



WHIPLASH REFORM: PROPOSALS ON FIXED COSTS FOR MEDICAL EXAMINATIONS/REPORTS AND RELATED ISSUES

RESPONSE OF THE ASSOCIATION OF BRITISH INSURERS

The UK Insurance Industry

The UK insurance industry is the third largest in the world and the largest in Europe. It is a vital part of the UK economy, managing investments amounting to 25% of the UK's total net worth and contributing £10.4 billion in taxes to the Government. Employing around 320,000 people in the UK alone, the insurance industry is also one of this country's major exporters, with 26% of its net premium income coming from overseas business.

Insurance helps individuals and businesses protect themselves against the everyday risks they face, enabling people to own homes, travel overseas, provide for a financially secure future and run businesses. Insurance underpins a healthy and prosperous society, enabling businesses and individuals to thrive, safe in the knowledge that problems can be handled and risks carefully managed. Every day, our members pay out £148 million in benefits to pensioners and long-term savers as well as £58 million in general insurance claims.

The ABI

The ABI is the voice of insurance, representing the general insurance, protection, investment and long-term savings industry. It was formed in 1985 to represent the whole of the industry and today has almost 300 members, accounting for some 90% of premiums in the UK.

The ABI's role is to:

- Be the voice of the UK insurance industry, leading debate and speaking up for insurers.
- Represent the UK insurance industry to government, regulators and policy makers in the UK, EU and internationally, driving effective public policy and regulation.
- Advocate high standards of customer service within the industry and provide useful information to the public about insurance.
- Promote the benefits of insurance to the government, regulators, policy makers and the public.

Executive Summary

The ABI welcomes the Government's desired policy objective to reduce the number and cost of whiplash claims. Whiplash claims, a number of which are exaggerated or frivolous, are a significant problem, not just for insurers but for society as a whole. Whiplash costs insurers over £2 billion each year, representing approximately 20% of the average motor insurance premium.

The ABI welcomes the move to fix the fees for whiplash medico-legal reports in the Civil Procedure Rules (CPRs). While the Medical Reporting Organisation Agreement (MROA), a voluntary agreement between insurers and MROs, has gone some way to helping ensure the cost of medical reports is kept at a proportionate level, too many medical reports are still charged at rates which are completely disproportionate to the overall cost of the claim and the work required to produce the report.

The proposed figure of £180 for GP reports would be appropriate if that includes the still to be implemented accreditation process. However, if it is the intention that the figure is for the current process then the figure is still too high given that it incorporates an element charged for a referral fee that is now banned under the Legal Aid, Sentencing and Punishment of Offenders (LASPO) Act. In our view, therefore, the fee should be no higher than £170. This fee would remove most of the referral fee element and still leave a sufficient profit element for the doctor and the MRO.

Insurers have significant concerns with enabling physiotherapists to produce the initial medical report. Firstly, there is a question about the physiotherapist's ability to provide a diagnosis for a psychological element of a claim, as this does not fall within their core competency. As such, this is likely to lead to an increase in additional medical reports being commissioned given that a psychological assessment will likely be required following an assessment by a physiotherapist. The costs of obtaining two medical reports will lead to increased costs overall which will put upward pressure on motor insurance premiums. Secondly, inclusion of physiotherapists is likely to lead to a steep rise in the number of recommendations for rehabilitation, where the cost benefit for low value soft tissue injuries has not been demonstrated. This physiotherapy will no doubt be paid for privately, with the cost added to the claim, even though there may be little or no additional benefit to the claimant. To be clear, the duration of the claimant's pain and suffering might not reduce as a result of physiotherapy, leading to the original damages award plus the cost of the additional physiotherapy.

Insurers have significant concerns over the unintended consequences of allowing non-GP specialists, with their proposed higher fees, to carry out the initial medical report. As it is the intention for the fees for medical reports to be fixed at a proportionate cost in the CPRs, claimant lawyers with financial links to MROs are likely to change their business strategies once the proposals are implemented, by using more non-GP reports to attract higher disbursements and thereby generating greater profits. This is unlikely to lead to the Government's desired policy objective of reducing the number and cost of whiplash claims, indeed it could lead to higher costs.

