

A SMART(ER) APPROACH TO INSURANCE FRAUD

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ABSTRACT

Insurance fraud is not one thing but many. For political reasons, this simple truth is often hidden, as cumulative figures describing the sum total of insurance fraud are deployed to bring about legal and administrative measures that favour the insurance industry. Rule design must recognise those apparently conflicting truths that insurance fraud is socially harmful and that the insurance industry's approach to counter-fraud is often self-serving. This paper draws on recent developments in the United Kingdom to show how incremental advances in the fight against fraud can be delivered without creating excessive opportunities for the insurance industry to limit the recovery of honest claims.

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I. INTRODUCTION

Insurance fraud is a global issue. There is probably little else that can be said about the subject without dividing the audience. This paper seeks to break apart that polarised debate in search of new methodologies that enable us to better understand the nature and extent of insurance fraud. Much of my attention will be focused on “soft fraud” (what the U.K. calls “opportunistic fraud”), as it represents the vast majority of fraudulent claims.¹

There are three overlapping reasons why a more considered approach to ‘soft fraud’ is important:

1. Fraud committed by “otherwise honest” policyholders provides a rich and diverse series of doctrinal issues, as shown by litigation in the English courts, which challenges simplistic doctrinal responses;
2. Opportunistic fraud makes up the vast majority of fraud, and measuring it accurately is vital if the extent of fraud in insurance is to be properly estimated and countered; and
3. Soft fraud is more amenable to the application of behavioural science—to “nudge” policyholders away from acting dishonestly. This provides a testbed for developing strategies that seek to prevent rather than react to insurance fraud.

These interlocking approaches go beyond the traditional call to deter on the basis of rational economic incentives. These innovations are being adopted in the United Kingdom as a result of two decades of concerted study by academics, courts and industry. The concerted effect promises substantial improvements in the industry’s response to opportunistic fraud. Unlike traditional visions of deterring insurance fraud, the image is one of persuasion rather than punishment. This has numerous advantages, not least that it reduces the industry’s unfortunate reputation as treating its customers with grave suspicion.²

English and American insurance fraud have much in common that allows these comparisons to be made. Each makes assumptions as to the efficacy of deterrence by private law rules, and there is considerable

¹ *Complex Challenges Remain with Growth in Liability and Application Fraud*, IFB (Aug. 28, 2019), <https://insurancefraudbureau.org/media-centre/news/2019/complex-challenges-remain-with-growth-in-liability-and-application-fraud/>.

² See RICHARD V. ERICSON, AARON DOYLE & DEAN BARRY, *INSURANCE AS GOVERNANCE* (2003) (especially chapters 7 (Prospects as Suspects) and 9 (Claims of Fraud)).

overlap in the “working parts” of that system: issues such as materiality, reliance, and remedy are part of a shared language.³

II. THE OPTIMAL DESIGN OF INSURANCE FRAUD RULES

In any interesting insurance law situation, there are normally at least three interests at play: the commercial interests of the insurer; the comparable interest of the insured; and the wider public interest. At times, and certainly within subrogation or liability insurance issues, we add third parties to the mix. Assume for now that we are seeking to design the optimal insurance fraud rule to apply between the insured and its underwriter. A simple model would suggest that any intervention which deters fraud by the insured is justified because fraud is inherently socially wasteful.⁴ This is the approach that is most commonly espoused by the insurance industry. It assumes that the public interest and the commercial interest of the underwriter are aligned in a “zero tolerance” model. The most significant limiting factor is the cost of the intervention. In such case, we might as a society look to reduce the costs of deterring fraud by limiting the application of competition (“anti-trust”) law to these developments, allowing the insurance industry to take concerted action.

The lessons from more careful study of this field identify serious flaws in this model. The commercial interests of insurers do not perfectly align with the public interest in all cases. The threat of “insurance fraud rules” can be used in practice to limit legitimate claims. This is an opportunity for insurers. The risk of fraud is used as a key element in lobbying undertaken by insurers to remodel judicial rules and regulatory

³ See Feinman’s discussion of the “moving parts” within the U.S. “false swearing” doctrine:

A broad, insurer-favorable version of the false swearing rule has generous standards for materiality and intent, no reliance requirements, and has the effect of avoiding the insurer’s obligations under the policy altogether. Narrower versions of the rule require that the insurer have relied on the misrepresentation or the false swearing enables an insurer to avoid coverage only as to the portion of the claim that was misrepresented.

Jay M. Feinman, *Contract and Claim in Insurance Law*, 25 CONN. INS. L.J. 153, 188 (2018) (internal citations omitted).

⁴ For information on wasted transaction costs, see DONALD HARRIS, DAVID CAMPBELL & ROGER HALSON, *REMEDIES IN CONTRACT & TORT* 554–57 (2d ed. 2001).

systems in their favour. An example of this from the English courts is given below, but they are legion. In short, the strictness of insurance fraud rules to limit opportunistic conduct⁵ by the insured creates the possibility of opportunistic conduct by the underwriter in response. This is a factor which must be considered when judging the effectiveness of counter-fraud measures.

The active involvement of insurers in the enforcement of counter-fraud rules through private law, criminal and quasi-criminal sanctions has not gone without notice. In the U.S., Feinman has written persuasively of the misuse of fraud rules to limit the insurers' exposure to valid claims⁶ and Abramovsky has done likewise in respect of insurer-sponsored prosecutions.⁷ The U.K.'s Financial Ombudsman Service has, on occasion, treated the occurrence of soft fraud as a consequence of an insurer's unrealistic demands of proof of loss rather than the customer's dishonesty.⁸ In the U.K., the concerted use of actions for contempt of court as a means of control over insurance claims processes has received detailed attention from Hjalmarsson.⁹ These contempt cases are judicial proceedings, instigated by insurers, for the use of false evidence by insureds during litigation and often result in custodial sanction. The limits of much of this scholarship is that it tends to assume that the opportunism ends there. In reality, things are a little more complicated than that. As recent contract scholarship shows these changes in the position of the underwriter and the insured would continue in turn, at least until a point of equilibrium is reached.¹⁰

⁵ I adopt here the standard definition of opportunism as "self-interest seeking with guide," drawn from OLIVER E. WILLIAMSON, *THE ECONOMIC INSTITUTIONS OF CAPITALISM: FIRMS, MARKETS, RELATIONAL CONTRACTING* 47 (1985) and readily acknowledge the uncertainties within the definition. See Clayton P. Gillette, *Legal Supervision of Commercial Opportunism*, in *CONTRACT GOVERNANCE: DIMENSIONS IN LAW & INTERDISCIPLINARY RESEARCH* (Stephan Grundmann, Florian Möselin, & Karl Riesenhuber eds., 2015).

⁶ JAY M. FEINMAN, *DELAY, DENY, DEFEND*, ch. 10 (Delden Press, 2010); and more recently in Jay M. Feinman, *supra* note 3.

⁷ Aviva Abramovsky, *An Unholy Alliance: Perceptions of Influence in Insurance Fraud Prosecutions and the Need for Real Safeguards*, 98 J. CRIM. L. & CRIMINOLOGY 363, 363–427 (2008).

⁸ James Davey, *Unpicking the Fraudulent Claims Jurisdiction in Insurance Contract Law: Sympathy for the Devil?* LLOYD'S MAR. & COM. LAW Q. 223 (2006).

⁹ Johanna Hjalmarsson, *Fraudulent Insurance Claims as Context: Moral Support for Contempt of Court Decisions* 39 CIV. JUST. Q. 118 (2020).

¹⁰ See JONATHAN MORGAN, *CONTRACT LAW MINIMALISM: A FORMALIST RESTATEMENT OF COMMERCIAL CONTRACT LAW* 137–48 (2013) ('Regulating opportunism'). Much of this scholarship owes a debt of gratitude to the work

An example might be useful here. Assume that courts impose a rule which is at the stricter end of the “false swearing” rule. In the United States, this would normally be the enforcement (under some conditions) of a contractual provision, such as:

This entire policy shall be void if, whether before or after a loss, the insured has willfully concealed or misrepresented any material fact or circumstance concerning this insurance or the subject thereof, or the interest of the insured therein, or in case of any fraud or false swearing by the insured relating thereto.¹¹

This enables an insurer to avoid the entirety of a claim for a relatively minor, and perhaps unnecessary, lie. Insurers might justifiably feel that it is to their commercial advantage to be stricter (“nit-picky”) in reviewing claims.¹² In light of this altered behaviour, a regulator, or Ombudsman, decides that this rule is too strict and imposes additional restrictions to prevent the underwriter from using this rule where disproportionate. That new restriction creates a potential opportunity for the insured to game that rule. And so on.

It is this possibility of “reflexive opportunism” through law-making that lies at the heart of this piece. In the United Kingdom, this feedback loop has been used to argue against the use of contract as an instrumental tool.¹³ This neo-formalist turn operates on the following model: assume that all instrumental rules create a shift in legal and economic environment in which commercial actors operate. If change is dynamic in these systems, then the ultimate effect of every instrumental rule of law is unknowable because the iterative response of each party to the other’s change of position will take too many steps to reach a point of equilibrium for effective planning.¹⁴ This is instrumental contract law as a chaotic system, or at least a system that is sufficiently chaotic for courts or legislators to be unable to predict outcomes.

of CAROL HEIMER, *REACTIVE RISK AND RATIONAL ACTION: MANAGING MORAL HAZARD IN INSURANCE CONTRACTS* (1992).

¹¹ See Jay M. Feinman, *Insurance Fraud, Agency, and Opportunism: False Swearing in Insurance Claims*, INS. FRAUD SYMP. 2 (2016), <https://rucore.libraries.rutgers.edu/rutgers-lib/51227/> (tracing it back to ‘[t]he first paragraph of the 1943 New York Standard Fire Policy—the “165 Lines” that became the basis for many standard, legislatively adopted policies . . .’).

¹² Jean-Marc Bourgeon & Pierre Picard, *Fraudulent Claims and Nitpicky Insurers*, 104(9) AM. ECON. REV. 2900, 2912 (2014).

¹³ See MORGAN, *supra* note 10, at 137–48.

¹⁴ David Campbell, *The Incompleteness of Our Understanding of the Law and Economics of Relational Contract*, 2004 WIS. L. REV. 645, 651 (2004).

My central claim is that English insurance law and practice has developed a more sophisticated model to counter insurance fraud through the utilisation of data and behavioural science. Rather than deny the “feedback loop” that intervention creates, we consider those costs in the design of rules. This transformation to a smarter vision of counter-fraud action is not yet complete, but offers significantly improved outcomes in the reduction of fraud, with limited risk to the insured’s interests. These incremental improvements have been delivered in part by reducing the barriers between academics, lawyers, judges and the insurance industry. This is the purposeful pursuit of applied research by academics and the creation of lines of communication by industry and government so that research can be properly understood and implemented.

The superiority of English practice is based on three interlocking claims:

1. The shift from a contractarian to a public policy basis for determining the default rules for soft fraud has allowed for considerable development of the moving parts of insurance fraud rules (especially materiality, reliance, and remedy for breach) which appear to be more limited¹⁵ in the U.S. system. This is Part II;
2. The reporting of insurance fraud, largely within the control of the insurance industry, is a classic example of insurer opportunism, with data reported in a manner designed to encourage legal and political change in the interest of insurers, and not the general good. Academic criticism of the process has highlighted the limits of the data. This is found in Part III; and
3. The doctrinal advantages developed within the U.K. system have been added to considerably by the development of a behavioural vision of opportunistic (“soft”) fraud. Changes to the “choice architecture” presented to insureds at claims (and at placement) can generate significant savings in fraud reduction. This is Part IV.

III. A NATURAL HISTORY OF INSURANCE FRAUD RULES IN ENGLAND & WALES

English insurance law draws upon a wide range of markets to generate the hypotheticals and real-world fact patterns to inform its development. Sometimes, hard cases make good law too. Unlike the account given of U.S. law, the design of the rules to deter insurance fraud

¹⁵ I rely here on the thorough review of the U.S. position in law given in Feinman, *supra* note 11.

is largely non-contractual in nature.¹⁶ That is, the rules do not depend on the inclusion of a specific contractual provision in the policy which is then enforced (or not) by the courts. Rather, the judiciary and the legislature have designed rules to deter insurance fraud that operate more-or-less independently of party intention. This does not mean that contractual clauses do not exist, either to reiterate the common law position or to strengthen it, but they are a secondary source, and rarely litigated.

