



House of Commons
Transport Committee

**Driving premiums
down: fraud and the
cost of motor
insurance: Government
and Association of
British Insurers
Responses to the
Committee's First
Report of Session
2014–15**

**Fifth Special Report of Session 2014–
15**

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The Transport Committee

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Fifth Special Report

On 4 September 2014 we received a response from the Government to the Transport Committee's First Report of 2014–15, *Driving premiums down: fraud and the cost of motor insurance*, which we publish with this Special Report.¹

We also received a response from the Association of British Insurers.

Introduction

1. Many people depend on their cars to travel to work and for an active social life, yet for some the high cost of motor insurance makes running a car too expensive. For too long honest drivers have been bearing the cost - through higher premiums - of a system open to abuse. This must change.

2. On 1 April 2013 the Government introduced a number of reforms to the area of civil litigation funding and costs through provisions in the Legal Aid, Sentencing and Punishment of Offenders Act 2012. These reforms were aimed at removing unnecessary costs from the system, and we have already seen a fall in premiums paid by motorists - the latest ABI comprehensive premium survey (August 2014) shows a 13% drop in actual premiums² paid over the past two years.

3. The whiplash reform programme published on 23 October 2013 complements and builds on these earlier reforms. Action to reduce the number of speculative or fraudulent claims made each year will lower the costs for insurers, and the Government fully expects insurers to continue to meet their commitment to pass on these savings to consumers.

4. The impact of fraudulent personal injury claims on the cost of motor insurance is a problem which we are working hard to tackle with our suite of reforms related to whiplash and to personal injury claims more generally. We want to ensure the right action is taken, with everyone playing their part; the Government therefore welcomes the Committee's work.

5. This paper sets out the Government's response to the conclusions and recommendations in the House of Commons Transport Committee's first report of session 2014/15 '*Driving premiums down: fraud and the cost of motor insurance*'. The Committee's text is in bold, and the Government's response is in plain text. Paragraph numbers in parentheses refer to the Committee's report.

1 HC 285, published on 4 July 2014.

2 ABI average comprehensive motor insurance premium tracker -figures relate to Quarter 1 2012 and Quarter 1 2014. Figures are not verified by Government. <https://www.abi.org.uk/News/Industry-data-updates/2014/08/ABI-average-motor-insurance-premium-tracker-Q2-2014-data>

Government Response

Better data

We reiterate our earlier recommendation that the Government should act to ensure that there exists better data about fraudulent or exaggerated personal injury claims, so that there is a stronger evidence base for policy decisions. Since the Government has cited the ABI's figures for dishonest claims in 2013 it should explain how the figures have been arrived at and how dishonest claims have been defined. (Paragraph 6)

6. The Ministry of Justice is currently discussing options to improve data quality with a number of stakeholders. Work is progressing with representatives from Claims Portal Limited on the feasibility of establishing a link between the Claims Portal and the Department for Work and Pensions' Claims Recovery Unit (CRU) database for greater alignment between CRU figures and Claims Portal figures. In addition, Claims Portal Limited is discussing with the Insurance Fraud Bureau proposals to explore the feasibility of using the Portal data to assist them in detecting fraud.

7. Claimant representatives, medical experts and medical reporting organisations have been working with Ministry of Justice officials to assist with evidence gathering to inform the development of our reforms. The ABI has committed to providing baseline data on soft tissue claims. This data will enable the Government to gain a better understanding of the types of claims, the level of damages and the period of time between an accident, claim notification and settlement.

8. The Government does not centrally collect information on fraudulent or exaggerated personal injury claims and therefore may refer to data collated via industry sources. Such figures have not been verified by Government and when used are clearly marked as having been sourced from industry.

9. The Committee has requested an explanation of the Association of British Insurers' (ABI) data on the number of dishonest claims in 2013. This question is best answered by the industry, and we suggest the Committee writes to the ABI for a detailed answer. However, for clarification the Government understands the process to be based on an ABI survey of its membership, which requests data in response to a list of scenarios in which it is believed fraud is likely to be involved. Members then provide the numbers of cases which fall into categories based on the Fraud Act 2006.