In an attempt to crack down on the increase of exaggerated and fraudulent claims, the new RTA portal rules now provide for the defendant's version of events to be submitted, so as to allow the expert to comment on and have regard to both versions of events when carrying out the medical assessment. If, on the defendant's version of events, the expert concludes that no or little injury could have been sustained, then the next step must be for the parties to proceed to a hearing so that causation can be determined by a judge.

We propose that the opportunity for the defendant's version of events to be taken into account should apply to all claims, not just those that are admitted at Stage 1 of the RTA portal process.

From a public policy perspective, the lack of independence and the complete lack of transparency in the process must be addressed if the wider concerns around fraudulent and/or frivolous claims are to be tackled effectively. Transparency should be at the centre of the process going forward and should be targeted at addressing negative behaviours in the current system.

The need for a robust accreditation process for medico-legal experts, including peer review, is **absolutely fundamental** to the Government's reforms. The medical experts should be required to have a specified level of clinical experience in, and a working knowledge of, up to date, recognised research in the relevant medical area. It would also be helpful if the experts are aware of the latest engineering research into vehicle design and safety which could be

provided by Thatcham – recognised experts in this area. The ABI recognises that it would not be appropriate to expect medical practitioners to determine whether or not any injury has occurred. Experts can only give their objective view of an appropriate diagnosis based on the evidence presented to them. In our view the Government is right to recognise that the current safeguards have proved inadequate in providing sufficiently objective medico-legal reporting.

Provided all interested parties to the consultation continue to engage in the process it should be possible to ensure that the improvements are made to remove the commercial drivers at play, leaving a system that is fit for purpose and capable of providing objective reports to set criteria in which all parties can have confidence. It is this drive for transparency that will help tackle fraudulent and exaggerated claims, which will in turn, help to drive down the cost of insurance premiums. The ABI believes that if independence cannot be achieved then the overall impact on the cost of whiplash claims will be greatly diminished.

Fixed fees for medical reports:

1. Do you agree with the proposal to introduce mandatory fixed fees as set out in Annex B for all initial medical reports?

1. The ABI strongly supports the proposals to introduce mandatory fixed fees as set out in Annex B of the Ministry of Justice's (MoJ) consultation. The Medical Reporting Organisation Agreement (MROA) is a voluntary industry agreement that has been in place since 2007. The MROA and fee levels were put in place following mediation between the relevant stakeholders, insurers and Medical Reporting Organisations (MROs) and both were approved by the Civil Justice Council. The MROA has worked effectively to an extent to both cap the costs of obtaining a medical report and to reduce the frictional cost of disputing fees at the end of the case.
2. The fee levels for a GP report in 2007 were: for Rate B £220; and for Rate A (which allows for early payment) £195. The fees are currently set at £225 and £200 respectively, having been increased in 2012. The fees represent the total cost of obtaining the report, including the doctors' fees, the necessary administration that goes into producing the report. This is the fee charged to the at-fault insurer.
3. A minority of MROs have chosen not to operate within the MROA scheme and therefore have not applied the capped fees. Many of those MROs operating outside of the MROA have either direct or indirect financial links with solicitor firms. Those firms that operate outside the agreement will tend to charge excessive fees that will likely represent a pure profit element for the MRO, which drives up overall costs for defendant insurers at the expense of policyholders.
4. Whilst there are no definitive figures available, approximately 75% of all medical reports supporting RTA and EL/PL claims in cases with a value of up to £15,000 are currently being provided by MROA signatories. In 2012/13 there were 710,217 RTA claims for either whiplash or neck injury¹, the vast majority of which would be valued at less than £15,000. Taking the 75% figure, we can estimate that approximately 532,660 medico-legal reports in RTA soft tissue injuries claims were obtained via MROA signatory companies.
5. Given the vast majority of medico-legal reports that have been produced over the seven year period since the inception of the MROA have been produced within what has effectively been a "capped fee" regime, the ABI does not consider the independent and reputable elements of the medico-reporting industry will encounter any problems in moving from what is a voluntary agreement to a wider fixed fee arrangement.