In relation to insurance fraud, this led to at least four distinct threads of law and policymaking, which are broadly aligned to claims from three sectors of insurance: private individuals, domestic commerce, and international commerce. This is not an absolute correlation, but claims arising from marine insurance heavily influenced the doctrines of “wilful misconduct” and “utmost good faith”; commercial fire insurance policies led to the “forfeiture” doctrine; and consumer markets encouraged the development of rules on contempt of court and the striking out of claims. These developments did not occur contemporaneously, and the threads merged and de-merged over time. There has been a noticeable intensification in the development of doctrine during the past two decades, with frequent litigation in the U.K.’s highest appellate courts. The vast majority of these cases moved from the English commercial court and on upwards through the appellate courts. The judges concerned have considerable experience in these matters from their previous work as counsel in similar cases and from the volume of litigation that flows through this court. This body of litigation represents a wide panoply of claims, from personal injury litigation to complex commercial losses.¹⁷

A. MARINE INSURANCE AND THE DOCTRINE OF “WILFUL MISCONDUCT”: THE U.K.’S “INTENTIONAL ACTS” EXCLUSION

Wilful misconduct is the historic basis by which maritime fraudulent claims were denied in the English courts. It has a dual effect as a rule of interpretation whereby it is assumed that insurance policies do not cover the reckless or deliberate actions of the insured and as a rule

¹⁶ Feinman, *supra* note 3, at 153.

¹⁷ The possibility of awarding damages against the fraudulent insured, which is an undeveloped area of law, is the subject of Katie Richards, *Time’s Up For Wholly Fraudulent Insurance Claims: The Case For New Statutory Remedies*, J. BUS. L. 580 (2020).

of public policy to the same effect.¹⁸ Its dual nature as a canon of interpretation and as a mandatory rule of public policy is unusual and probably reflects differences in judicial reasoning prior to codification.¹⁹ The statutory codification of the rule is neutral in this regard, but applies irrespective of party intention: “The insurer is not liable for any loss attributable to the wilful misconduct of the assured....”²⁰

The rule has an important limiting factor. The placement of the wilful misconduct rule within the proximate cause doctrine restricts it to actions by the insured to bring about or fail to prevent the loss. It is not effective at controlling fraudulent actions by the insured *after* the loss has occurred, such as during the claims process, or in evidence at trial.

A recent case exemplifies the commercial and doctrinal significance of the rule. In *The Brilliante Virtuoso*,²¹ Mr. Justice Teare oversaw a 52-day trial that resulted in a finding that the ship-owner had conspired with the master of the vessel, the chief engineer, a key figure from the local salvage company and a group of armed men to stage a fake seizure of the vessel by armed pirates. By this stage, the ship-owner was no longer a party to the litigation, and the claim was pursued on behalf of the innocent co-insured bank which had mortgaged the vessel.²² During this “attack,” the vessel was sufficiently damaged by fire and explosion to be judged a constructive total loss.²³ This was a complex, high-stakes, fraudulent endeavour. Had the fraud been successful, the claim would have provided a full indemnity for the vessel insured in total for \$77 million, with a further \$10 million recoverable for costs.²⁴ At the time of the loss, as a result of the financial crash, the vessel’s value had reduced to closer to \$13.5 million.²⁵ The use of valued policies of this nature is viewed by many in the market as a commercial necessity—to

¹⁸ CA Blackwell (Contractors) Ltd v. Gerling General Insurance Co., [2007] EWCA Civ 1450, [2008] Lloyd’s Rep 529, [49].

¹⁹ JONATHAN GILMAN, ROBERT MERKIN, CLAIRE BLANCHARD, & MARK TEMPLEMAN, ARNOULD: LAW OF MARINE INSURANCE AND AVERAGE 22–56 (19th ed. 2018 & Supp. 2020).

²⁰ Marine Insurance Act 1906, 6 Edw. 7 c. 41, § 55(2)(a) (UK).

²¹ Suez Fortune Inv. Ltd. v. Talbot Underwriting Ltd., *The Brilliante Virtuoso* [2019] EWHC 2599 (Comm), [2019] 2 Lloyd’s Rep. 485 (Eng.).

²² Earlier actions in this litigation tested various issues. *See* Suez Fortune Inv. Ltd. v. Talbot Underwriting Ltd., *The Brilliante Virtuoso* [2018] EWHC 2929 (Comm) (UK) (“whistle blower” anonymity); Suez Fortune Inv. Ltd. v. Talbot Underwriting Ltd., *Suez Fortune Inv. Ltd. v. Talbot Underwriting Ltd., The Brilliante Virtuoso* [2016] EWHC 1085 (Comm) (UK) (strike-out of ship-owner’s claim); Suez Fortune Inv. Ltd. v. Talbot Underwriting Ltd., *The Brilliante Virtuoso* [2015] EWHC 42 (Comm) (UK) (nature of the loss).

²³ *Suez Fortune Investments Ltd.*, [2019] EWHC (Comm) 2599 at [8]–[16].

²⁴ *Id.* at [15], [160].

²⁵ *Id.* at [32].

reflect the interests of finance houses in these vessels—but it adds to the criminogenic nature of insurance.²⁶

The precise juridical effect of the defence of wilful misconduct is important here. The “false swearing” doctrine at play in American law depends on the interpretation and enforcement of a contractual provision. The standard clause describes a remedy (“the contract is void”) which is familiar to English lawyers, but is one that we have discarded, for good reason.²⁷ A case like *The Brillante Virtuoso* illustrates the problem. The co-insured Bank was in no way party to the fraud. The wilful misconduct rule does not prevent enforcement of the contract by other contracting parties, it operates as a personal bar to enforcement by those guilty of the misconduct.²⁸ The insurance policy may therefore provide cover for the effect of fraudulent conduct by one insured on innocent co-insureds. The litigation in *The Brillante Virtuoso* was one of contractual interpretation: could the bank establish a loss within policy limits?²⁹ On the facts, it failed to do so, but under a false swearing provision, the contract would have been *prima facie* void and entirely unenforceable. The remedial clumsiness of making a policy void *ab initio* for a fraudulent claim is why English law has refused to develop a substantive doctrine of utmost good faith in performance of an insurance contract. We turn to this issue next.

B. THE UNCERTAIN PAST AND FUTURE OF THE DOCTRINE OF UTMOST GOOD FAITH

English case law is the source of the doctrine of utmost good faith for much of the common law world. Derived from *Carter v. Boehm*,³⁰ the application of “utmost good faith” at the claims stage has been severely limited in English law by the doctrine’s remedial consequences.

The effect of a fraudulent statement made during the presentation of an insurance claim, but prior to legal proceedings being commenced, was discussed in detail in *The Star Sea*³¹ at the highest

²⁶ Eeuwke Faber, *Shipping and Scuttling: Criminogenesis in Marine Insurance*, 28 CRIME, L. & SOC. CHANGE 111 (1997).

²⁷ *Manifest Shipping Co. Ltd. v. Uni-Polaris Insurance Co. Ltd., The Star Sea* [2001] 1 Lloyd's Rep. 389, [64], [71].

²⁸ *Suez Fortune Investments Ltd.*, [2019] EWHC (Comm) 2599, at [479].

²⁹ Peter MacDonald Eggers QC, *Third Party Aggressors as Insured Perils Under a Marine Insurance Policy*, 27 ASIA PAC. L. REV., 270–85 (2019).

³⁰ [1766] 3 Burr. 1905; 97 Eng. Rep. 1162.

³¹ *Manifest Shipping Co. Ltd. v. Uni-Polaris Insurance Co. Ltd., The Star Sea* [2003] 1 AC 469 (U.K.).

appellate level. These cases sought to establish—by reference to hypotheticals—how marginal cases would be decided in the future:

The presentation of a dishonest or fraudulent claim constitutes a breach of duty that entitles the insurer to repudiate any liability for the claim and, prospectively at least, to avoid any liability under the policy. Whether the presentation of such a claim should be regarded as a breach of a continuing duty under [S]ection 17 that entitles the insurer to avoid the policy with retrospective effect, enabling any payments made in satisfaction of previous unimpeachable claims to be recovered by the insurer, is more debatable.³²

The remedy was—until recently—fixed by statute. Section 17 of the Marine Insurance Act 1906 was viewed as codifying the doctrine of utmost good faith as it applied across all aspects of insurance contract law, and stated: “A contract of marine insurance is a contract based upon the utmost good faith, and, if the utmost good faith be not observed by either party, the contract may be avoided by the other party.”³³

The remedy of avoidance is that of avoidance *ab initio*: a lack of good faith would remove contractual force from the apparent agreement. Whilst this might be justified for failure to perform pre-contractual duties, in that consent might be said to be vitiated, it lacks logical force when the failure occurs during the performance of the contract. In *The DC Merwestone*,³⁴ Lord Sumption JSC expressed a clear preference for a contractual or public policy basis for deciding the consequences of a fraudulent claim:

I am inclined to agree with the view expressed by in *The Star Sea* . . . that once the contract is made, the content of the duty of good faith and the consequences of its breach must be accommodated within the general principles of the law of contract. On that view of the matter, the fraudulent claims rule must be regarded as a term implied or inferred by law, or at any rate an incident of the contract. The correct categorisation matters only because if it is a manifestation of the duty of utmost good faith, then the effect of [S]ection 17 of the Marine Insurance Act 1906 is that the whole contract

³² *Id.* at 110.

³³ Marine Insurance Act 1906, 6 Edw. 7 c. 41, § 17 (U.K.).

³⁴ *Versloot Dredging BV v. HDI Gerling Industrie Versicherung AG*, *The DC Merwestone* [2016] 1 AC 5.

is voidable *ab initio* upon a breach, and not just the fraudulent claim. If, on the other hand, one adheres to the contractual analysis, the right to avoid the contract for breach of the duty must depend on the principles governing the repudiation of contracts, and avoidance would operate prospectively only.³⁵

The great reluctance of English courts to develop the post-contractual doctrine of utmost good faith, even in the face of a fraudulent claim, led to statutory reform. After more than a century as the prime statutory source for insurance law, the Marine Insurance Act 1906 was substantially amended by the Insurance Act 2015. For contracts made after the entry into force of the 2015 Act, Section 17 has been severely pruned and now reads: “A contract of marine insurance is a contract based upon the utmost good faith.”³⁶ The duty and associated remedy of avoidance under Section 17 have been repealed, along with any analogous common law rule.³⁷ The intended purpose of this change is to reduce Section 17 to an explanatory provision, devoid of any substantive legal content.³⁸ It provides context only. The nature of insurance contracts as based on the utmost good faith could (and probably would) be used to justify the development of rules on fraudulent claims but would not be the juridical source of the rule.

C. THE FORFEITURE DOCTRINE: THE U.K.’S “FALSE SWEARING” RULE

The limited nature of the doctrines of wilful misconduct and utmost good faith prevented their ascendance as the dominant rule for fraudulent claims. Wilful misconduct could not address fraud in the presentation of the claim, and utmost good faith lacked a credible remedy. To fill this lacuna came the “forfeiture” rule, which was substantially developed in recent years by the U.K.’s leading insurance judge of the early 21st Century: Lord Mance. Jonathan Mance is the son of a former Chairman of Lloyd’s, a member of the U.K.’s leading specialist insurance Chambers, and author of numerous books on

³⁵ *Id.* at 8.

³⁶ Marine Insurance Act 1906, 6 Edw. 7 c. 41, § 17 (UK) (as amended).

³⁷ Insurance Act 2015, c. 4, § 14(3) (UK).