10. These statistics do not include claims which involve exaggerated personal injury, particularly for whiplash, where the claim has been paid. Although some of those cases will have an innocent explanation, it is also true to say that a number of cases of successful fraud will go undetected. So the ABI fraud statistics provide a useful indication of the volume and value of fraud detected by the industry but they should not be considered an absolute indication of the level of fraud in the industry.

Use of small claims procedure

We recommend that the Government inform us of what work is underway or planned to develop adequate safeguards to protect claimants from adverse consequences of raising the threshold for using the small claims procedure for personal injury cases. (Paragraph 11)
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11. As previously stated, the Government believes that there is evidence to support raising the small claims limit for personal injury claims. For now, however, our main focus remains the implementation of the reforms to medical evidence and reporting announced on 23 October 2013.

12. Further consideration will be given to this issue in due course.

Medical panels

Although we welcome the Government's obvious desire to get on with establishing independent medical panels as soon as possible, we are concerned that numerous detailed matters are being decided hastily and, in some cases, without much consideration of different options. We recommend that the Government publish for consultation comprehensive proposals for how medical panels will work, in time for the new system to be introduced by next Easter. (Paragraph 15)

In our view, medical reporting organisations should be prohibited from providing reports on whiplash and other soft tissue injuries for claims being pursued by solicitors belonging to the same business structure. Furthermore, a robust accreditation system should provide mechanisms for penalising practitioners whose work is influenced by their view of what the claimant might want in a report. We welcome the Government's intention to act in this area. (Paragraph 17)
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We recommend that the Government explain how it will prevent small firms being squeezed out by the introduction of independent medical reporting panels for whiplash and related injuries. (Paragraph 18)

13. The Government has noted the Committee's recommendation and is currently consulting on changes to the Civil Procedure Rules and the Pre-Action Protocol for Low Value Injury Claims in Road Traffic Accidents to implement its proposals in this area. Working with industry experts, we are developing a new system for commissioning medical evidence in low value whiplash claims. This will be underpinned by an IT based allocation process for registered medical experts or medical reporting organisations. This will break any direct links between those commissioning medical reports and the medical

experts themselves, removing potential conflicts of interest from the system. In addition, we propose the establishment of a new independent organisation representing a cross-section of interests to operate this system in a fair and impartial way, irrespective of the size of the reporting organisation.

14. Linked to this will be a new accreditation (and re-accreditation) scheme for experts, which will include a peer review and auditing element to identify substandard reporting. Accreditation will not be limited to doctors; experts from other disciplines who meet the required criteria may also seek to obtain accreditation. Accredited experts will be subject to audit and any who do not continue to meet appropriate standards will face sanctions such as the removal of, or restrictions applied to, their accreditation.

15. There is no Government funding available for this project and it is the Government's opinion that this scheme must be established and owned by those operating in the personal injury sector. There will be significant start up costs associated with developing an IT system and the Government is grateful that the Association of British Insurers has agreed to meet these costs. We will ensure that there is a suitable independent governance structure in place to ensure that the scheme reflects cross-industry interests and will become self funding through receipt of accreditation/re-accreditation fees from experts.

16. The Government expects the new system - assuring independent and high-quality medical evidence - to be in place by early in the new year.

Striking out exaggerated claims

We call on the Government to clarify how and when it intends to introduce measures requiring courts to throw out compensation applications in full where the claimant has been fundamentally dishonest. Although we broadly support this initiative we would caution against hasty legislation: the legal issues need to be fully thought through so that the eventual solution is effective and does not have unintended consequences. (Paragraph 22)
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17. The Government has introduced measures in the Criminal Justice and Courts Bill, which is currently before Parliament, to tackle personal injury claims where the claimant has been fundamentally dishonest.

18. These measures provide that in any personal injury claim where the court finds that the claimant is entitled to damages, but is satisfied on the balance of probabilities that the claimant has been fundamentally dishonest in relation to the claim, the court must dismiss the claim entirely unless it is satisfied that the claimant would suffer substantial injustice as a result.

19. This provision applies in both "primary" claims (for example where the claimant grossly exaggerates his or her own claim) and "related" claims (for example where the claimant colludes in a fraudulent claim brought by another person in connection with the same incident or series of incidents in connection with which the primary claim is made).