¹ DWP Compensation Recovery Unit (CRU) July 2013

6. Fixing the fees for medico-legal reports brings certainty around the cost of obtaining a medico-legal report for both claimants and defendants. Whilst fixed medico-legal report fees will not prevent claimant lawyers obtaining reports outside of the fixed fee scheme, the deterrent will be such that in those cases, those reports cannot be relied upon at a Stage 3 hearing should the claim remain within the portal. Nor could they be adduced as evidence in Court should the claim exit the portal process. Proportionality and certainty as to the cost of a medico-legal report should have a positive impact in reducing claims costs and ultimately driving down the cost of motor insurance premiums.

Definition

7. The ABI believes the fixed fees for medico-legal reports should apply in all low value RTA cases. There are significant circumvention risks with trying to create a medico-legal process for one type of injury, i.e. whiplash, as claimant lawyers and MROs will look to try to get claims to fall outside the scope of that definition in order to attract higher fees.
8. There remain significant concerns that there are likely to be attempts to over-diagnose the psychological element of an injury and to under-diagnose the physical element. This behaviour, which is likely to be driven by claimant lawyers, would seek to ensure that the claim falls outside of the definition of “soft tissue injury” that has been developed to support the proposed regime. Any behaviour of this sort needs to be closely monitored in the interim period prior to the introduction of accreditation for medical experts.

2. Do you agree with the level of fixed fees for all initial medical reports as set out in Annex B? If you do not agree with the level, please provide evidence for that argument.

9. At present the MROA Rate B fee (see above) for a GP report is £225 and for an orthopaedic report is £465. Those fees include an element of referral fee and, following stakeholder discussions post the introduction of LASPO, MROA subscribers have agreed, in principle, that the fees should be reduced so that there is no longer any referral element within the fee.
10. The MROA allows for an early payment reduction so that the rate (Rate A) is £200 for a GP report and £425 for an orthopaedic surgeon report respectively if the fee is paid within 90 days of the invoice date. It should be noted that the proposed new rules in the consultation allow for early payment by insurers, on presentation of the Stage 2 settlement pack rather than at the end of the claim. Therefore any early payment element to the fee should be removed and Rate A fees would be the best comparator.
11. The figures outlined in Annex B of the MoJ consultation have been developed during discussions with a cross industry group, including claimant lawyers, insurers and medical representatives. It is understood that the discussion in that group was based on an assumption that these would be the fees applied to the accredited process, rather than the current non-accredited process that is to be put in place as an interim measure. It is not clear whether the fees set out in Annex B are the fees that will apply to an accredited scheme which is, as yet, neither developed nor implemented. If the fees in Annex B are the intended fees which are to apply once an accredited medical scheme is in place, then the ABI agrees with the GP fees but believes the Consultant Orthopaedic fees are too high (see paragraph 20)
12. However, if the fees in Annex B of the MoJ consultation are intended to cover the current process, the ABI believes that the figures below would be the only appropriate figures as they reflect the ban of referral fees whether direct or indirect. The figures outlined in

Annex B would then be the appropriate figures once accreditation had been implemented:

General Practitioner	£170
Consultant Orthopaedic Surgeon	See Below
Member of the Chartered Society of Physiotherapy	See Below

13. The costs of accreditation should be borne in part by the medical expert, who will no longer be in a position to provide medico-legal reports unless accredited. However, even if some of the cost of the accreditation process is passed on to the liable insurer through the cost of the reports, then, given the number of reports produced each year, it is anticipated the cost of accreditation on a per report basis will be minimal. The ABI considers that the figures outlined in paragraph 12 would be reasonable for a process that is, in effect, a continuation of what is currently in place and that these fees should be implemented now. The fees proposed in Annex B should not be introduced until an accreditation process is implemented.

14. The ABI therefore proposes two additional options:

Option 1 – the fees proposed in Annex B for GP and Consultant Orthopaedic Surgeons (see paragraph 20) are put in place now:

- (a) with an acknowledgement that the fee represents a sum that remains appropriate once the accredited scheme is in place.
- (b) there should be a review mechanism, but any increase to the currently proposed fee should only be implemented if the costs of the accreditation scheme are demonstrated to be higher than is anticipated and clearly demonstrates that the fee would no longer be appropriate.

Option 2 – A lower fee is implemented at this stage, as proposed in para 12, with a further review required once the accreditation scheme has been developed and implemented.