³⁸ See Baris Soyer & Andrew Tettenborn, *Mapping (Utmost) Good Faith in Insurance Law – Future Conditional?*, 132 L. Q. REV. 618 (2016); see also Margaret C Hemsworth, *The Fate of “Good Faith: in Insurance Contracts*, LLOYD’S MAR. & COM. L.Q. 143 (2018).

insurance law. He retired as Deputy President of the U.K.'s Supreme Court in 2019 after twenty-five years as a judge.³⁹

The forfeiture rule in English law is the closest analogue to the U.S. “false swearing” rule. It evolved from the practice in commercial policies of including a contractual provision denying indemnification if the claim was fraudulent.⁴⁰ In early policies, the provisions looked very similar to the U.S. positions, but the effect of the provisions has evolved. The crucial judicial reclassification of this clause came in *Britton v. Royal Assurance* in 1866.⁴¹ The court treated the clause as merely indicative of a public policy rule, which enabled the courts to reshape it over time.⁴² This was not simply a matter of enforcing a contractual bargain; it was implementing judicially established rules of good conduct. Parties would remain free to contract for alternative standards (within reason), but the courts established a default rule under its control. This rule is brethren to similar public policy rules on contractual illegality⁴³ and is not reliant on party consent to apply. The reshaping of the duty from a contractual to a public policy device can be seen in the judgment of Mr. Justice Wiles in *Britton*:

It is the common practice to insert in fire-policies conditions that they shall be void in the event of a fraudulent claim; and there was such a condition in the present case. Such a condition is only in accordance with legal principle and sound policy. It would be most dangerous to permit parties to practise such frauds, and then, notwithstanding their falsehood and fraud, to recover the real value of the goods consumed. And if there is wilful falsehood and fraud in the claim, the insured forfeits all claim whatever upon the policy.⁴⁴

This opinion was vital for evolution of the English jurisdiction because English law did not develop the range of judicial limits on the enforcement of insurance policy terms seen in the United States. There is no doctrine of “reasonable expectations” in England and Wales, no doctrine of “bad faith,” and so on. In England and Wales, insurance contracts are generally subject to the same standard of contractual

³⁹ 7 King’s Bench Walk, Lord Mance, 7KBW (2019), <https://7kbw.co.uk/barrister/lord-mance/>.

⁴⁰ *Britton v. The Royal Ins. Co.* [1866] 176 Eng. Rep. 843.

⁴¹ *Id.*

⁴² *Id.* at 844.

⁴³ See *Patel v. Mirza* [2017] AC 467; ILLEGALITY AFTER *PATEL V MIRZA* (Sarah Green & Alan Bogg eds., 2018).

⁴⁴ *Britton*, [1866] 176 Eng. Rep. at 844.

interpretation as any other commercial or consumer contract. This means that English law largely lacks the “public interest” element identified as crucial to insurance law by Abraham,⁴⁵ and in this context, by Feinman.⁴⁶ Insurance contract law in England is largely a version of contract law and not a system of regulation.

The precise legal basis of the forfeiture rule emerged over time, with the competing explanations offered, shaping the limits of the duty and remedy by iterative judicial processes.⁴⁷ The judiciary was faced with a series of increasingly challenging “hard cases” in which the Draconian nature of the rule was challenged and slowly unpicked.⁴⁸

The first great limit on the application of a contractual approach to insurance fraud came with the exclusion of lies told during litigation. This is significant, as it is the start of legal proceedings that marks the shift from a contractual to a litigious relationship. It is not limited to false statements made in evidence. In one of the last great House of Lords decisions before it was remade as the Supreme Court, *The Star Sea*⁴⁹ confirmed that once litigation had commenced, the rules of the court governed falsehoods in oral representations and in written statements, rather than the rules of the contract. The power of the court to strike out claims for fraud during litigation is considered below when considering insurance fraud in the tort system.⁵⁰

The effects of the forfeiture doctrine at the claims stage is considerable, but its impact varies. It is axiomatic that the insured has no right to an indemnity under the contract where it submits an entirely fraudulent claim. The loss that never occurred, or more likely, was orchestrated by the insured, is not a loss within the policy. To say that the insured’s rights are forfeit stretches the point. There are no substantive rights to forfeit, as there was no genuine loss to indemnify.⁵¹

⁴⁵ Kenneth S. Abraham, *Four Conceptions of Insurance*, 161 U. PA. L. REV. 653 (2013).

⁴⁶ Feinman, *supra* note 3.

⁴⁷ For a fuller account of the development of the doctrine than is possible in this piece, see James Davey & Katie Richards, *Deterrence, Human Rights and Illegality: The Forfeiture Rule in Insurance Contract Law*, LLOYD’S MAR. & COM. L.Q. 314, 326 (2015).

⁴⁸ The forfeiture rule was perceived by Lord Justice Mance (as he then was) as “a rule which is deliberately designed to operate in a draconian and deterrent fashion” in *Axa Gen. Ins. Ltd. v. Gottlieb*, [2005] EWCA Civ 112, [2005] Lloyd’s Rep. IR 369, [31].

⁴⁹ *Manifest Shipping Co. Ltd. v. Uni-Polaris Insurance Co. Ltd.* [2003] 1 AC 469.

⁵⁰ See *infra* “Insurance Fraud, Tort Fraud and the Overlap.” at p. 55.

⁵¹ Davey & Richards, *supra* note 47, at 326.

The rule has real teeth where the insured exaggerates its claim and seeks an indemnity greater than that permitted under the contract. In *Axa General Insurance Ltd v. Gottlieb*,⁵² Lord Justice Mance was faced with an insured that had dishonestly exaggerated a claim on a residential property insurance policy.⁵³ The claim was a relatively complex one, with substantial repairs needed to the house after extreme weather had damaged the roof and burst water pipes.⁵⁴ Some elements of the claim were settled and paid relatively quickly, but others remained in negotiation.⁵⁵ The insured then submitted a dishonest claim for alternative accommodation (of £4,500) whilst repairs were completed. The underwriter submitted that it was therefore discharged from liability for the remainder of the claim and could recover sums already advanced.⁵⁶

The Court of Appeal, led by Lord Justice Mance, aligned the “forfeiture rule” with his interpretation of an express fraudulent claims clause in a previous case.⁵⁷ The standard English clause described the benefit under the policy as “forfeit” rather than the policy being void,⁵⁸ and this gave the “forfeiture rule” its label and direction of travel. To best explain the approach of the English courts, imagine an insured who combines bad luck with bad character. During the operation of a one-year insurance policy, he suffers three losses. The first and third losses—which occur at month three and month nine of the one-year term—are

⁵² *Axa Gen. Ins. Ltd.* [2005] EWCA Civ 112, [2005] Lloyd’s Rep IR 369.

⁵³ *Id.* at [2].

⁵⁴ *Id.*

⁵⁵ *Id.*

⁵⁶ *Id.*

⁵⁷ *Ins. Corp. of the Channel Islands Ltd. v. McHugh* [1997] LRLR 94 (Eng.). The clause reads:

Fraud- If the claim be in any respect fraudulent or if any fraudulent means or devices be used by the insured or anyone acting on his behalf to obtain any benefit under this Policy or if any destruction or damage be occasioned by the wilful act or connivance of the insured all benefit under this Policy shall be forfeited.

⁵⁸ The move away from describing the policy as ‘void’ occurred sporadically, and over time. Counter-examples can be found: in 1831, in *Levy v. Baillie*, [1831] 131 Eng. Rep. 135, 135 the following clause was inserted in the policy: “And if there appear fraud in the claim made, or false swearing or affirming in support thereof, the claimant shall forfeit all benefit under such policy.” By contrast, *Lek v. Matthews*, [1927] 29 Ll.L.L.Rep 141, included: “if the assured shall make any claim knowing the same to be false or fraudulent as regards amount or otherwise the policy shall become void, and all claims thereunder shall be forfeited.”

entirely honest in all aspects. The claim at six months is exaggerated, in that the insured seeks to wrongfully claim for an additional \$5,000 on a \$20,000 claim. *Gottlieb* seeks to answer what happens to each of the three claims, even though, strictly speaking, it is only concerned with the middle, exaggerated claim. As Lord Justice Mance explained: “To my mind, there is no basis or reason for giving the common law rule relating to fraudulent claims a retrospective effect on prior, separate claims which have already been settled under the same policy before any fraud occurs.”⁵⁹

This settles the effect on the first claim, as the subsequent fraud does not affect the validity of that recovery, and it need not be repaid. The “forfeiture” is of the benefit of indemnification for the claims touched by fraud, and not earlier claims. What of the exaggerated claim at six months? Does it matter if the lie occurred only part way through the settlement of that claim? Lord Justice Mance was clear that the entirety of that claim was forfeit, whether or not the underwriter had already settled part of those losses.⁶⁰

What remained unsettled in English law was the effect on future claims. Some obiter comments suggested that the contract might be terminated, but without much discussion.⁶¹ On standard contractual principles, the submission of a fraudulent claim would often be such a serious breach of contract that the agreement might be terminated on notice to this effect, but underwriters are often unaware of fraudulent conduct by insured until some time after the policy term has elapsed. Is the underwriter on risk until it takes steps to terminate the agreement? English insurance law has normally reflected the systemically weak position of insurers in monitoring compliance by insureds, and most remedies operate automatically, whereas general contract law takes the opposite approach.⁶²

Ultimately, the precise effect of a fraudulent claim on an insurance contract is now found in Section 12 of the Insurance Act

⁵⁹ *Axa Gen. Ins. Ltd.* [2005] EWCA Civ 112, Lloyd’s Rep IR 369 at [22].

⁶⁰ *Id.* at [32].

⁶¹ [2005] Lloyd’s Rep IR 369, at [19]–[20].

⁶² *White & Carter (Councils) Ltd v. McGregor* [1962] AC 413, 427 (Eng.) per Lord Reid, on the effect of repudiatory breach of contract:

The general rule cannot be in doubt . . . If one party to a contract repudiates it . . . the other party, the innocent party, has an option. He may accept that repudiation and sue for damages for breach of contract, whether or not the time for performance has come; or he may if he chooses disregard or refuse to accept it and then the contract remains in full effect.

2015.⁶³ Whilst it is not without its uncertainties, it is generally an attractive model for reform of the U.S. position. Under the new provision, the insurer is discharged from liability for the claim in question, but existing rights under the contract (for earlier claims) are untouched. The insurer may terminate the contract by notice, but the termination takes effect retroactively so that the contract ends at the moment the fraudulent action occurred. The statute does not explain whether the right to terminate is time-bound, but English law normally requires such rights to be exercised within a reasonable period from the moment the claimant discovers it has the right to terminate.⁶⁴

We complete our review of the forfeiture rule by examining its final area of potential application: the lie in support of an honest claim. The application of this rule is perfectly demonstrated by the two most recent appellate decisions in the area. Both of these decisions feature

⁶³ The Act states:

(1) If the insured makes a fraudulent claim under a contract of insurance—

(a) the insurer is not liable to pay the claim,
(b) the insurer may recover from the insured any sums paid by the insurer to the insured in respect of the claim, and

(c) in addition, the insurer may by notice to the insured treat the contract as having been terminated with effect from the time of the fraudulent act.

(2) If the insurer does treat the contract as having been terminated—

(a) it may refuse all liability to the insured under the contract in respect of a relevant event occurring after the time of the fraudulent act, and

(b) it need not return any of the premiums paid under the contract.

(3) Treating a contract as having been terminated under this section does not affect the rights and obligations of the parties to the contract with respect to a relevant event occurring before the time of the fraudulent act.

(4) In subsections (2)(a) and (3), ‘relevant event’ refers to whatever gives rise to the insurer’s liability under the contract (and includes, for example, the occurrence of a loss, the making of a claim, or the notification of a potential claim, depending on how the contract is written).

Insurance Act 2015, c. 4, § 12 (U.K.), <https://www.legislation.gov.uk/ukpga/2015/4/section/12/enacted>.

⁶⁴ *Yukong Line Ltd. v. Rendsberg Investments* [1996] 2 Lloyd’s Rep. 604, 608.

Jonathan Mance as judge, the first at the height of his influence, and the latter as his lost control over the forfeiture doctrine. In *The Aegeon*, where Lord Justice Mance gave the leading judgment in the Court of Appeal, the insured's cover was subject to a marine insurance warranty that it not conduct "hot works" on the vessel.⁶⁵ This would preclude welding and similar activities, which generated an additional risk of fire. As part of the annual maintenance of the vessel, welding was required and so the insured requested that the warranty be waived for this purpose.⁶⁶ The underwriter agreed, subject to certain conditions being met prior to works commencing.⁶⁷ It was alleged that the insured did not wait for the conditions to be met and began welding almost immediately.⁶⁸ If the underwriter had been aware at the time of this behaviour, it would have had an arguable case that it was discharged from liability as a result of breach of warranty.⁶⁹ The insured therefore stated within its claim that no welding had occurred before permission was granted.⁷⁰ On discovery of this lie, the underwriter sought to amend its defence to deny liability for fraud.⁷¹ For procedural reasons, it could not do so, but Lord Justice Mance gave a fully reasoned obiter analysis on the application of the forfeiture rule to these facts.⁷²

He took the view that lies in the presentation of an otherwise honest claim required the operation of the forfeiture rule, providing the lie was material.⁷³ His definition of materiality was complex, but well crafted. It encompassed false evidence or statements in support of a claim: "[W]hich would, if believed, have tended, objectively but prior to any final determination at trial of the parties' rights, to yield a not insignificant improvement in the insured's prospects—whether they be prospects of obtaining a settlement, or a better settlement, or of winning at trial."⁷⁴

The question is whether the lie, if believed, would have made a noticeable difference to the insured's position in settling its claim. Any potential unfair advantage in the speed or level at which the claim would be settled would be material. This sets an objective standard above which the claim will be lost in its entirety.