20. The clause also contains supplementary provisions to:

- require the court to record in the order dismissing the claim the amount of damages that it would otherwise have awarded;
- provide that where an order for dismissal is made, the court may only require the claimant to pay the defendant's costs to the extent that they exceed the amount of damages recorded in the order; and
- provide for the order for dismissal to be taken into account in relation to the disposal of any proceedings relating to the same dishonest conduct against the claimant for contempt of court or criminal prosecution.

21. The Government welcomes the Committee's support for action in this area, and considers that these provisions will address the issue of fundamentally dishonest claims in a fair, proportionate and effective way. We expect the Bill to achieve Royal Assent before the end of this Parliament, with commencement to follow shortly thereafter.

Inducements to claim
Inducements to claim are likely to have encouraged fraudulent claims so we support the Government's intention to ban them. We call on the Government to publish details of how and when this change will be made. (Paragraph 25)

22. The Government banned the payment of inducements by claims management companies with effect from 1 April 2013. In conjunction with other Government reforms, this ban has led to a substantial reduction in the number of claims management companies now operating in the personal injury sector, from 2,553 companies in 2012 to 1,125 companies in 2014.³

23. Following calls from key stakeholders in the market - such as the Association of Personal Injury Lawyers and the Motor Accident Solicitors Society - for the ban to be extended to cover lawyers, the Government decided to take action. On 23 July 2014, a clause was introduced into the Criminal Justice and Courts Bill to prevent solicitors offering money or gifts such as tablet computers to encourage personal injury claims.

24. This measure complements other Government initiatives which have been introduced to help discourage fraudulent, exaggerated and trivial personal injury claims and to provide significant benefits for consumers, businesses and local authorities.

³ Claims Management Regulator: 2013/14 annual report <https://www.gov.uk/government/collections/claims-management-regulator-annual-reports>

Pre-medical offers

We are in no doubt that fraudulent and exaggerated claims have been encouraged by the insurers' practice of paying out for whiplash claims without requiring a medical examination. We strongly agree with the Government's intention to prohibit such offers, as part of the new system for independent medical panels for diagnosis and reporting. (Paragraph 28)

Problems caused by claims for injuries sustained months or years ago could be ameliorated by reducing the period in which claims can be made or by requiring firmer contemporary evidence of the impact of the injury. We have made the case for these changes previously, although the Government has not yet been persuaded. In our view, these changes will be required to make the system work effectively. (Paragraph 29)
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It is unfortunate that the ABI should argue that action to tackle fraudulent and exaggerated claims, by insisting on medical examinations, will increase premiums. We would have hoped for a firmer commitment from the industry to driving out fraud. In our view, money saved from reducing fraudulent and exaggerated claims should more than compensate for any extra costs resulting from more stringent requirements for dealing with whiplash claims. (Paragraph 30)

25. As stated in its response published on 23 October 2013, the Government is attracted to the idea of a rule to ensure that a medical examination and report are completed before a claim can proceed. However, following further discussion with stakeholders, it is apparent that this is a difficult issue and a new rule alone is unlikely to be sufficient to address this particular problem.

26. For that reason, we have amended the Pre-Action Protocol for Low Value Personal Injury Claims in Road Traffic Accidents (the RTA Protocol) to actively discourage pre-medical offers. The amendments provide that where a defendant's offer to settle is accepted before the defendant receives the fixed cost medical report; it will carry no costs consequences until after the report has been received. Some stakeholders are of the view that the whiplash reform programme will itself remove the drivers for pre-medical offers.

27. We will keep this matter under review and will continue to work with key stakeholders on further ways to tackle this issue effectively, as needed.

Claims for psychological damage

Once proposals for independent medical panels for whiplash injuries have been implemented and shown to work, the Government should be prepared to extend their scope to other types of injury if necessary. We also recommend that the Government press the Solicitors Regulation Authority to stop some solicitors from playing the system

to maximise their income from unnecessary medical reports. (Paragraph 33)

28. The Government has been monitoring the number of low value RTA claims in which a psychological report has been commissioned. Whilst there has been a marked increase in the number of these reports, overall the numbers remain low. Table 1 identifies the number of claims registered with the CRU since 2009/10 that were labelled as either 'post traumatic stress', 'PTSD' or 'psychological'. These figures are broken down by whether 'whiplash' was also mentioned.