Appropriate medical expert

Physiotherapists

15. It is noted that the fee proposals are for reports by: General Practitioners; Consultant Orthopaedic Surgeons; and Members of the Chartered Society of Physiotherapists only. The ABI has substantial concerns with allowing physiotherapists to carry out the initial medical report. Firstly, we question a physiotherapist's ability to provide a diagnosis for a psychological injury as this does not fall within their core competency. As such, there is a real risk of a dramatic increase in the number of psychological secondary reports, the costs of which are laid out in Annex A. Secondly, inclusion of physiotherapists is likely to lead a steep rise in the number of rehabilitation referrals, even if safeguards are implemented to ensure that the medical professional carrying out the medical report will not be the same person carrying out the treatment. Unless addressed robustly, both of these concerns will lead to an increase in the cost of whiplash claims, for very little benefit to the claimant.

16. However, if the Government decides that it is appropriate to allow physiotherapists to carry out the initial report, this should be limited to suitably qualified Members of the Chartered Society of Physiotherapists, such that they should be required to have a level of medico-legal expertise and would be able to consider and comment on any related psychological injury such as travel anxiety etc. The appropriate level of qualification should be set out in the Rules and monitored by the MoJ to ascertain whether the

proposed reforms lead to any sub-optimal behavioural outcomes such as increased prognosis periods or increased referrals for rehabilitation.

17. If a decision is taken to include physiotherapists, the ABI does not agree that a physiotherapist and a GP report should attract the same fixed fee level. The ABI notes that a salaried GP earns between £54,863 and £82,789 (midpoint £68,826)². For a physiotherapist (at Band 7) earnings are between £30,460 and £40,157 (midpoint £35,308.50)³. This equates to 50% of a GP's salary. That difference should be reflected in the fees and the element paid to the expert should be reduced by 50%.

Other medical experts

18. The ABI notes that the current proposals allow for Consultant Orthopaedic Surgeons but not for Accident and Emergency specialists. It is important to recognise that by enabling non-GP specialists to carry out the initial medical reports for low value RTA claims, there is a significant risk of unintended consequences. Claimant lawyers, who either own a medical reporting agency or have financial links to one, will be strongly incentivised to instruct those medical experts who attract higher fees in order to offset the loss of profit from the fixing of fees for GP reports. Furthermore, non-GPs are unlikely to have sufficient training to diagnose simple psychological elements, such as travel anxiety, thereby increasing the likelihood of a psychological report being required – which in turn would increase the cost of the claim.
19. Given there are no barriers to stopping a claimant lawyer from instructing whichever medical expert they want, there is little doubt that a number of claimant lawyers will adjust their business strategy by looking to use the more expensive expert wherever possible because of the increased level of disbursements that they would be able to charge. This problem is reinforced by the Courts, who have shown little appetite for deciding which type of medical report is appropriate.
20. If it is still deemed appropriate to include Consultant Orthopaedic Surgeons, the ABI believes that the disparity between the fee level for a GP and Consultant Orthopaedic Surgeon report is too great. Given the increased level of training, qualification and expertise required to be a Consultant Orthopaedic Surgeon, the cost of such a report should be more than that of a GP but not high as is currently set out in the MROA as this figure is disproportionate.
21. The ABI supports the decision of the medical and legal sub-groups not to include Accident & Emergency experts on the basis that Accident & Emergency experts are rarely instructed by claimant lawyers. The ABI does not consider that they have the required on-going training in soft tissue neck and back injuries to be able to offer an objective prognosis. If however, Accident & Emergency experts are to remain within the interim regime, we consider that the cost of such a report needs to be reflective of their relevant qualifications and experience. Therefore, we propose that the fee level is set at a midpoint between a GP and Consultant Orthopaedic Expert.
22. As noted above, only GPs of all the experts proposed have the relevant knowledge and training to give a prognosis for any psychological element of a claim. Therefore the ABI consider that the initial report should come from a GP unless there is good reason for another expert to be selected, as the use of other experts would be likely to lead to an increase in the need for follow up reports dealing with any psychological element of the claim. The presumption should be that medical reports should be provided by a GP in the

² <http://www.nhscareers.nhs.uk/explore-by-career/doctors/pay-for-doctors/>

³ http://www.prospects.ac.uk/physiotherapist_salary.htm

first instance unless there is a genuine reason why a different specialist is required, for example a soft tissue injury with a suspected or confirmed fracture which still falls within the definition of the new process. The ABI suggests that this should be reflected within the Rules with the onus on the claimant solicitor to demonstrate the reasonableness of commissioning a first medical report from a non-GP.