⁶⁵ *Agapitos v. Agnew, The Aegeon* [2002] 2 Lloyd's Rep. 42. The facts are as described at [5]–[11].

⁶⁶ *Agapitos*, [2002] 2 Lloyd's Rep.42, [5]–[11].

⁶⁷ *Id.*

⁶⁸ *Id.*

⁶⁹ *Id.*

⁷⁰ *Id.*

⁷¹ *Id.*

⁷² *Id.* at [13]–[53].

⁷³ *Id.* at [45].

⁷⁴ *Id.* at [38].

The difficulty with this test was that courts seemed unwilling to decide that any lie was immaterial. An entirely spurious lie could be portrayed as distracting the underwriter from a real issue, creating an unfair advantage. In a remarkable step, members of the judiciary contributed to a review of the law by the U.K.'s Law Commissions expressing concern about the potential injustice the rule could create.⁷⁵ This was echoed in a first instance decision by Mr. Justice Popplewell, although he was compelled by precedent to apply the *Aegeon* rule.⁷⁶

The Supreme Court was able to redefine the limits of the forfeiture rule in *The DC Merwestone*.⁷⁷ In an unexpected turn of events, the court overturned the version of materiality proposed in *The Aegeon*, in favour of a considerably stricter test. Lord Mance was part of the five-person panel, and the sole dissenting judge. The new test for materiality stated that: "although a lie uttered in support of a claim need not have any adverse effect on the insurer . . . it must at least go to the recoverability of the claim on the true facts."⁷⁸

This moves the moment for assessing the potential impact of the lie from the settlement process to the trial. The lie must relate to the recoverability of the claim in court. A lie which is told that is unrelated to a live issue at trial is merely a collateral lie and of no legal effect under this rule. Parties remain free to contract for stricter rules, but the court was not persuaded that it should interfere in a contractual process by which a lie was told in favour of a claim that was entirely with the contractual bargain made. The loss was insured against; the amount claimed for was an entirely honest assessment of the loss suffered. The insured foolishly told an unnecessary lie. Without an express clause to bolster the underwriter's position, it had no defence to a demand to a pay a claim that was otherwise honest. As Lord Sumption remarked: ". . . there is an obvious and important difference between a fraudulently exaggerated claim and a justified claim supported by collateral lies.

⁷⁵ THE LAW COMMISSION & THE SCOTTISH LAW COMMISSION, INSURANCE CONTRACT LAW: BUSINESS DISCLOSURE; WARRANTIES; INSURERS' REMEDIES FOR FRAUDULENT CLAIMS; AND LATE PAYMENT 220 (2014), https://s3-eu-west-2.amazonaws.com/lawcom-prod-storage-11j5xou24uy7q/uploads/2015/03/lc353_insurance-contract-law.pdf. The letter was signed by Mrs. Justice Gloster DBE, Mr. Justice Burton, Mr. Justice Beatson, Mr. Justice Christopher Clarke, Mr. Justice Flaux and Mr. Justice Popplewell.

⁷⁶ *Versloot Dredging BV v. HDI Gerling Industrie Versicherung AG*, The DC Merwestone [2013] EWHC (Comm) 1666 [64], which ultimately resulted in the Supreme Court decision above.

⁷⁷ *Versloot Dredging BV v. HDI Gerling Industrie Versicherung AG*, The DC Merwestone, [2017] AC 1.

⁷⁸ *Versloot Dredging BV v. HDI Gerling Industrie Versicherung AG*, The DC Merwestone [2016] 1 AC 5, at [36].

Where a claim has been fraudulently exaggerated, the insured's dishonesty is calculated to get him something to which he is not entitled."⁷⁹

The forfeiture rule has come a long way in the 150 years since *Britton*. It has shifted from the routine enforcement of a standard contractual provision to a rule of public policy. This has altered the key components of the test, in favour of a less Draconian approach to fraud and towards a more proportionate response, particularly in respect of the remedy for breach. This drift in approach reflects concerns from academics and judges, and the less strict approach found in neighbouring principles. We turn now to a key comparator, the effect on a claim of a lie told in litigation.

D. INSURANCE FRAUD, TORT FRAUD AND THE OVERLAP

The forfeiture rule, for all its potential universality, was limited by the judiciary to lies told in the contractual phase of the relationship. Once the parties are engaged in litigation—and this commences with the issue of the claims form (known previously as the writ)—the forfeiture rule ceases to apply. At this point the rules of the court take over. In recent years, these have been tested most thoroughly in what might be considered indirect insurance frauds. In these cases, the lie is told as part of a claim in tort, in order to obtain a larger than deserved payout. The ultimate payor of the claim will be the liability underwriter, but there is no fraud in the relationship between the insured and the underwriter. The insured is entirely honest, but the third-party claimant is not.

In *Summers*, the Supreme Court was faced with an extraordinary example of tort fraud.⁸⁰ The claimant suffered a genuine injury at work and would have been entitled to around £80,000 in compensation.⁸¹ However, the claimant exaggerated his symptoms to the extent that he underwent further unnecessary surgery.⁸² His eventual claim would have recouped around £800,000 (a ten-fold increase) were it not for surveillance evidence emerging of exaggeration of his symptoms.⁸³ As the Supreme Court noted: “the driving force behind the is the defendant’s

⁷⁹ *Manifest Shipping Co. Ltd. v. Uni-Polaris Insurance Co. Ltd.*, *The Star Sea* [2003] 1 AC 469 (UK), at [25].

⁸⁰ *Summers v. Fairclough Homes* [2012] UKSC 26, [2013] Lloyd's Rep IR 159.

⁸¹ *Id.* at [9].

⁸² *Id.* at [3].

⁸³ *Id.* at [6].

liability insurers, who say that fraudulent claims of this kind . . . are rife and should in principle be struck out as an abuse of the court's process."⁸⁴

The court confirmed that it had judicial discretion to strike out the claim, including the honest part, but refused to do so. This might seem to remove any deterrent from the rule, but the practical effect is that the negligent employer would still pay the £80,000 for the injury suffered, but that recovery would be lost to those who had treated him for his injuries and in costs awards. He would not retain any of his award on these facts.

Conscious of the impression (rather than the reality) that the *Summers* decision might give to would-be fraudsters, statutory intervention followed swiftly.⁸⁵ In personal injury cases, the court must now dismiss any claim where the claimant has been "fundamentally dishonest" unless the claimant would suffer "substantial injustice" if the claim was struck out. The emerging judicial practice in the application of this discretion suggests that the courts will routinely strike out claims, even where the fundamental dishonesty is only in one part of the overall recovery. In *LOCOG v. Sinfield*,⁸⁶ Mr. Justice Knowles responded to a claimant who had exaggerated the effect of a genuine personal injury by seeking to show that he had incurred additional costs by hiring a gardener for additional hours as fundamentally dishonest. In striking out the claim, Mr. Justice Knowles stated:

. . . [A] claimant should be found to be fundamentally dishonest . . . if the defendant proves on a balance of

⁸⁴ *Id.* At [1].

⁸⁵ The statute states:

(1) This section applies where, in proceedings on a claim for damages in respect of personal injury ("the primary claim")—

(a) the court finds that the claimant is entitled to damages in respect of the claim, but

(b) on an application by the defendant for the dismissal of the claim under this section, the court is satisfied on the balance of probabilities that the claimant has been fundamentally dishonest in relation to the primary claim or a related claim.

(2) The court must dismiss the primary claim, unless it is satisfied that the claimant would suffer substantial injustice if the claim were dismissed.

Criminal Justice and Courts Act 2015, (2015) § 57 (UK):

⁸⁶ [2018] EWHC 51 (QB) (Eng.).

probabilities that the claimant has acted dishonestly in relation to the [claim] . . . and that he has thus substantially affected the presentation of his case, either in respects of liability or quantum, in a way which potentially adversely affected the defendant in a significant way . . .

By using the formulation “substantially affects” I am intending to convey the same idea as the expressions ‘going to the root’ or ‘going to the heart’ of the claim.⁸⁷

Outside of personal injury, the standard judicial discretion to strike out a claim as described in *Summers* remains in force.⁸⁸ Whilst the court was not prepared to deprive the claimant of his cause of action in *Summers*, where a lie is made by the insured in a property insurance claim, the court is likely to strike out the claim, providing it is germane to the litigation. Lies told in litigation that are not fundamental to the claim will not deprive the claimant, even an insured, of its rights:

A regrettable but not uncommon phenomenon in the civil courts is the litigant, whether a claimant or a defendant, who thinks that he has a fairly good case but is worried that he just might lose, so he tries to improve his chances by embellishing the evidence and telling a few lies. Suppose that at the trial his lies are exposed, but the judge takes the view that he would have won the case anyway without them. Does he lose the case because he lied? The answer is: No. If his case is a good one anyway, he wins. It is deplorable that he lied, but he is not deprived of his victory in consequence.⁸⁹

In addition to the potential strike-out of the claim, dishonesty in legal proceedings carries a substantial risk of an action for contempt of court. In recent years, insurers have taken orchestrated action against claimants for lies in relation to insurance claims. The judiciary has often imposed custodial sentences on those found in contempt, citing industry figures on the prevalence and magnitude of insurance fraud as a justification for doing so. As will be detailed below, it is likely that these figures are seriously misleading.

⁸⁷ *Id.* at [62]–[63].

⁸⁸ *Summers v. Fairclough Homes* [2012] UKSC 26, [2013] Lloyd's Rep IR 159.

⁸⁹ *Agapitos v. Agnew* [2002] EWCA (Civ) 247, [58], [2003] QB 556 (Eng.).

E. THE COMPARATIVE DEVELOPMENT OF ENGLISH LAW & AMERICAN LAW ON INSURANCE FRAUD

From the outside, the impression formed of the US law on fraudulent insurance claims is reminiscent of the position in the U.K. in the early 2000s. It is an area of immense practical importance, and of great socio-legal significance, but not a core area of study or research as a body of law. The rules are either so obvious to be unworthy of study (the insured cannot recover for the arsonical destruction of its own property) or merely a further example of the tension between the insurance policy as written and the policy as it “ought” to be. There are significant exceptions to this,⁹⁰ but these are rare.

The review of English law presented above shows a drift towards a coherent body of law of “fraudulent insurance claims.” The volume and heterogeneity of disputes in the English courts, combined with a sizeable insurance market, has generated an expert judiciary to resolve them. There are enough difficult cases for a critical mass of judicial opinions to emerge, and for principles to be shaped and reshaped. Lord Justice Mance was a colossal figure as an insurance judge in the first two decades of the twenty-first century, but was challenged on points of intense doctrinal detail by Lord Justices Waller, Rix, and Aikens, among many others. The lack of jury trials in English civil procedure is also likely to be a factor.

The tectonic shifts were away from simple principles with no limiting factors to an increasingly proportionate regime. This was not driven by a desire to replace rules with standards, but from a growing appreciation of the systemic advantages given to underwriters when insurance law was first designed in the eighteenth century. During the past two decades, English law has replaced many of the strict principles of insurance law set in the eighteenth century with more neutral positions. In some cases, the minimum thresholds to meet a duty have been lowered, in others the remedies have been reduced in severity. Overall, the sense is that the judges had come to appreciate, as Lord Justice Mance put it: “English insurance law is strict enough as it is in insurers' favour. I see no reason to make it stricter.”⁹¹

In identifying the risk that insurers will be given opportunities to limit (by chilling effect) the payment of predominantly or wholly honest claims, by the threat of alleging fraud, American law was probably ahead of English law. The precise limit of tolerance in the tests for materiality

⁹⁰Jay M. Feinman, *Insurance Fraud, Agency, and Opportunism: False Swearing in Insurance Claims*, <https://rucore.libraries.rutgers.edu/rutgers-lib/51227/>.