Table 1 – Number of Claims Registered with CRU labelled as either 'Post Traumatic Stress Syndrome' (PTSD) or 'Psychological' and 'whiplash'⁴

Year	Claims for Post Traumatic Stress Disorder (PTSD) and psychological trauma, with no whiplash element	Claims for PTSD with 'whiplash' included in the injury description	Total
2009/10	2,745	1,457	4,202
2010/11	2,715	1,383	4,098
2011/12	3,091	1,560	4,651
2012/13	3,341	1,473	4,814
2013/14	3,463	1,685	5,148

29. The Government has taken steps to control this potential growth area by introducing amendments to the RTA Protocol and related Civil Procedure Rules. These changes emphasise the expectation that there will usually only be one report commissioned in low value RTA claims (except in exceptional circumstances). The revised Protocol only allows for a secondary specialist report to be obtained where the initial examination identifies a justifiable need for this, which we expect to be rare.

30. We believe that these measures will provide an effective and proportionate control.

Policing

We expect the insurance industry to continue funding the police Insurance Fraud Enforcement Department (IFED) in the long-term: we recommend that the Government oversee IFED's funding arrangements to make sure that the unit has a long-term future. (Paragraph 35)

31. The Government agrees with the Committee that the work performed by the Insurance Fraud Enforcement Department (IFED) in tackling insurance fraud is extremely important

⁴ Department of Work and Pensions Claims Recovery Unit snapshot data taken between May 2013 and July 2014.

Figures may be revised in future snapshots.

and should continue. We were pleased to note that the insurance industry recently reinforced its commitment to fighting fraud by agreeing to continue to fund IFED by £11.7 million.

32. This will ensure that IFED is fully funded for the next three years, and the Government will continue to monitor its performance. To date IFED has made 430 arrests and secured 223 police cautions and court convictions.⁵

Data sharing
We are pleased to note that better data sharing to tackle motor insurance fraud is now beginning. We share the Government's wish to see results as soon as possible, but it will also be important to get the details of the scheme right. In particular, data sharing should be compulsory: otherwise, only the most reputable firms will take part and the impact on fraud will be limited. (Paragraph 36)

33. Lord Faulks QC, Minister of State for Justice, wrote to representatives of the ABI, the Law Society, the Motor Accident Solicitors Society and the Association of Personal Injury Lawyers earlier this year to urge them to continue their productive discussions on data sharing. This has resulted in an agreement in principle to share data held by insurers on potential claimants to help combat fraud at source. We are supporting the industry to take this work forward as a priority. The Government firmly believes that such sharing of data is crucial in the fight against fraudulent claims.

34. We are currently consulting on a new requirement for claimant representatives to perform a 'previous claims' check on potential clients. This will ensure that the sharing of data at the early stages of a claim is firmly embedded in the civil justice system.

5 Insurance Fraud Enforcement Department press release:

http://www.cityoflondon.police.uk/advice-and-support/fraud-and-economic-crime/ifed/ifed-news/Pages/Insurance_industry%E2%80%99s_%C2%A311.7m_investment_will_fund_expansion_of_Insurance_Fraud_Enforcement_Department-.aspx

Conclusion

35. As the Transport Committee has recognised, the Government is committed to reforming the personal injury industry to drive out the perverse and dysfunctional behaviours which can push up the cost of motor insurance. The reforms introduced to date and those planned for the near future will create an improved, robust system for independent medical evidence by accredited experts which will deter unnecessary or speculative claims and ensure the genuinely injured can get the help they need.

36. We welcome the Transport Committee's continued interest in this important area of reform. The Government will continue to engage with all stakeholders as our programme for reform progresses.

37. The Government's reform programme will enable further reductions to be made to the insurance premiums of honest, hardworking motorists, and we will monitor the effect of our reforms to assess whether more can be done. In addition, we will carefully consider the outcome of the Competition and Markets Authority's investigation into the private motor insurance market, expected during September.

38. Our reforms are paying dividends. We have already seen a fall in the level of motor insurance premiums paid, and we expect this to continue.

Response from the Association of British Insurers

I am writing to you following the publication on 30th June of the Transport Select Committee's report Driving premiums down: fraud and the cost of motor insurance. We welcome the Committee's continued work to recognise the significant impact that fraudulent and exaggerated whiplash claims have on the premiums of honest motorists and the fact that you continue to work closely with the industry to examine ways to help effectively tackle the problem.