Answering questions

23. The ABI supports a fixed fee for asking questions under CPR R35.6. Insurers do not envisage questions being asked in every case, but this process will encourage the reporting expert to produce as comprehensive a report as possible in the first instance. We accept there may be some occasions when questions may be numerous and the expert may take longer to complete them than the fee allows. However, we believe that the expert should endeavour to cover everything within their original report, thereby limiting the number of requests from both claimant and defendant parties.

Claims outside the Portal

24. There appears to be some uncertainty as to whether the fixed fees will apply to cases that fall outside of the portal. The ABI consider that the Rules on this point are clear but the confusion would be eliminated if the wording at 45.29I (2A) was amended to read "In a soft tissue injury claim started under the RTA Protocol only". This wording picks up and reflects the current wording of 45.19I (3).

Extra Information for Medical Experts:

3. If an insurer submits a version of events, the defendant would need to give the insurer specific authority to do this. We would therefore be grateful for views on how this can most appropriately be achieved, and on the provision of the defendant's version of events more generally.

25. The ABI notes that the defendant will not usually see the version of the accident circumstances which the claimant provides to the medical expert. Without sight of this description, which is often significantly more detailed than the very basic information provided within the CNF, the insurer is not in a position to decide whether they need to provide the expert with their own version of events. As such, the ABI does not agree with the draft wording of 6.19A in the proposed Protocol. Furthermore, given that a significant number of medical reports are requested prior to service of the CNF, this would preclude the defendant entirely from providing their version of events.

26. The defendant must see the version of the accident circumstances that is to be provided to the claimant's medical expert as they can then either advise whether the version is agreed, or not agreed at which point the defendant should be provided a specified amount of time to provide their own version of the accident circumstances to the medical expert by email. The process should be reflected in the Rules.

27. Where appropriate, however, it is vital that the medical expert is aware of any differing versions of the accident circumstances and where possible and appropriate, the defendant should be able to provide supportive evidence, such as images of the damage to the respective vehicles or easily understandable telematics evidence. Despite the medical expert not being an engineer, this information would assist them to develop a holistic view of the accident in which the Claimant sustained their injury(s). The intention is purely that the expert is aware of all of the facts - they would not be asked to be an arbiter of those facts.

28. For an insurer to be in a position to dispute the claimant's version of the accident circumstances at all, they will need to be provided with their insured's version of the accident circumstances. The insurer should seek their insured's authority to rely on this version of the accident circumstances at the point that the incident is reported, including specific authority for these purposes. If such authority is obtained at the first notification by the insured, delays should not arise as a result of needing to obtain that authority at a later stage. Insurers would all need to ensure that they have a process in place whereby written authority is obtained from their insured to use their version of the accident circumstances in this way.
29. Defendant insurers would need to set out the Defendant driver's version of the accident circumstances in an email that accompanies their response to the CNF. The email should be annexed to the instructions sent to the expert. If the defendant has any independent witness evidence then that witness evidence should be referred to, however, there should be no reason to set that evidence out in full as the medical expert is not being asked to arbitrate on that point.
30. There should be no need for a statement of truth in these circumstances as it does not create parity with the requirement for the claimant or their legal representative to sign a statement of truth. The position for defendants would be different:
 1. If there was a requirement for the defendant driver to sign a statement of truth it would cause significant practical difficulties and impose unnecessary administrative burdens on insurers in terms of requiring them to post forms to their insured and the insured then posting those forms back. It would not provide parity with the requirements on claimants given that there is no requirement that it must be the claimant that signs a statement of truth;
 2. Any requirement that there be a signature by a solicitor instructed by the defendant or their insurer would be inappropriate and impractical as, with very limited exceptions, solicitors are not usually instructed by insurers at this early stage. The role of defending the claim would usually be undertaken by specialists in an insurer's claims handling teams;
 3. CPR Part 22 permits an insurer to sign a statement of truth in a case where they have a financial interest. However, the signature must be as the company via a director, other officer, or senior manager. Again, this creates serious practical difficulties and does not provide parity with claimants where any person authorised to do so may sign. In any event, the insurer would be signing on their own behalf as a company and would not be verifying that they have authority from the insured to sign.
31. The proposal that insurers submit their insured's version of events upon receipt of authority to do so is the most practical and effective method for the defendant driver's version of events to be provided to the experts preparing the medical report, rather than relying upon the insurer's own belief or interpretation of events. This is crucial where an issue of causation arises. Written authority should mean electronic authority so that email confirmation from the insured can be relied upon by the insurer.