⁹¹ *Friends Provident v. Sirius* [2005] EWCA Civ 601 [33], (Eng.), [2005] 2 Lloyd's Rep 517, 531.

and the like can fairly be thought to represent political choice. Less convincing is that the remedy of “avoidance” has any place in this field, at least without very clear explanation of its effect. If what is meant by this in practice is forfeiture of the claim, then the U.S. should leave behind the nineteenth century clauses that inspired the “false swearing” rule and move to a twenty-first century suite of remedies. The U.K. model, with total loss of claim (where materiality is shown) and termination at the option of the insurer, but from the date of the fraud, is an excellent starting point. This is not to deny party autonomy. Parties may vary the rule within the limits of the public policy prohibition on fraudulent recovery. But the English case law reviewed above shows that the default position matters. In all of this, the search is for a rule that does not readily permit either the insured or the underwriter to take undue advantage of the rule. That is a challenge to those who draft policies, but one which is not met by the remedy of avoidance.

Insurance fraud is, of course, not governed solely by the courts or the contract. The politics of insurance fraud extends into the civil justice system more widely. We move at this stage from the industry’s design of contractual clauses to its measurement of insurance fraud data and the misleading picture that emerges.

IV. ADOPTING AN EMPIRICAL APPROACH TO INSURANCE FRAUD DATA

A. THE “RAWLINGS” QUESTION

Insurance fraud analysis routinely starts with the estimated level of insurance fraud. The figures vary by jurisdiction, but these are often given as both the net total cost to the industry as a whole and as an average annual cost to the consumer. In the U.K., these figures are produced by the industry trade body, the Association of British Insurers (ABI), and launched with the finesse expected of an experienced lobbying organisation. The headline figures are cited and repeated in a wide range of market and legal situations, not least before the courts.⁹² My initial focus is the accuracy of the figures, before moving on to the impact of this data set on the insurance fraud environment. Many insurance commentators are sceptical of the accuracy of these headline figures.⁹³ Feinman’s chapter in *Delay, Deny, Defend* is a paradigm

⁹² See *infra*, text accompanying note 105.

⁹³ Empirical criminologists note the wide range of predictions, and the wide range of methods used to estimate insurance fraud. See Etienne Blais & Jean-Luc Bacher, *Situational Deterrence and Claim Padding: Results from a*

example of this and reminds us of the socioeconomic and political context in which these figures are generated.⁹⁴ With the help of some relatively simple data science, this section will improve this account. The apparently scientific calculation underpinning the headline figure of the volume of fraud is best understood as a series of choices reflecting the best interests of insurers and not the public at large.

My particular interest in the insurance fraud data was piqued by a question asked by a fellow academic member of the U.K.'s Insurance Fraud Taskforce in 2015. Professor Philip Rawlings enquired of the room of industry and legal experts: why detected insurance fraud is always more-or-less £1.2 billion per year.⁹⁵ The flatness of the trajectory in recent years in the ABI insurance fraud data is indeed surprising.⁹⁶ Much is made in insurance industry briefings of the wide-ranging and innovative response to fraud, and of the growing role of artificial intelligence in its detection. These might be expected to 'move the dial' on the level of detected fraud. The ABI's latest annual fraud briefing explains the dynamic nature of the system:

- A total of 469,000 insurance frauds were detected by insurers. Of these, 98,000 were fraudulent claims, with 371,000 dishonest insurance applications. The number of fraudulent claims detected fell 6% on 2017, while the number of dishonest applications for cover rose by 5%.
- The value of the 98,000 dishonest claims detected, at £1.2 billion, fell marginally by under 1% on the previous year.
- Motor insurance scams remained the most common and most expensive, with 55,000 dishonest claims worth £629 million detected. The number and value of these claims both fell on the previous year - down 8% and 9% respectively.

Randomized Field Experiment, 3 J. EXPERIMENTAL CRIMINOLOGY 337, 347 n.10 (2007).

⁹⁴ FEINMAN, *supra* note 6, ch 10.

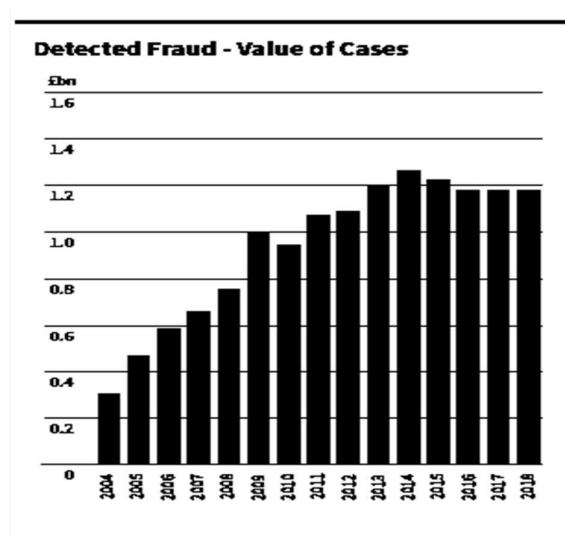
⁹⁵ This is recorded in the published minutes as: 'discussion about the accuracy of existing statistics on fraud and debate about the existence of certain trends', see Minutes from Insurance Fraud Taskforce, Stakeholder Roundtable Apr. 21, 2015, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/454535/Insurance_fraud_taskforce_-_stakeholder_roundtable_21_April_summary_note.pdf.

⁹⁶ See Association of British Insurers, *U.K. Insurance & Long-Term Savings Key Facts*, 18–19 (2019), <https://www.abi.org.uk/data-and-resources/industry-data/insurance-and-long-term-savings-key-facts/>.

- Of the 55,000 motor insurance frauds, 80% involved personal injury fraud. These ranged from staged crash for cash frauds to opportunistic scams. The measures in the Civil Liability Act will help ensure fair compensation for genuine claimants.
- There were 20,000 property frauds detected, down slightly on the previous year. However, the value of these frauds, at £115 million, rose by 11%.⁹⁷

Within all of these moving parts, the element that moved the least was the overall figure of almost £1.2 billion in detected fraud. As the table below shows,⁹⁸ this figure has been largely unchanged for a number of years, despite methodological changes in the capture of insurance fraud data.

Figure 1: ABI figures on Detected Insurance Fraud, 2004-2018



What follows is an attempt to unpick the headline statistics within insurance fraud. This is based on the U.K. figures, but similar

⁹⁷ ABI, *Detected Insurance Frauds in 2018*, (Aug. 28, 2019), <https://www.abi.org.uk/news/news-articles/2019/08/detected-insurance-frauds-in-2018/>.

⁹⁸ ASS'N OF BRITISH INSURERS, *supra* note 96, at 18.

methodological “sleights of hand” are very likely at play in the U.S. market.

B. UNPICKING THE INSURANCE FRAUD DATA

Access to the underlying data on which the ABI calculates its annual figures is heavily restricted. Members of the trade body can get the data for internal use for £500, but those wishing to use it for “external” purposes (such as independent academic analysis) would be required to pay £2,600 for access.⁹⁹ These fees would have to be paid every time the data was updated. Whilst this may reflect the cost of collating the data, the fees effectively remove the data from public scrutiny. Similar charges are imposed for other ABI datasets.

The ABI has improved the transparency of the process in recent years by publicising the methodology by which it collects data and giving practical examples of what would (not) be recorded as fraud. This methodology is now provided as an extensive footnote on its press releases and reports.¹⁰⁰ But this is not enough. Distinguish two distinct

⁹⁹ Ass’n of Brit. Insurers, *Industry Data and Subscriptions*, ABI, <https://www.abi.org.uk/data-and-resources/industry-data/industry-data-and-subscriptions/> (last visited Sept. 7, 2020).

¹⁰⁰ The ABI seeks information from its members which fall into the following description, which has been based around 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

And 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;

elements in the fraud data at this point: frequency and magnitude. The first measures the number of incidents of insurance fraud. These figures were given in annual reports produced by the ABI and showed considerable variation year-on-year.¹⁰¹ The second measures what appears to be the level of fraud, this is our £1.2 billion per annum.

The revised methodology for estimating the frequency of insurance fraud represents a “best efforts” attempt to capture data that is inherently uncertain. Insurance fraud is not only those cases where successful litigation ensues; it includes the abandoned claim and the low-ball settlement where neither side was entirely sure of success. In an ideal world, we would have an independent body design the method and collate the data, but this is not a high priority for government agencies. I am less critical of this part of the data science.

My focus is the “headline figure” of magnitude, as raised in the “Rawlings question,” and here the method is much less transparent. The analysis is developed by reference to leading U.K. cases, but the circumstances described are routine. The facts of *Gottlieb*,¹⁰² considered above in the development of the “forfeiture rule” illustrate the issue. A routine household claim generated several heads of loss. Some were settled quickly; others were ongoing. Towards the end of the claims process, the insured padded the genuine claim (valued at around £72,400) by adding two fraudulent invoices. These sought to evidence credible expenses: the rental of alternative accommodation whilst work was carried out (for £16,250) and a forged invoice for £1,200 (claiming to be work carried out by an electrician). This was a claim exaggerated by around 24 percent of the true value.

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- 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(s) 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;

Provided that the relevant party has 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.

See ASS’N OF BRIT. INSURERS, *supra* note 96.

¹⁰¹ ASS’N OF BRIT. INSURERS, *supra* note 96.

¹⁰² *Axa Gen. Ins. LTD V. Gottlieb*, [2005] EWCA (Civ) 112, [2005] Lloyd’s Rep IR 369.

The response of English law is settled. The whole claim is forfeit. But what do we report as the level of insurance fraud? There are two possibilities: the dishonest part (£17,450) and the total claim avoided (honest and dishonest parts combined) at £89,950. These are not only substantially different in size, but represent different things being measured and reported. The detailed description of how insurers estimate fraud does not give us the answer on what elements are reported—only what circumstances are treated as fraud.

The static nature of the overall fraud figure suggests that what is reported is the overall figure, the size of the claim avoided. But this is not the actual level of fraud, rising and falling each year; that would be the lesser figure. What the insurance industry is most likely reporting in these reports is the amount of insurance business tainted by fraud. This will not vary according to the precise level of fraud in each claim but will capture the extent to which insurance fraud is distributed through the system. That is much more likely to be stable.

There are obvious reasons for reporting these figures separately if we wish to create an accurate impression. If we use the higher figure to report the prevalence of insurance fraud, then a \$1,000 fraud on a \$100,000 total claim would make the figures look worse than a \$25,000 fraud with no underlying honest claim. That cannot be right. One immediate suggestion might be to run two sets of data, but this is a limited solution. It does not help us where the entire claim is supported by a dishonest statement. The classic example is a situation where the dishonesty is found in forged documents to support an otherwise honest claim. We cannot then separate the honest part from the dishonest. As before, a recent case provides a useful exemplar.

In the commercial insurance case of *Sharon's Bakery*,¹⁰³ two separate businessmen came together to set up a bakery. The new business was created by the input of some capital and some equipment as a benefit in kind. When the business was destroyed in an accidental fire, the owners submitted a forged document claiming to be an invoice for the machinery. The precise reason why this forgery was created is not apparent on the facts, but there seems to have been some concern that the insurer would seek to pay only a limited sum for the second-hand machinery used in the business. The insurance policy contained an express fraudulent claims clause on the standard English terms that: "If any claim upon this Policy shall be in any respect fraudulent or if fraudulent means or devices be used by or on behalf of the insured to obtain any benefit under the Policy . . . all benefit under this Policy shall be forfeited."

¹⁰³ *Sharon's Bakery (Europe) Ltd. v AXA Ins. U.K. PLC* [2011] EWHC 210 (Comm), [2009] QB 1120 (Eng.).

On the basis of the express clause, the claim was forfeit. The judgment was explicit in stating that the claim was only dishonest due to the forged invoice, and the level of indemnity sought was justifiable:

[T]his is not... a case in which the insured is dishonestly advancing a claim under the insurance policy to which it knows it is not entitled . . . [T]here was valuable equipment in the premises, which were used as an operational wholesale bakery business. There was a fire on 8 June 2008, which caused extensive damage and no evidence of arson. On its face, the claimant's claim is a perfectly legitimate one for reinstatement and business interruption indemnity under the policy.¹⁰⁴

This kind of situation poses a particular difficulty for recording insurance fraud. The claim was for around £400,000, the level of exaggeration is zero. The evidence in support of the claim was dishonestly created, but the claim is otherwise perfectly good. It is not within the spirit of the insurance fraud figures to record the fraudulent element as zero—this claim was avoided for fraud—but neither does it make sense to record the fraud as £400,000. There is no immediately calculable figure that weighs the fraudulent conduct here in monetary terms that is compatible with the figure recorded for a *Gottlieb* loss. They are incommensurate. This creates a break in the data recording system along fault lines not normally used in recording insurance fraud. This is not simply a matter of uncertainty (we do not know how much fraud is in the market), but of pooling data across two very different data sets. The selection of this method favours insurers, as it makes the overall figure for insurance fraud much higher.