We are pleased that the Committee recognises that the current system does not result in the provision of robust and high quality medical reporting in whiplash claims. Further, we welcome the Committee's support for the creation of an independent medical panel of medical experts.

Within the report there were a number of areas where I felt it would be helpful to provide you with an update on the ABI's ongoing work aimed at combating exaggerated and fraudulent claims and our commitment to passing on costs savings to motorists through reduced motor insurance premiums.

Independent medical experts

As you will be aware, the Secretary of State for Justice has indicated that medical reports for whiplash injury claims should be supplied by independent medical experts (who are accredited professionals) using a standard medical report form. It cannot be right that claimant solicitors who commission medical reports and the medical experts who prepare them have any financial linkages which might have a bearing on the outcome of the examination and what is ultimately contained within the medical report.

The insurance industry considers this issue to be of such importance that we are prepared to fund the set up costs of an IT platform and we are working at pace with the Ministry of Justice to get the new system up and running as soon as possible. We envisage a system where the claimant solicitor will be randomly allocated a medical expert who has no financial link to the claimant solicitor and who is accredited to prepare medical reports.

The ABI is in favour of using a random allocation approach, where a central body is responsible for receiving requests for medical reports and allocating them to experts on a random basis based on the expert's availability/capacity and location. Medical Reporting Organisations (MROs) add value to the provision of medical reporting through the efficiencies they bring to the system and we support their continued involvement in the medical reporting system of the future.

Accreditation

Insurers have long argued that the fundamental underpinnings of the medico-legal reporting process are not fit for purpose. Making sure that the experts preparing medical

reports are up to the job is absolutely critical. We are pleased to see that medical experts will be required to become accredited in order to carry out medico-legal reporting work.

The process of accreditation is essential to ensure that those responsible for diagnosing whiplash are suitably experienced, skilled and qualified to do so. The government is committed to setting up a full process of accreditation as soon as possible and insurers are working collaboratively with other stakeholders to develop an accreditation framework in which we can all have more confidence than we do now. The process will need to become self-funding over time and medical practitioners will need to choose whether they wish to become accredited and be part of the new framework.

Fraud data

The ABI collects information regarding detected fraud to provide our members and wider stakeholders with one indication of the extent of fraud that the industry faces at both the application and claims stage.

This activity does not provide anything more than an indication of the level of detected fraud impacting on the insurance industry. In turn, individual insurers have their own mechanisms for understanding their own exposure to fraud and taking steps to mitigate the related risks.

Reporting on and measuring all cases of fraud encountered by insurers presents some challenges. Insurers are able to report on and measure acts of clear detected fraud; that is where evidence of fraud is compelling. However, where an insurer has prevented an individual from obtaining insurance cover by way of, for example, its automated system-based fraud defences, or a claim is no longer pursued due to an insurer probing the circumstances of a loss, such scenarios are not always clear instances of detected fraud.

Insurers would positively welcome increasing the number of convictions for insurance fraud. However, there are two important factors to bear in mind. Firstly, despite significant investment from the insurance industry in the form of the Insurance Fraud Enforcement Department (IFED) within the City of London Police, there is currently insufficient Police resource available to respond to and manage the wider insurance industry referring cases of fraud for enforcement action on a daily basis. This has been compounded (over recent years) by regional Police forces reducing the resources they allocate to combat fraud and financial crime and having no specific objectives to devote resources to such criminality.

Secondly, insurers' attempts to combat suspected fraudulent whiplash claims have often proved to be fruitless. Given there is no objective medical evidence for whiplash type injuries, with diagnosis often being made on the basis of the claimant's subjective description of their injury, the ability to prove beyond a reasonable doubt that the claimant has not sustained an injury is both challenging and expensive. Therefore, whilst insurers use various tactics to dissuade fraudsters and defend spurious claims, the standard of evidence required means many such cases are not pursued in the courts.

As such, actual criminal convictions for insurance fraud clearly only represent the tip of the iceberg, and are not a true reflection of the level of fraud that insurers, and wider society, face on a daily basis.

