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"It's a really grey area": An exploratory case study into the impact of the Jackson Reforms on organised insurance fraud

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ABSTRACT

The Jackson Reforms were designed to address the mounting cost of UK civil justice by reducing personal injury claims' costs, yet the government presented them as part of wider counter insurance fraud initiatives. This case study utilises counter fraud practitioner interviews and industry data to explore the reforms' impact on organised insurance fraud. The study highlights how a market of supplier-induced demand may exist in the personal injury market whereby fraud need only be committed by one actor to have a financial benefit to other parties. Such a situation causes difficulties identifying actual fraud, particularly as actors may unconsciously participate. Despite this the insurance industry has already publicised its own conclusions and supports further reforms to the sector. This study will argue that without further examination of the Jackson Reforms subsequent reforms may inadvertently serve to shift fraud into new areas and cause further challenges for counter fraud practitioners.

1. Introduction

In 2009 Lord Justice Jackson was asked by the Master of the Rolls to conduct a review into UK civil litigation following concerns over increasing civil justice costs (Jackson, 2009). In December 2009 the final report published recommendations designed to promote access to justice at a proportionate cost (Jackson, 2010). Recommendations in relation to personal injury claims were implemented as part of the Legal Aid, Sentencing and Punishment of Offenders Act (2012) (LASPO), which came into effect in April 2013. Further changes were made to the Civil Procedure Rules 1998 and Referral Fees (Regulators and Regulated Persons) Regulations 2014 (MOJ, 2015a).

The Jackson Reforms, as they are now known, included the following changes to personal injury claims:

- Making any 'success fee' payable by the winning party.
- Limiting the success fee to 25% of the damages in personal injury cases.
- Banning referral fees and inducements in personal injury cases.
- Fixing the costs of getting medical reports in whiplash claims.
- Reducing the fixed recoverable costs in road traffic accident claims up to £10,000 and extending the scheme to £25,000, and to include employer's liability and public liability claims.

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(MOJ, 2015a).

Before examining how these reforms have impacted insurance fraud it is prudent to provide a brief explanation of whom they affect. The first two points impact the amount claimant solicitors can recover from successful litigation. The 'success fee' is an additional fee paid to a claimant solicitor upon winning a case, calculated as a percentage of the claimant's general damages (SRA, n.d). Pre-Jackson this was borne by the unsuccessful defendant up to 100% of the lawyer's fee, but is now deducted from the client's damages at a limit of 25% for personal injury claims (MOJ, 2015a). Pre-Jackson, protection against costs was offered to claimants in the form of After The Event (ATE) insurance with the premium recoverable from the defendant. Post-Jackson the premium is payable by the claimant regardless of success; however, it was recommended that claimants be provided with a 10% uplift in general damages to compensate for this financial loss (Jackson, 2010).

These changes to funding form part of the principle of Qualified One-Way Cost Shifting (QOCS) which Jackson (2010) recommended be introduced. The cost shifting is 'one-way' in the sense that a successful claimant's costs can be recovered from the defendant but not vice versa. However, the 'qualified' element is invoked if certain criteria are met, including proof on the balance of probabilities that the claim was fundamentally dishonest (Justice, 2016a). In this circumstance the defendant is able to recover costs from the claimant (Justice, 2016a).

Referral fees at their most basic were a solicitor's acquisition cost which is outsourced to a claims management company (CMC) (Higgins, 2012), although payments may also have been made to claimants or other individuals involved in the claims process. The ban therefore removes an income stream for various parties. The ban is regulated by The Ministry of Justice (MOJ) Claims Management Regulator which regulates the use of inducements to attract claimants (MOJ, 2011).

The fixed costs for medical reports were implemented as part of the Civil Procedure Rules and based the cap on recoverable costs on a 2009 agreement between insurers and compensators on the one hand, and medical reporting organisations on the other (Jackson, 2010). The Pre-Action Protocol for Low Value Personal Injury in Road Traffic Accidents defines the term 'Medical Report' and explains that reports should be provided in order to assist defendants calculate appropriate damages (Justice, 2016b) and does not include reports associated with rehabilitation.

The final change effects the definition of low value road traffic accident (RTA), employer liability (EL) and public liability (PL) personal injury claims. As a result of the reforms the financial limit for damages in low value claims has risen from £10,000 to £25,000. Low value claims fall within the fixed recoverable costs regime, and are processed through the MOJ Claims Portal, which provides an electronic means to share claims information (Claims Portal, 2013). However, claims will not proceed via this process if the defendant has identified contributory negligence on the part of the claimant, does not admit liability or has not been provided with adequate details in the Claim Notification Form (Justice, 2016b). Claims removed from the portal can be subjected to further investigation but risk incurring substantially increased costs due to the removal of the protection of fixed costs (QBE, 2013).

2. Aim and methodology

This study aims to act as an exploratory case study into how the Jackson Reforms have impacted organised insurance fraud and organised fraud investigation, utilising counter fraud practitioner interviews, fraud data and secondary sources. Through critical analysis it is hoped that it will be possible to identify gaps in knowledge and future research questions to study the reforms.

Eight semi structured interviews were conducted in February and March 2016 with counter fraud practitioners working in insurers, compensators and the Insurance Fraud Bureau (IFB). All participants had experience of organised insurance fraud investigations and were contacted using contact lists provided by the IFB. Table 1 below details the roles of participants and the sector their respective employers.

Permission was also gained from the IFB to use investigations' data collected from November 2012 to June 2016. Each IFB investigation is categorised with the modus operandi of the fraud. Investigations may involve more than one type of fraud; therefore, the data presented is not representative of the total investigations. Instead it provides an insight into the shift of the type of investigations managed by the IFB over time.

The IFB categorise their claims investigations into four categories of modus operandi:

Table 1
The roles and organisations of participants interviewed.

Interview	Organisation	Sector
A	IFB	Counter Fraud
B	Insurer	Commercial & Personal Motor
C	Insurer	Personal Motor
D	Insurer	Commercial & Personal Motor
E	MIB	Compensator for losses resulting from uninsured or untraced drivers
F	Insurer	Commercial & Personal Motor, Commercial Property, Household, Travel
Ga	Self-Insured Organisation	Public Transport
Gb	Self-Insured Organisation	Public Transport
H	Insurer	Commercial & Personal Motor, Household, Employer and Public Liability

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