C. HOW MUCH FRAUD IN INSURANCE FRAUD?

The best interests of the insurance industry lie in reporting insurance fraud in one of two ways: the cumulative figure or the personal. The first figure—the £1.2 billion per year for U.K. markets—is for government consumption. The second one is for consumers, and part of the storytelling that insurers do to present an image of the trusted counterparty, protecting honest policyholders from the bad people in society.¹⁰⁵ It is well-established that our reaction to data is not purely

¹⁰⁴ *Id.* at [13].

¹⁰⁵ See Tom Baker, *Constructing the Insurance Relationship: Sales Stories, Claims Stories, and Insurance Contract Damages*, 72 TEX. L. REV. 1395, 1397 (1994).

rational, and that the framing of information influences our perception of it.¹⁰⁶

Just as insurance fraud is not one thing, but many, the way in which insurance fraud data must be presented needs to change according to the context in which it is used. The data are packaged for political and marketing purposes. The standards to which we hold parties engaged in politics and advertising are low. The NAIC, United Policyholders¹⁰⁷ (and in the U.K., the Financial Conduct Authority) should present competing accounts of the fraud data in the wider public interest.

More troubling is the use of this data within the judicial system. It is evident from a review of the judgments in U.K. insurance litigation that judges have been persuaded that the headline figure (the £1.2 billion) represents the sum total of fraud, and not the higher figure of insurance business affected by fraud. This matters because the court is developing rules to counter insurance fraud based on a misleading account of what is being measured. This issue is particularly acute when the figures are used in seeking to persuade the court to impose a custodial sentence for contempt of court or insurance fraud.

The penetration of these statistics into the judicial psyche is near complete. In a case that is frequently cited as setting the appropriate sentencing standard for participation in staging motor accidents, Mr. Justice Thomas stated:

This fraud has occurred in the area of motor insurance. It appears that in 2010 dishonest motor insurance fraud occurred on an extensive scale. There were 40,000 of them. Motor frauds were, of all the frauds, the most costly. They totalled over £466 million. The insurance industry estimates that insurance fraud costs £2 billion a year adding on average an extra £44 per year to the insurance bill for every U.K. policy holder . . . As was said by counsel for the insurers today, that is the tip of the iceberg.¹⁰⁸

He was initially minded to imprison the defendants for twelve months for contempt of court but reduced the sentence to six weeks in recognition of the guilty plea and cooperation with insurers.

What should be done in response to this? For data used solely within the political arena, the insurance industry should be required to

¹⁰⁶ BEN GOLDACRE, *BAD SCIENCE*, chs 13–14 (Fourth Estate, 2nd ed. 2008)

¹⁰⁷ UNITED POLICYHOLDERS, <https://www.uphelp.org/> (last visited Sept. 5, 2020).

¹⁰⁸ *Liverpool Victoria Ins. Co. v. Bashir* [2012] EWHC 895 (Admin), [2011] QB 2257 (Eng.).

share its method and data with regulators and trusted consumer groups. This is a situation in which the industry has privileged access to information, and it should—at the very least—be vetted by regulators to ensure that the claims made are accurate. It would stretch irony beyond breaking point for this not to take place. When used in the courts, the headline figure should be described for what it actually is: a measure of prevalence of fraud, and not a measure of magnitude.

To provide equality of arms in the judicial arena, judges need to be presented with well-informed counter-narratives. In an ideal world, prosecuting lawyers and counsel for insurers would be exercising professional restraint in introducing to the court headline figures that are potentially misleading. In the absence of that ideal, consumer groups and regulators should provide counter-narratives. A useful first step would be the application of the “frequency/magnitude” distinction developed above.

The final substantive section of this paper moves to administrative change, and the application of behavioural science in the design of counter-fraud initiatives. This has met some resistance from those who favour traditional models of deterrence based on rational choice theory. Recent empirical research suggests that this traditional view is deeply flawed.

V. INSURANCE FRAUD, BEHAVIOURAL SCIENCE & DETERRENCE

A. INSURANCE FRAUD RULES AND “RATIONAL DETERRENCE”

In a Supreme Court decision focused (somewhat unusually) on issues of public policy in commercial law, Lord Sumption gave an insight into the kinds of evidence that informed his design of commercial law rules: “Courts are rarely in a position to assess empirically the wider behavioural consequences of legal rules. The formation of legal policy . . . depends mainly on the vindication of collective moral values and on judicial instincts about the motivation of rational beings, not on the scientific anthropology of fraud or underwriting.”¹⁰⁹

Lord Sumption’s description of the working of the judicial mind when deciding significant matters of principle—here, the design of rules to combat commercial insurance fraud—was noteworthy not only for its content but for its scarcity. There are relatively few occasions on which

¹⁰⁹ *Versloot Dredging BV v. HDI Gerling Industrie Versicherung AG*, The DC Merwestone [2016] UKSC 45 [10], [2017] AC 1 (Lord Sumption SCJ).

U.K. judges have explained the basis by which they derive the outcome of a case in this way.¹¹⁰ He tells us several things about his approach to resolving problems, and this combines positive and negative elements. He begins by rejecting a form of knowledge offered to the court in the case: empirical evidence casting doubt on the prior policy basis for the rule. At this point it is necessary to declare an interest: although not cited in the judgment, previous work of the author¹¹¹ was considered in detailed argument before the Supreme Court in promoting the use of empirical evidence on deterrence effects in private law. It is a reasonable assumption that Lord Sumption referenced the above and the wider literature contained in its footnotes. The wider empirical literature was supplied to the Court at the request of another of the judges on the panel.

The empirical evidence was rejected by Lord Sumption, not because it was uninformative, but because it was not normally available. Instead of relying on external evidence of this type to determine the optimal shape of commercial law rules, he favoured a largely internal process, by reflection on “collective moral values” and on “the motivation of rational beings.” Assuming Lord Sumption is not misspeaking, the inference to be drawn from this is that the court routinely has sufficient evidence before it to assess these matters: that morality and rationality are self-evident to an experienced judge. The function of this part of the paper is to establish that he is wrong on this point.

Lord Sumption’s version of forfeiture is a deterrent by which he is seeking to effect a change in the behaviour of a subset of society (those who might commit insurance fraud). As a rule intended to alter behaviour by imposing a sanction, we need to understand how the targeted group would respond to different types of sanction. This we might call the “efficiency” of the rule. It is not the only variable: we would need to consider any change in underwriters’ ability to deny genuine claims. There is also the possibility of externalities. If the rule imposes additional burdens on society, that is a relevant consideration. But if the primary benefit of intervention is the deterrence of some behaviour, then it cannot be correct to measure that benefit by ignoring the actual effect it has on the group targeted. This needs empirical support.

¹¹⁰ For an insightful consideration of values and implicit policy considerations in English law, see R. J. Cahill – O’Callaghan & B. J. Richards, *Policy, Principle, or Values: An Exploration of Judicial Decision-Making*, 79 LA. L. REV. 397 (2018).

¹¹¹ James Davey & Katie Richards, *Deterrence, Human Rights & Illegality: The Forfeiture Rule in Insurance Contract Law*, LLOYD’S MAR. & COM. L. Q. 314, 326 (2015).

B. THE INHERENT LIMITS OF RATIONAL DETERRENCE VS
RATIONAL INCENTIVES

Let us assume that judges and other policymakers know and understand that not all parties are perfectly rational. Moreover, that they are—on occasion—not even boundedly rational,¹¹² and that their conduct may be irrational under certain conditions. We further assume that the extent to which any given party is (ir)rational is not predictable, but that the overall effect across all participants is fairly predictable. We know our market, but not the nature of every participant.

If a rule-maker wishes to encourage a certain form of socially useful behaviour, it might reasonably choose to distribute a benefit such that those who are at least boundedly rational will alter their behaviour and claim the reward. This has two effects. It incentivises parties to change their behaviour in a desirable way, but it also rewards those behaving (boundedly) rationally. Those who behave irrationally would have reduced access to the benefits distributed. This type of incentive structure should “educate” participants to be more rational.¹¹³ This does not always work in practice, but there is at least a certain logic behind it.

Much of the justification for the continued use of neo-classical law and economics in counter-fraud looks like this. If Lord Sumption could be interrogated on the point, he might say something similar. It is not that he believes that everyone is rational, but it is the best working approximation for conduct in these kinds of exchanges. There is a fundamental logical flaw in the application of this model to deterrence. The kinds of cases that the Supreme Court has been facing in this and related areas are not about the promotion of conduct through the possibility of reward (“be rational and you get a free cake”) but by the imposition of prescriptive rules designed to disincentivise certain conduct.

Let us repeat the thought experiment using the Sumption methodology but using the proper fact pattern. We imagine that rule-makers wish to discourage a form of socially-harmful conduct. Recognising that not all people are rational, it designs a system of sanctions that bite most effectively on those who are at least boundedly rational. This is what Lord Sumption is proposing. This does not generate a series of rational disincentives as he imagines, it shifts punitive action away from the irrational and towards the rational. The more rational parties are, the more the sanctions are felt. As Thomas Ulen said:

¹¹² Herbert A. Simon, *Bounded Rationality*, in *UTILITY AND PROBABILITY* 15 (John Eatwell et al. eds., 1990).

¹¹³ Thomas Russell & Richard Thaler, *The Relevance of Quasi Rationality in Competitive Markets*, 75 *AM. ECON. REV.* 1071, 1074 (1985).

Specifically, people may not respond to the traditional policy correctives in the manner predicted by rational choice theory. Consider, for example, that many potential criminals may be overoptimistic about their ability to avoid detection, arrest, and conviction or to adapt to prison life and, therefore, may not be deterred by criminal sanctions that deter you and me.¹¹⁴

Questioning the applicability of rational choice theory as a universal tool is not to say that it is never useful. As with so many models, we have to check that its use is apt. If rational choice theory is not predictive of conduct in the context in which the lawmaker seeks to intervene, then the lawmaker will be falsely overconfident of the accuracy of the judgment.

The counter-veiling argument that law will incentivise increasingly rational conduct is credible¹¹⁵ but only in circumstances where law provides benefits (for example in certainty of outcome) to those who behave rationally: “namely, that decision makers may learn the value of more rational behavior through experience and, importantly, that the competitive market may be a significant device for inducing more rational behavior.”¹¹⁶

It is far less credible where we seek to proscribe conduct by the imposition of sanctions. Why would a market participant behave more rationally so as to fall within a punitive scheme of sanctions? The reverse is more likely. Moreover, recent empirical evidence (reviewed in Section C below) suggest that parties do not “drift towards rationality” when deciding whether to commit soft fraud.

We need to unpick the system-wide effects of the characterisation of Lord Sumption’s refusal to move beyond rational choice theory. He did not refuse to do so because the empirically derived behavioural approach is “bad science,” but because the data that enhances the design of the rule in this specific example are not generally available. He favoured simplicity over accuracy. The behavioural approach to law undoubtedly makes our predictions about human conduct more uncertain. It would have required him to be less dogmatic and less confident. I suspect that his rejection of the behavioural science

¹¹⁴ Thomas S. Ulen, *Behavioral Law and Economics: Law, Policy, and Science*, 21 SUP. CT. ECON. REV. 5, 9–10 (2013).

¹¹⁵ *Id.* at 31.

¹¹⁶ John A. List, *The Behavioralist Meets the Market: Measuring Social Preferences and Reputation Effects in Actual Transactions*, 114 J. POL. ECON. 1 (2006).

as “scientific anthropology”¹¹⁷ is because it required him to draw on external data, rather than his own internal monologue. I would rather have a judge that understands the limits of legal process than one who closes his mind to the possibility that he is wrong. I deliberately do not rephrase this in gender-neutral language.

The crucial argument here is that insurance fraud takes place in a complex and messy ecosystem. The iconic work undertaken by the U.K.’s Financial Conduct Authority¹¹⁸ and in the U.S. by Baker & Siegelman¹¹⁹ showed this mixture of rational and irrational at play in insurance purchasing decisions. We should expect a similar mix of models underlying insurance fraud.

To support these claims, I review recent evidence on whether parties involved in soft fraud are engaged in rational decision-making. A complete review of the prior academic literature in this area is beyond the scope of this paper, and has been provided in other work.¹²⁰ I move instead to recent empirical work in this field, and how it came about.