Accordingly, the ABI has developed a list of scenarios in which we believe fraud is likely to be involved and ask our members to provide the numbers of cases which fall into those categories (see Annex A). Some of these cases may have an innocent explanation. But what is important to recognise is that many more cases of successful fraud are likely to go undetected, especially for whiplash.

The ABI's fraud statistics are therefore intended to provide an indication of the volume and value of fraud detected by the industry. These statistics do not include claims which involve exaggerated personal injury, particularly for whiplash, where that claim has been paid.

Pre-medical settlement offers

Pre-medical settlement offers are a useful method by which insurers are able to settle whiplash claims where the injuries sustained are very minor and do not justify the time and cost of a medical report being commissioned. Insurers do recognise that the lack of any medical evidence to substantiate a claim for compensation does provide the opportunist claimant the ability to pursue spurious claims where there is the possibility of requesting a pre-medical offer from the at fault insurer. Balanced against this, however, it cannot be right to assume that every claimant who requests a pre-medical offer is an opportunist looking to take advantage of the system. Insurers take the view that pre-medical settlement offers have a place within the system, by allowing minor injury claims to be settled quickly and without the need for unnecessary legal costs and disbursements being incurred.

We note that a number of claimant solicitors, and indeed the Committee in your report, call for a ban on the use of pre-medical settlement offers. I am, however, aware that claimant solicitors ask insurers to make a settlement offer before a medical report has been obtained and indeed recommend acceptance of pre medical settlement offers to their clients. Therefore, if claimant solicitors dislike the practice of pre-medical settlement offers, they might stop requesting them. I also note that, although considering pre-medical offers should be prohibited, the Ministry of Justice has indicated that this is a difficult issue and a new rule alone is not enough to address this particular problem. As a result, the new rules announced on 4 August and to come into force on 1 October were drafted to discourage the use of pre-medical offers.

Striking out of exaggerated claims and inducements

The government has indicated an intention to reform the law on "gross exaggeration" in personal injury claims following the Supreme Court's decision in *Summers v Fairclough Homes*. There is currently no clear disincentive to prevent claimants from bringing exaggerated claims given that, even where a genuine claim has been deliberately exaggerated, the courts will still order the defendant to pay the genuine part of the claimant's claim.

In essence, this is a no lose situation where the claimant will enjoy a pay day regardless. This is simply not acceptable and we are pleased to see this being addressed through the Criminal Justice and Courts Bill currently before Parliament.

Similarly, we are pleased that the distasteful practice of solicitors offering inducements like cash or ipads to claimants to make personal injury claims is to be banned. This practice only serves to reinforce to unscrupulous claimants that there is a compensation culture to exploit. It is positive that the Committee has supported this change.

Policing

We are pleased that the Committee recognises the vital contribution that IFED has made to counter the threat of insurance fraud since its inception in January 2012. We were surprised, however, by the Committee's assertion that IFED's funding "beyond this year appears to be uncertain" (paragraph 35). Please find attached a joint letter (Annex B) from Otto Thoresen and John O'Roarke to you dated 16 April 2014 which underlines the insurance sector's ongoing commitment to combatting insurance fraud, including through renewal of the IFED contract for a further three year period until the end of 2017.

The increased level of funding, which will provide for an additional investigative team, will enable IFED to continue to lead the national enforcement response to insurance fraud, bring more fraudsters to justice, recover and return more assets to the victims of insurance fraud and undertake more quarterly themed days of action.

The insurance sector will review its funding commitment beyond 2017 during the course of 2016. We do however, seek clarification of what the Committee means by its recommendation that the government should "oversee" IFED's funding arrangements to ensure that the unit has a long-term future.

Data sharing

MyLicence is a joint initiative between DVLA and the insurance industry, represented by the ABI and the Motor Insurers' Bureau (MIB), to use up to date and accurate information from the driver licence record. This supports the drive by the industry to reduce insurance fraud and help honest motorists save on their premiums. Some drivers could save up to £15 on their premium, due to the correct driver record and history being used at the point of a quote being offered for motor insurance.

Insurers will use MyLicence for motorists with a British licence who are insuring a personal car, van or motorbike. All other types of licence holders will need to continue to self-declare their driving endorsements and history. The MIB and DVLA are in the process of preparing the service for insurers to use, including extensive testing. Once we are satisfied the service is meeting all the performance requirements it will begin to roll out for use by motorists which we hope will occur in early September 2014.