Independence:

4. Do you agree with the proposal that claimant and defendant representatives may only commission a specified proportion of medical reports via any given intermediary? If so, what should the proportion be and why?

32. The financial links between those commissioning medical reports and those producing them have been identified as one of the key drivers behind the increase in costs associated with low value RTA claims. The concern is twofold: firstly, there is a potential for the experts preparing medico-legal reports to be incentivised to produce a certain clinical finding for whiplash and/or a particular prognosis for recovery in return for personal financial gain; secondly, for those claimant law firms with direct or indirect financial interests in medico-legal reporting, there is a concern that not only are those individuals carrying out the medical report incentivised to produce a particular clinical finding, there is also an incentive to drive up costs, and therefore profits, by making referrals for rehabilitation and psychological assessment and treatment. This layering of costs is exacerbated by the links between solicitors firms, MROs and treatment providers. An example of the costs that can be incurred by a psychological injury is laid out in Annex A.
33. The Ministry of Justice recognised that this lack of independence is a problem in their response to their consultation *Reducing the number and cost of whiplash claims*. They noted "*we also wish to address the links which may impair the independence of medical examiners, so that they are not paid by those who favour a certain outcome in their diagnosis and so they do not have other financial interests in the outcome of the claim*". The cross industry group of AMRO, MASS ABI and FOIL identified the lack of independence when it comes to medical experts providing reports in support of claims as a key area that needs to be addressed. Where a medical expert is paid by a body that has a financial interest (direct or otherwise) in the outcome of the claim, then that expert's independence will remain an issue, especially in circumstances where the medical expert is then recommending a referral for further treatment which is then provided by someone else with a financial interest in the outcome of the claimant's claim.
34. This lack of independence and complete lack of transparency in the process must be addressed if the wider concerns and public perceptions around fraudulent and/or exaggerated claims are to be tackled effectively. Transparency should be at the centre of the process going forward and should be aimed at now and consolidated where appropriate through the relevant accreditation process. It is this drive for transparency that will help tackle fraudulent and exaggerated claims, which will in turn help to drive down the cost of insurance premiums. The ABI believes that if independence cannot be achieved then the overall impact on the cost of whiplash claims will be greatly diminished, which will in turn impact on car insurance premiums.
35. While all stakeholders have agreed with the aspiration of independence, achieving it in practical terms and where circumvention of the rules is difficult will be challenging to achieve. As such, the ABI favours a process whereby a claimant and/or defendant representative can only commission a proportion of their reports obtained from any one source. It is noted that the draft Rules are designed to ensure that the claimant/defendant or their legal representatives are unable to obtain a medical report from any intermediary in which they have any direct or indirect financial interest and the ABI strongly support this.
36. Limiting the number of reports that any legal representative can obtain from an MRO would be positive in that it would limit the benefit to those with a financial interest in an intermediary, in cross referring business on a reciprocal basis to another MRO. The

proposed solution would clearly not prevent this from happening entirely, but would dilute the process to such an extent that the impact on independence would be minimal.

37. The ABI believes that no more than 20% of medical reports should be obtained from any one intermediary. We consider that a lower percentage would make the proposition too onerous for those obtaining medical reports, while any higher percentage would take away from the benefit that is intended. The above would, of course, require some form of policing of the medical agencies with a declaration as to their work/instruction sources.

5. Do you agree with the proposal that representatives should be required to commission reports on a rota basis from a variety of intermediaries?

38. The ABI is not entirely clear what the Government is trying to achieve with the proposal. However, a rota basis could be used to achieve the outcome referred to in response to 4 above.

