and/or training was provided;
- Neglecting to mention: -
  - A previous claim for deafness;
  - Significant non-occupational noise exposure from shooting, motorcycling, playing in or listening to bands;
  - That they have known about the hearing loss for very many years (such that the claim is statute barred), or specifically alleging that such knowledge is only within the last 3 years.
  - Presenting unreliable medical evidence, such that an independent test reveals only the normal deafness associated with ageing and no noise induced hearing loss; or
  - Any combination of the above.

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Any one of these "rough edges" can be enough to "kill" a claim when identified and properly challenged – they have led us to achieve an overall nil settlement rate in excess of 70%.

Total noise claims notifications in the market rose from around 20,000pa in 2010/11 to over 100,000pa in 2014 and 2015. They have fallen significantly since 2016 and are now back to levels last seen in 2010/11. The fact that claims numbers have fallen at such rate is testament to a defendant market that has collaborated to raise awareness and take the profit out of these claims, forcing those perpetuating fraud to look elsewhere for an easier return. Despite market eagerness, collaboration has been hampered by business and regulatory restraints; such as data protection legislation, intellectual property issues, unique selling points of solicitors and insurers and possible cartel complications. These have all hindered the sort of big data sharing that might have accelerated the demise of this claim type.

Paul Debney
is a Partner at Weightmans.