Access to CUEPI - The insurance industry has agreed to share data from the Claims and Underwriting Exchange Personal Injury (CUEPI) database with claimant lawyers. The ABI has worked collaboratively with Motor Accident Solicitors Society, Association of Personal Injury Lawyers and The Law Society to define and agree how this can be delivered in practice. We have jointly requested that the Ministry of Justice consider implementing changes to the RTA Protocol to deliver the proposed new system and we are awaiting a response from officials on this issue.

Further work on whiplash

Although outside the scope of the Ministry of Justice's current whiplash reform programme, there are a number of other potential options available to further reduce the cost and number of whiplash claims. These include shortening the limitation period for soft tissue injury claims; raising the small claims track limit for personal injury claims to £5,000 or above (perhaps with the benefit of a predictable damages calculation tool); or even removing the entitlement to claim general damages at all, and providing for treatment in lieu of damages. The Committee is aware of the arguments in support of these proposals so I do not intend to repeat them here.

I have copied this letter to the Secretary of State for Justice.

I do hope that you find this information useful and of interest.

Yours sincerely

James Dalton

Assistant Director, Head of Motor

August 2014

ANNEX A

The ABI seeks information from its members which fall into the following description, which has been based around the Fraud Act 2006:

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
- 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.

The ABI also collects information from its members relating to cases of Suspected Insurance Fraud.

Where a handler having an actual suspicion of fraud (eg manual fraud indicator(s), tip off, system generated "high risk" referral etc) challenges the applicant/claimant by letter, telephone call or instruction of an investigator etc, to clarify key information, provide additional information or documentation etc, and the applicant/claimant subsequently:

- Fails to provide further documentation or co-operation
- Formally withdraws the application/claim (by phone, e-mail or letter) without a credible explanation.
- Allows all communication with the insurer to lapse despite the insurer's reasonable attempts to re-establish contact.
- Accepts (without a credible explanation) either a substantially reduced settlement offer in respect of a claim, or a substantially increased premium in respect of an application/renewal (other than in cases where there has been a careless misrepresentation).

All other gone away claims/applications arising in the course of normal (i.e. non exceptional) handling do not represent suspected fraud under this definition. These would include (but not necessarily be limited to):

- Gone away/withdrawn claims or applications when no preceding combination of suspicion and subsequent challenge has occurred.
- Gone away/withdrawn claims or applications where a "challenge" is applied to all new claims/applications of a particular class (e.g. Household accidental damage) as a matter of routine.
- Lapsed quotes, where no formal application for insurance cover has been made.

ANNEX B

ABI commitment to combatting insurance fraud

Tackling Fraud

- The insurance industry invests around £200m pa in preventing, detecting and enforcing against the ongoing, increasing fraud problem.
- The recent renewal of the contract with the Insurance Fraud Enforcement Department until end 2017 takes the ABI's total investment in IFED to more than £20m.
- The Insurance Fraud Register- the first database of known insurance fraudsters - is now operational.
- The ABI has reached agreement in principle to share data with claimant lawyers to help tackle fraud.
- These initiatives -which complement the excellent work of the Insurance Fraud Bureau- demonstrate that the infrastructure and expertise are in place across the industry to combat fraud.
- The Government and Judiciary can play their part by creating a legislative and regulatory environment that supports insurers' efforts to bring fraudsters to justice. Raising the Small Claims Track limit would help to combat fraudulent injury claims and reduce motor premiums further.
- We main resolute in our goal to work in partnership to beat the fraudster and protect our honest customers.

Given the political, media and consumer interest in the cost of insurance, I am writing to provide an update on current key ABI counter fraud initiatives given that insurance fraud is a key unnecessary cost for insurers leading to higher premiums than are necessary for consumers.

Background

Insurance fraud remains an ongoing, burgeoning problem. In 2013, the amount of fraud detected by the insurance sector exceeded £1 billion for the first time and it is estimated that at least double that amount goes undetected each year. So fighting insurance fraud remains a key strategic industry priority and collectively the industry invests around £200 million a year in preventing and detecting fraud.