39. Once experts are accredited there is no reason why a pure rota system could not be applied via the portal, such that the choice of expert is taken out of claimant solicitors hands entirely. The outcome would be a “cab rank rule” where the claimant would have the next available appointment with a local expert. Clearly software would need to be developed to allow for this. The ABI understands, following the recent public meetings, that some providers already operate a system along these lines and therefore we consider that this outcome is achievable.

6. Do you have any other proposals as to how such independence could best be secured?

40. With section 56(2) of LASPO banning the payment or receipt of referral fees in personal injury cases, there is a need for a review to check if the existing rules are sufficiently clear that no referral fee element is being paid for a medical report. This will help ensure that the medical reports do not include excessive elements as well as going some way to helping to break the inappropriate financial links between claimant lawyers and MROs or doctors that the Government wants to tackle.

41. The ABI believes that there is merit in exploring the option to achieve true independence by allocating medical experts via an extension to the functionality of the Claims Portal. While this would require some IT infrastructure to be built (the Portal Board will be tendering for an IT change programme later this year), this would ensure the choice of expert would be fully “independent” of all parties to the process.

42. The ABI believes that if the Government decides not to take forward the proposals on independence as set out in the consultation paper, there will need to be a compelling reason articulated by the Government. Furthermore, it will be imperative that the issue of independence is revisited during the work to develop the accreditation process. Without true independence, which is vital to stop the layering of costs that insurers have been experiencing, the overall impact of these reforms will be greatly diminished and thereby have little impact in terms of reducing motor insurance premiums.

Reports Commissioned outside the fixed fee scheme:

7. Do you agree with the proposal that the cost of the report is not recoverable if the report is commissioned outside the fixed fee scheme?

43. The ABI fully support this and understands that this position is supported by all stakeholders. There should be no reason why those operating outside of the Rules should benefit from doing so.

8. Do you agree the above proposal is a sufficient deterrent?

44. See response to question 9.

9. Do you agree with the proposal that a pre-medical offer could be made if a report is commissioned outside the fixed fee scheme?

45. The Rules as drafted provide that an insurer can, in these circumstances, rely on a pre-medical offer in costs. However, it is not clear how this would work as the defendant insurer would not know whether a report has been commissioned outside of the fixed-fee scheme until they have received the report and therefore they would not know if there is any benefit in making a pre-medical offer.

46. This could only work in practice once a pattern of working has been established for any particular claimant firm. It will become obvious at an early stage if firms are failing to comply with the rules. It is likely that if a number of reports are commissioned by a claimant law firm outside of the fixed fee scheme, then the defendant can reasonably expect this behaviour in the future.

47. A pre-medical offer that has an impact on costs, together with non-recovery of the costs of the report, may be a sufficient deterrent for claimant solicitors to not want to pursue that course of action in the first instance as it may be to the detriment of their client. However, the ABI has concerns that this may create a situation that can be abused. Claimant firms who find that they are receiving pre-medical offers because their reports are non-compliant would be in a position to accept pre-medical offers. This provides them the opportunity to thus they will recover damages for their client and some fixed portal costs, even where it is necessary to pay for the medical report from those costs. In situations where a pre-medical offer is made prior to obtaining a medical report at all, full costs recovery may be made if no medical report is ever obtained. This is exactly the kind of behaviour that the Ministry's reforms are designed to prevent.

48. The ABI therefore considers that by applying Part 36 rules to pre-medical offers in these circumstances may well drive the behaviours that this regime is designed to eradicate.

49. A better deterrent against non-compliance with the proposed Rules is that a claimant cannot rely on a report that is commissioned outside of the fixed fee regime. The ABI considers that this would be the most effective deterrent and there is no reason for a claimant in these circumstances to seek to gain an advantage by operating outside of the CPRs.

50. If a claimant cannot rely on the report commissioned outside of the fixed fee regime, then they should not be able to rely on it either as part of the Stage 2 settlement pack, or on the issue of proceedings at Stage 3. This would force claimants to provide a report within the fixed fee regime, as otherwise the report would have no effect and the case cannot progress.

Further Comments:

10. Please also provide any further comments you may have in relation to any of the proposals or amendments covered by this letter and its annexes.