C. INSURANCE FRAUD: THE EMPIRICAL TURN

To explain the move towards an empirical picture of insurance fraud, a little historical context is required. The dominant judicial narrative at the start of my career was that judicial enforcement of private law rules were a core (and effective) part of the deterrence of insurance fraud. Much of my work on insurance fraud has been to challenge this simplistic model and provide a richer narrative. Early work showed that considerable sectors of the insurance market were not subject to the strict judicial rule, and received more sympathetic treatment under the Financial Ombudsman Service.¹²¹ Moreover, this work drew on the lack of any equivalent “bad faith” rule in English law to restrain opportunism on the part of insurers. My objection was based in part to the unilateral

¹¹⁷ *Versloot Dredging BV v. HDI Gerling Industrie Versicherung* [2016] UKSC 45, [2017] 1 AC 10 (UK).

¹¹⁸ FIN. CONDUCT AUTH., GEN. INS. ADD-ONS: FINAL REPORT – CONFIRMED FINDINGS OF THE MARKET STUDY (2014), www.fca.org.uk/publications/market-studies/general-insurance-add-ons-market-study.

¹¹⁹ Tom Baker & Peter Siegelman, “*You Want Insurance with That?*” *Using Behavioral Economics to Protect Consumers from Add-on Insurance Products*, 20 CONN. INS. L.J. 1 (2013).

¹²⁰ See Davey & Richards, *supra* note 47, at 327 n.76–81.

¹²¹ James Davey, *Unpicking the Fraudulent Claims Jurisdiction Insurance Contract Law: Sympathy for the Devil?*, LLOYD’S MAR. & COM. L.Q. 223 (2006).

nature of the rule: an underwriter that claimed an operative defence to liability that it could not evidence suffered no effective sanction, but an insured that over claimed its indemnity was to be treated punitively. This did not win me many friends within the insurance industry. Alongside this work on insurance fraud, I explored the role of behavioural science in explaining other aspects of the insurance relationship, such as the parties' willingness to negotiate duties and not remedies in claims notification provisions,¹²² and in "contracting out" of the default rules on insurance warranties.¹²³ This placed me in an ideal position to engage with industry at the intersection of these two fields: the behavioural aspects of insurance fraud.

The Insurance Fraud Taskforce¹²⁴ was created in 2015 as a joint initiative between the British government (under the Ministry of Justice) and the insurance industry (represented by the Association of British Insurers). It drew on insurance industry, legal, and academic expertise to produce an interim and a final report on the best practical steps to reduce insurance fraud. At the request of the Chair, I provided a specific briefing on the possibility of using behavioural science to better understand opportunistic fraud. By reflecting on the outcomes from experimental economics in equivalent government processes, such as tax and benefits fraud, a process was developed for modelling key insurance processes. The U.K. government's willingness at this time to engage with behaviourally informed policy provided key strategies that could be tested in the insurance environment:

Insight 1. Make it easy: Make it as straightforward as possible for people to pay tax or debts, for example by pre-populating a form with information already held.

Insight 2. Highlight key messages: Draw people's attention to important information or actions required of them, for example by highlighting them upfront in a letter.

Insight 3. Use personal language: Personalise language so that people understand why a message or process is relevant to them.

¹²² James Davey, *Claims Notification Clauses and the Design of Default Rules in Insurance Contract Law*, 23 INS. L.J. 245 (2012).

¹²³ James Davey, *The Reform of Insurance Warranties: A Behavioural Economics Perspective*, J. BUS. L. 118, 119 (2013).

¹²⁴ *Insurance Fraud Taskforce*, GOV.UK, <https://www.gov.uk/government/groups/insurance-fraud-taskforce> (last visited Sept. 26, 2020).

Insight 4. Prompt honesty at key moments: Ensure that people are prompted to be honest at key moments when filling in a form or answering questions.

Insight 5. Tell people what others are doing: Highlight the positive behaviour of others, for instance that ‘9 out of 10 people pay their tax on time.’

Insight 6. Reward desired behaviour: Actively incentivise or reward behaviour that saves time or money.

Insight 7. Highlight the risk and impact of dishonesty: Emphasise the impact of fraud or late payment on public services, as well as the risk of audit and the consequences for those caught.¹²⁵

My work for the Insurance Fraud Taskforce led to specific recommendations for the industry to invest in behavioural research on the topic.¹²⁶ Unlike some law and economics models that predict near universality, there is no assumption that these principles would be effective in insurance because of positive results in similar processes. The insights above provided a series of hypotheses to be tested empirically. These tests can be undertaken through a variety of different methods.

In important work in 2007, Blais and Bacher¹²⁷ carried out field work in the Canadian insurance market.¹²⁸ The work ran for six months and involved four large Canadian insurance companies. Claimants (outside of the control group) were provided with a copy of a letter,

¹²⁵CABINET OFFICE BEHAVIOURAL INSIGHTS TEAM, *APPLYING BEHAVIOURAL INSIGHTS TO REDUCE FRAUD, ERROR AND DEBT* 4 (2012),

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/60539/BIT_FraudErrorDebt_accessible.pdf.

¹²⁶INSURANCE FRAUD TASKFORCE, *INSURANCE FRAUD TASKFORCE: FINAL REPORT* 57 (Jan. 2016), https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/494105/PU1817_Insurance_Fraud_Taskforce.pdf (“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.”).

¹²⁷ Etienne Blais & Jean-Luc Bacher, *Situational Deterrence and Claim Padding: Results from a Randomized Field Experiment*, 3 J. EXPERIMENTAL CRIMINOLOGY 337 (2007).

¹²⁸ As described by Blais and Bacher, this built on earlier studies in experimental criminology. Blais & Bacher, *supra* note 127, at 340.

which arrived at the point at which they had to commit to their claim. It provided three salient types of information:

- (1) to inform the claimant that the insurance company was concerned about claim padding and was prepared to prosecute claimants that had exaggerated their claims;
- (2) to remind claimants of the sanctions associated with claim padding;
- (3) to encourage social conformity, by pointing out that most people consider claim exaggeration to be dishonest.¹²⁹

The findings from the survey are open to interpretation. The effect on claims across the impacted groups was noticeable, a reduction of around \$300 per claim, but this was ‘only 1% of the variance, which indicates a very weak relationship between the stimulus and the outcomes.’¹³⁰ The difficulty is that the study had no benchmark for the existing level of fraud within the control group by which to assess the effect. It could be that this reflected substantially lowered claims from those who would otherwise have padded their claim. It is also possible that this lowered the claims of honest claimants, below the honest level of recovery, as the letter made them overly cautious. It could be a combination of both.¹³¹

The behavioural research commissioned by the United Kingdom’s Insurance Fraud Bureau (which represents the industry on these matters) sought to control for the limitations in the earlier work. Rather than running a field experiment, requiring the cooperation of third-parties, it was run as an experimental economics laboratory test. The research was undertaken by a behavioural science consultancy, Decision Technology,¹³² rather than by an academic unit. The report was embargoed until September 2019, although the author was provided with a copy.¹³³ It can now be discussed in print and the principal researchers have done so.¹³⁴ As the method and findings of this research are central

¹²⁹ Blais & Bacher, *supra* note 127, at 342.

¹³⁰ *Id.* at 347.

¹³¹ See *id.* at 347–48 (the authors of the Blais and Bacher study recognise this as a limiting factor).

¹³² See generally DECTECH, <https://www.dectech.co.uk> (last visited Sept. 12, 2020).

¹³³ DECISION TECH. LTD., REDUCING OPPORTUNISTIC INSURANCE FRAUD WITH THE USE OF BEHAVIOURAL INTERVENTIONS: INSIGHTS REPORT (2018) (on file with author).

¹³⁴ Tim Mitchell & Benny Cheung, *Using Behavioural Science to Reduce Opportunistic Insurance Fraud*, 5 APPLIED MKTG. ANALYTICS 294 (2020). Pre-print available at:

to my claims for the development of English Law, I review each in some depth.

1. “Reducing Opportunistic Insurance Fraud with the Use of Behavioural Interventions”: Method

The use of experimental economics to generate empirical evidence of consumer decision-making to test hypotheses is well-established. In academic papers, this is often limited to observing volunteer undergraduates.¹³⁵ The Decision Technology method adopted a more professional approach to sampling, and produces a reasonably representative group of auto (motor) insurance customers.¹³⁶ This group was then run through a series of mock insurance decisions, including an online application for insurance and a claims process. A total of around 12,000 processes were completed, with subtle differences each time. In addition to the control group, where the website mirrored standard procedures, “a total of 19 nudges were tested as behavioural interventions in a simulated online experiment. These interventions took the form of pop up messages placed immediately before a contentious question i.e. where the customer could lie or exaggerate in order to get a better deal.”¹³⁷

The nudges were designed to test a number of distinct hypotheses as to “soft” fraud in consumer insurance, broadly themed around “norming”; “self-consistency”; “priming”; “framing”; and “reciprocation.” The interventions are displayed in detail in the results section below.

Alongside this empirical evidence on decision-making, Decision Technology sought to measure two other key elements: propensity to commit insurance fraud and effect on the “consumer journey.”

The baseline propensity data looks to establish the likelihood of the experimental group to commit insurance fraud at the application stage and the claims stage. This was acknowledged in previous work (including Blais & Bacher) as a limiting factor in assessing the effectiveness of interventions. The data for this study was obtained by

https://www.dectech.co.uk/studies/200129_AMA_Reducing_Opportunistic_Insurance_Fraud.pdf.

¹³⁵ The work of Russell Korobkin is a good example of this. *E.g.*, Russell Korobkin, *The Endowment Effect and Legal Analysis*, 97 NW. U. L. REV. 1227 (2002).

¹³⁶ Aged 18 or over, based in the U.K., and motor insurance customers. The data set controlled for age and other expected variables. DECISION TECH. LTD., *supra* note 133, at 27.

¹³⁷ DECISION TECH. LTD., *supra* note 133, at 4.

means of an “unmatched count technique” analysis.¹³⁸ This method is useful where direct questioning will not give completely truthful answers. Assume that we wish to know how many people would admit to having been caught speeding by the police. In one survey (to Group A), we ask directly and record the answer. That comes out at twenty-one percent. In a second, we compare the answers of two groups of people with similar profiles to Group A:

Table A: Unmatched Count Technique

Group B: How many of the following are true?	Group C: How many of the following are true?
I ate a packet of crisps in the past 24 hours	I ate a packet of crisps in the past 24 hours
I have played a team sport in the last week	I have played a team sport in the last week
I have read a novel cover to cover in the past six months	I have read a novel cover to cover in the past six months
I have been to Spain	I have been to Spain
	I have been caught speeding before
Average: 1.83	Average: 2.22

¹³⁸ The technique can be traced to D. Raghavarao & W. T. Federer, *Block Total Response as an Alternative to the Randomized Response Method in Surveys*, 41 J. ROYAL STAT. SOC'Y B. 40 (1979).

The difference between the answers between Group B and C are those who will disclose a speeding offence when it is bundled together with other non-culpable information. This is likely to be closer to the real figure. On this basis, whilst twenty-one percent of people would disclose when questioned directly, thirty-nine percent disclose when the moral costs of disclosing are removed. That gives us a baseline of fifty-four percent honesty; forty-six percent dishonesty in relation to that question: $Honest = (21/39 * 100)\%$; $Dishonest = (18/39 * 100)\%$.

This baseline serves two functions, and these must be distinguished. The primary use is as a comparator for this experiment. It does not matter for this purpose if this figure is accurate, as we will test for relative frequency of insurance fraud under variable conditions. In other words, which of the interventions trialled are most effective? The ancillary purpose is more controversial. If we assume these findings describe real-world behaviour, then it suggests that a high percentage of insurance applications and claims are fraudulent. This inference is not justifiable. In the real world, there would be sanctions for a failure to disclose, and no such sanctioning threat was present in the unmatched answers test. This, if anything, only answers the extent to which moral force alone limits the propensity to commit fraud.

The Decision Technology research also sought to measure the effect of behavioural interventions on customer perceptions of the process. This represents the real likely cost to insurers. The direct monetary cost of changing websites and claims forms is low, as the ability to spread the cost across multiple business streams and over time is considerable. Insurers were more concerned that these interventions might be seen as intrusive, unfair or manipulative. The existing sociological evidence¹³⁹ points towards consumers feeling untrusted by insurance professionals and the industry was alert to the risk of exacerbating that feeling. Those working through the dummy websites were therefore asked to respond on the standard 7-point Likert scale¹⁴⁰ about their experience of the process, and changes in attitude towards the insurer.