The Insurance Fraud Enforcement Department

In the last three years, the insurance industry has intensified efforts to combat fraud and protect its genuine customers. Since its inception in January 2012, the Insurance Fraud Enforcement Department (IFED), a bespoke unit housed within the City of London Police, has made 462 arrests, secured 84 convictions in court, and issued 139 cautions. It currently has around £29 million of fraud under investigation.

IFED has also coordinated two national 'days of action' in respect of 'ghost braking' and credit-hire fraud in which a total of 47 people were arrested. But it isn't just about enforcement. IFED takes every opportunity to use its high media profile to raise awareness of insurance fraud as an issue impacting honest customers that is not a victimless crime and to underpin the deterrent message.

In September 2013, the ABI extended the remit of IFED to cover the Lloyd's market. And in March the insurance industry agreed to invest a further £11.7 million to extend the IFED contract until the end of 2017 taking the industry's total investment to more than £20 million. This increased funding, which will provide for an additional investigative team, will enable IFED to continue to lead the national response to insurance fraud, bring more fraudsters to justice, recover and return more assets to the victims of fraud and undertake more quarterly days of action.

Insurance Fraud Register

Another key initiative is the Insurance Fraud Register (IFR), the insurance industry's first database of known fraudsters, operated by the Insurance Fraud Bureau (IFB) on behalf of the ABI. The IFR provides a visible deterrent that delivers tangible consequences for fraudsters. Insurers represented on the IFR Steering Board have started to load data to the IFR, and we are now rolling out the register to the rest of the insurance market.

The IFR Steering Board spent considerable time developing the governance framework and standard contractual arrangements and has built a number of safeguards into the process. Above all, the Board has ensured that the provisions regarding privacy and security of data are robust and transparent.

Whiplash

There is still more to do to tackle the UK's whiplash epidemic. Raising the Small Claims Track limit is vital to help to combat fraudulent personal injury claims and reduce premiums further; not increasing the limit was a missed opportunity to introduce real meaningful reform.

We welcome the Government's intention to introduce robust reform to the medico-legal reporting system, which has an important role to play, but it should not be seen as the panacea for delivering further reductions in car insurance premiums. Given that there remains no objective test for whiplash, in addition to the number of vested interests in the wider claims industry, the impact of the Government's proposed reforms to tackle frivolous and exaggerated claims may not be as great as first anticipated.

Sharing Data to Reduce Personal Injury Fraud

The insurance industry understands the benefits of sharing data with claimant lawyers to help tackle fraudulent claims and the Claims and Underwriting Exchange Personal Injury (CUE PI) database has been identified as the best source of information to be shared. There is now an agreement in principle to do so. The ABI and the MIS have held a number of meetings with claimant lawyer representatives in recent months to define how the data will be shared in practice.

In the spirit of cooperation and maximising the benefits of data sharing to combat fraud, insurers have requested that claimant lawyers provide the referral source of the claimant to the solicitor and whether the solicitor has declined to act for the client on suspicion that the claim is fraudulent. This information would support organisations such as the IFB and IFED in their investigations into organised fraud networks. In addition, the data could be shared with both the Solicitors Regulation Authority and the Ministry of Justice to assist in identifying those Claims Management Companies that refer a disproportionate number of cases declined by solicitors on the suspicion of fraud.

Conclusion

These initiatives send strong signals of the industry's ambition to reduce fraud and complement the excellent ongoing work of the IFB which has spearheaded the fight against organised insurance fraud since 2006, and is currently managing 109 investigations worth in the region of £120 million, the vast majority of which involve professional enablers.

The infrastructure and expertise are now in place across the industry, and there should be no let-up in identifying, deterring and enforcing against fraudulent activity.

The Government and the judiciary can play their part too. Firstly, we require a legislative and regulatory environment that supports, rather than stifles, insurers' legitimate efforts to combat fraud. We are encouraged, for example, by the Law Commission agreeing to take forward for further consideration the ABI's proposal for a law reform project on personal injury fraud. Secondly, we need the courts to promote deterrence. We are encouraged by growing evidence that the judiciary is beginning to take a tougher stance, handing down more, and stiffer, custodial sentences.

We remain resolute in our goal to beat the fraudster and will continue to work in partnership with the Government, regulators, consumer groups and those within the insurance sector to take action to protect our honest customers.

Please feel free to contact me should you require any further information in relation to the industry's efforts to combat insurance fraud.

Yours sincerely
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