Part 36

51. The proposed amendments are likely to be effective in encouraging defendants to make offers after a fixed fee medical report has been disclosed in order to obtain costs protection from that offer. If operating within the Rules, a claimant can proceed in the knowledge that they are protected from any pre-medical offer having an impact on costs. In the post-LASPO era with qualified one way costs shifting in place, a claimant solicitor would need to think very carefully before advising their client to obtain anything but a fixed cost medical report.

Part 45

52. The ABI supports the proposed amendments to 45.19(2A) and 45.29(2A) and believes that the draft Rules work with the proposals that are set out in Annex B of the consultation paper. We do not envisage any issues arising with the proposed amendments which appear both clear and workable.

Pre-Action protocol for Low Value Personal Injury Claims in Road Traffic Accidents from 31 July 2013.

53. The ABI considers that the proposed amendments are clear and workable. However, the ABI believes the fixed fees should apply for all RTA low value cases. There are significant circumvention risks with trying to create a medico-legal process for one type of injury, i.e. whiplash, as claimant lawyers and MROs will seek to ensure that claims fall outside the definition.

54. The ABI considers that it is appropriate that costs should not be recoverable for obtaining a medical report that is not in accordance with the Rules. We would, however, like to see this Rule widened so that claimants cannot rely on a non-compliant medical report.

Transitional Provisions

55. The ABI endorses the proposal that the amendments apply in cases where a CNF is submitted after a certain date. The amendments proposed are on the basis that this is a change to cases that are by definition already within the protocol. The change does not extend the protocol in any way to cases that would have already been within it. This logic was applied when the fixed fee regime was introduced on the same basis as is proposed here.

56. Any attempt to change this to "accidents after" will create a two tier process that will continue for a significant time given the limitation period in which to make a claim. The ABI has seen statistics that demonstrates a significant time lag between date of accident and the CNF:

The statistics indicate that around 25% of claims presented are over 120 days post-accident. Six of the top 20 claimant law firms by volume of claims notify their claims an average of 160 days post-accident with four of those firms averaging between 297 and 413 days.

Annex A:

The Psychological Injury Claims Process and the Impact on Solicitor Fees

This section sets out the typical process followed when assessing a psychological injury, as well as the financial benefits accruing to claimant solicitors where claims are made for psychological injury.

An example of a Claims Process for Psychological Injury Claims

The first contact between the claimant and the law firm is by telephone following an accident. The call is handled by the solicitor's first response team.

The first response team administer the General Adjustment Disorder questionnaire (GAD -7) and the Patient Health Questionnaire (PHQ- 9) which indicate the level of anxiety and depression that is being suffered.

The tolerance of each test is extremely low in that a score of 5 out of 21 under GAD-7 means mild anxiety and a score of 5 out of 27 under PHQ – 9 means mild depression.

Where scores indicating anxiety or depression are attained, the claimant is then referred to the medical agency who arranges a telephone examination with a graduate psychologist.

The graduate psychologist (who is not an expert as defined in the protocol) produces a report, recommending cognitive behavioral therapy (CBT) without sight of the claimant's medical records and not having actually met the claimant.

CBT is arranged whereby the claimant has a course of 30 minute telephone calls with a cognitive behavioral therapist who, upon completion of the course, produces a discharge report.

Invoices are raised by the medical agency and sent to the firm to recover as damages and disbursements.

The Impact of Psychological Damages and Disbursements on Solicitor Fees

To illustrate the incentive for claimant solicitors to claim for psychological injuries, the model used by a well known firm of solicitors in the northwest of England is set out below. The firm owns its own medical agency, and regularly seeks to recover the following fees:

- i. Psychological triage assessment fee – £90
- ii. Copying psychological triage notes fee – £60
- iii. 6 sessions of telephone cognitive behavioral therapy (£162.50 each) - £975
- iv. Discharge report fee – £60
- v. Administration fee – £36
- vi. Psychology Report Fee – £900
- vii. Administrative fee – £36

It can be seen that an additional £2,157 can be derived by including a psychological injury claim.

In addition, the solicitor can take a further £243.75 (25% of the £975 CBT recovered) out of the claimant's damages as the success fee.