2. “Reducing Opportunistic Insurance Fraud with the Use of Behavioural Interventions”: Results

The benchmark figures from above predicted that thirty-nine percent of people have been stopped for speeding, and that only fifty-

¹³⁹ ERICSON ET AL., *supra* note 2.

¹⁴⁰ A Joshi, S Kale, S Chandel & D. K. Pal, *Likert Scale: Explored and Explained*, 7 BRIT. J. APPLIED SCI. & TECH. 396, 397 (2015).

four percent of those in that position would disclose this information voluntarily. This is the benchmark for honesty with no interventions. As consumers are processed through the dummy websites, a series of messages appeared on the screen at key moments, when honest disclosure was required. In this model, this is when the insured is asked whether (s)he has been stopped for speeding. The eighteen different types of message are shown in the table below, and the accompanying figures show the estimated effect on those who would have improperly withheld the requested information. Almost all interventions had a positive effect, in that a greater level of disclosure occurred. The percentage figure shown is the amount of expected fraud that was converted to an honest disclosure. The effect on those making an application for insurance varied considerably from those making a claim.

Dishonesty Swayed			
Domain	Intervention	Application	Claim
Norming	Statistics on others' honesty	55%	74%
	Case study of being caught	47%	71%
	Fraud is a crime / how to avoid	53%	54%
	Agency investigating fraud	44%	50%
	Techniques investigating fraud	44%	50%
	Example of how fraud is a crime	45%	33%
Self-consistency	Telling people they will be honest	30%	63%
	Honesty declaration at the top	44%	41%
Priming	Direct appeal to honesty	38%	48%
	Authority logos (Police)	33%	43%
	Honesty words	46%	25%
Framing	Negative consequences	48%	53%
	Human / friendly tone	-2%	27%
Reciprocation	Someone affected by fraud	36%	44%
	Statistics on claims paid out	48%	15%
	Fraud causing higher premium	22%	20%
	Lemonade charity approach	14%	16%
	Insurer honesty pledge	15%	5%
Average intervention		36%	37%

Table 3: Operational Communications Experiment Dishonesty Swayed Results

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On average, the use of a “nudge” of the type tested reduced the propensity to lie about a pre-existing motor conviction by thirty-six percent. Some of this will undoubtedly be boundedly rational, with useful information provided costlessly to the claimant.¹⁴² But other pieces of information are less obviously rational in their effect, and in particular, the “herd effect” information about how others act. This was one of the most significant factors in changing behaviour, with the

¹⁴¹ DECISION TECH. LTD, *supra* note 133, at 15.

¹⁴² Oren Bar-Gill & Omri Ben-Shahar, *Rethinking Nudge: An Information-Costs Theory of Default Rules*, (Univ. Chi., Pub. L. Working Paper, Paper No. 744, 2020), http://www.law.harvard.edu/programs/olin_center/papers/pdf/Bar-Gill_1031.pdf.

display of statistics on the honesty of most claimants reducing the level of expected fraud by seventy-four percent. This is crucial for the future design of insurance interventions. The threat of increasingly severe sanctions might reduce the tendency that insureds have to fraudulently withhold information, but this research suggests that it is less effective than making clear that most people are honest. The routine use of statistics informing consumers how much insurance fraud costs them (a routine tactic used by the insurance industry) is effective, but again less effective than a direct appeal to honesty. The measured effect on the “customer journey” of these positive messages was also negligible, which means that they present an achievable mechanism for reducing the levels of insurance fraud without demonising the average policyholder and without over-stating the effects of fraud.¹⁴³

Insurers have been harming their own best interests by operating the political message that fraud is rife and that the costs are vast. More effective messages can be phrased in positive terms. For those who follow behavioural science in insurance, it is notable that the “Lemonade” model, by which premiums not used to pay claims are donated to charity, was one of the least effective interventions. This may reflect a lack of familiarity with this model in the U.K., but does not support its wider adoption, at least on the counter-fraud agenda.

In response to this research the U.K. insurance industry designed an implementation blueprint for insurers wishing to adopt these techniques. Much of what will be done by the industry from this point will be commercially confidential and provide an opportunity for insurers to compete on the best implementation of this technique. Part of the savings from those interventions can be reinvested to refine and retest the messages used. Behavioural science favours empirically driven iterative approaches, and does not rely on the assumption that immediate, simple answers will arise from a single test.

D. CHOICE ARCHITECTURE AND REFLEXIVE OPPORTUNISM: THE GOLDEN TICKET?

Let us assume that as a society we would wish to achieve a ten percent reduction in the level of “soft” (opportunistic) fraud. Assume that this could be achieved by either of two means. First, the removal of any judicial or State regulation on the enforcement of “false swearing” and related provisions. Policies would be void on the occurrence of any fraudulent misrepresentation, irrespective of proven materiality, reliance or proportionality of outcome. Alternatively, by the widespread

¹⁴³ DECISION TECH. LTD, *supra* note 133, at 3 (“Historically, there has been some reluctance amongst insurers to over-play counter fraud during the customer journey, not least for fear of alienating customers.”).

introduction of “pop-ups” at key moments when information which is commonly misrepresented is submitted online, during applications for insurance and submission of claims. The empirical evidence generated by Decision Technology suggests that these pop-ups will operate as behavioural cues that have the population wide effect of reducing the incidences of dishonesty. It is not a complete solution. But it carries with it significantly reduced costs—both monetary and social—compared to the deterrence by sanction model routinely proposed.

The use of behavioural science to nudge insureds away from soft fraud is beneficial in three distinct ways. First, it maintains customers within the market as honest participants. Here, prevention is better than cure. Second, it is almost costless to implement. Not only do these consumers continue to participate in insurance markets, but the industry avoids the enforcement costs, both financial and reputational, associated with the denial of a claim. Thirdly, it carries a much lower risk that the intervention will be operated to limit the recovery of honest claims.

The reminder that most insureds are honest at the key moments of contracting and claim were tested to see if the customer’s experience of the process was affected. Against a control group, insureds left with a slightly *more* positive view of the process, and not less. I suggest that a comparable increase in the severity of the sanction would not produce the same result. Indeed, the sense that insureds are “under suspicion” when submitting claims runs strongly through the sociological studies in this field.¹⁴⁴ My claim is that there are credible reasons to suppose that the behavioural insights tested would not have the chilling effect on honest claims that increased monitoring, enforcement and criminalisation often bring. This is an important benefit.

To this proposal to adopt behavioural insights, I add two caveats. First, this is a single empirical study, and the generality of these finding will need to be tested. There will be cultural differences within the U.S., let alone between the U.K. and the U.S. Home insurance may not work in the same way as motor insurance. And so on. The “replication” crisis is real.¹⁴⁵ But the use of these techniques is not instead of a legal response to fraudulent claims, but as a primary filter. We should look to prevent where possible.

Second, I do not hold a naïve assumption that behavioural science could not be repurposed to create a chilling effect on honest claims. The potential misuse of behavioural science is a real, but distinct,

¹⁴⁴ ERICSON ET AL., *supra* note 2.

¹⁴⁵ Donald A. Hantula, *Editorial: Replication and Reliability in Behavior Science and Behavior Analysis: A Call for a Conversation*, 42 PERSP. ON BEHAV. SCI. 1 (Mar. 11, 2019), <https://doi.org/10.1007/s40614-019-00194-2>.

regulatory imperative. There is bureaucratic “sludge”¹⁴⁶ as well as “nudge for good.”¹⁴⁷ The regulation of those interventions is for a later paper. The insurance industry has a blueprint here for effective, cost efficient interventions that have a less stringent effect on honest customers than draconian legal remedies. Unwillingness to adopt the smart solution can, in time, be judged as a preference for the selfish desire to lower claims payable overall under the guise of the socially desirable reduction of fraud. “Therefore by their fruits you will know them.”¹⁴⁸

VI. CONCLUSION

Insurance fraud is entirely undesirable. But some of the actions taken to reduce it create further undesirable effects. Part of the difficulty is that we do not know how much fraud exists in insurance markets. One of the ways in which insurers use insurance fraud to their advantage is by persuading legislators, regulators and courts that insurance is rife, and that insurers need protection. This produces sub-optimal outcomes in the design of private law rules in civil justice and within insurance contract law. This regulatory dilemma is best viewed through the lens of “reflexive opportunism” but this in many ways simply labels a phenomenon known for many years.

The search is for practices that can lower the incidence of fraud without carrying the chilling effect produced by stricter formal legal rules. English law has moved in this direction by a series of changes across the tiers of insurance law and practice. The judiciary has sought to develop a more proportionate response, with particular focus on the materiality component within “false swearing” cases, and a more nuanced remedial response. Academics have sought to demonstrate the power-games within the presentation of insurance fraud data. Administrative action has sought “best practice” ideas from a range of stakeholders and moved the industry towards behaviourally informed policy.

The change is gradual. Insurers still seek the implementation of restrictions on personal injury claims,¹⁴⁹ a rate reduction in the tax

¹⁴⁶ Cass R. Sunstein, *Sludge Audits*, BEHAV. PUB. POL’Y 1, 3 (Jan. 6, 2020), <https://doi.org/10.1017/bpp.2019.32> (“*sludge*: ‘a viscous mixture’, in the form of excessive or unjustified frictions that make it difficult for consumers, employees, employers, students, patients, clients, small businesses and many others to get what they want or to do as they wish” (internal citation omitted)).

¹⁴⁷ Leonhard K. Lades & Liam Delaney, *Nudge FORGOOD*, BEHAV. PUB. POL’Y 1 (JAN. 27, 2020), <https://doi.org/10.1017/bpp.2019.53>.

¹⁴⁸ *Matthew* 7:19 (New King James).

¹⁴⁹ Ass’n of Brit. Insurers, *Whiplash Claims*, ABI,

imposed on the industry¹⁵⁰ and to vilify claimant lawyers.¹⁵¹ But within this is the hope that change in the design of insurance process—chiefly electronic proposal and claims forms—that reduce the incidences of insurance fraud without reducing the recovery of honest claims. The behavioural turn in countering insurance fraud does not mean abandoning past practices, but it does provide us with a mechanism for checking the relative efficacy of each. There will be those who argue that this is simply a more advanced form of utility maximisation, or an example of highly bounded conduct. I do not agree, but that is also irrelevant. The rule-maker conception of rational choice theory is often as simplistic as that of Lord Sumption's. That is what I am seeking to dismantle. If it takes a behavioural approach to shift from the use of simplistic models to empirically informed policy making, then that is a price worth paying.

The future of insurance law cannot be left to partisan attempts to shift the legal and political football slightly towards either insurers' goals or those of insureds. We can do better than that. There are some developments that benefit both sides of the aisle. A more sophisticated regime of remedies is within the control of the lawyers. Regulators can work to narrow the gap between how each side measures and describes the incidences of fraud. A single agreed figure is unlikely ever to be reached, but at least let us recognise the contested nature of the process. The development of low-cost measures to nudge insureds towards honesty at key moments improves the outcomes for all concerned. The outcome of a single empirical test is of course not the basis for immediate policy change. Behavioural science should be based on thoughtful trial and error. It supplements formal legal measures and need not replace

<https://www.abi.org.uk/products-and-issues/topics-and-issues/personal-injury-claims/whiplash-claims/> (last visited Sept. 6, 2020).

¹⁵⁰ Ass'n of Brit. Insurers, *As Motor Premiums Continue to Rise, Time for Insurance Premium Tax to Fall*, ABI, <https://www.abi.org.uk/news/news-articles/2020/01/as-motor-premiums-continue-to-rise-time-for-insurance-premium-tax-to-fall/>.

¹⁵¹ Neil Rose, *ABI Lashes Out at MPs Over Small Claims Report as Claimant Lawyers Urge Government to Act on It*, LEGAL FUTURES (May 18, 2018), <https://www.legalfutures.co.uk/latest-news/abi-lashes-out-at-mps-over-small-claims-report-as-claimant-lawyers-urge-government-to-act-on-it> ("James Dalton, the ABI's director of general insurance policy, said: 'If accepted, these recommendations would achieve absolutely nothing in terms of reducing the number and cost of whiplash-style claims, would allow lawyers to continue to line their pockets and honest motorists would continue to pay higher car insurance premiums as a result.'").

them. The interventions can be trialled in different States and different markets, and nuanced positions will emerge. They need only to have minimal effect to be justified on a cost/benefit basis. The insights derived from those further studies can be applied more widely. We might consider how forms completed within litigation might be amended to reduce fraud in litigation. The lessons from English law's thoughtful study of the causes of insurance fraud deserve to be repeated in all major insurance markets.