November 21, 2011

Mr. Peter Wallace
Deputy Minister
Ministry of Finance
Office of the Deputy Minister
Frost Building South
7 Queen’s Park Crescent
Toronto, ON  M7A 1Y7

Dear Deputy Minister:

Please find attached the interim report of the Automobile Insurance Anti-Fraud Task Force, in accordance with our terms of reference.

We are pleased to transmit this report to you, for distribution to the Minister of Finance. The report describes what we have learned in the four months since we were appointed and actions now underway, makes some recommendations for further action we believe can be implemented in the short-term with beneficial results, and sets out our agenda for further work through the balance of our mandate.

We wish to acknowledge the excellent support we have received from your officials in the Ministry of Finance. They have supported the work of the Task Force with the professionalism, dedication and competence that reflect all the very best that one should expect of public service, and our report has been substantially enhanced by their contribution. We have also received solid support, and excellent advice, from officials in the Ministry of the Attorney General, the Ministry of Community Safety and Correctional Services, and the Financial Services Commission of Ontario.

While we appreciate and are grateful for the input of officials, we stress that this report reflects our own conclusions on the issues you have charged us to consider.

Respectfully submitted,

[Signatures]

Frederick W. Gorbet
Chair, Steering Committee

[Signature]

Margaret Beare

George Cooke

James Daw

Bob Percy
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Introduction

Automobile insurance costs in Ontario, and particularly those related to accident benefits, have risen dramatically over the past several years. A number of observers believe that fraudulent activity has increased, and that those bent on defrauding the system are better organized than previously. Much of their evidence is anecdotal and difficult to prove or to quantify. What can be demonstrated, however, is that costs have risen faster than can be explained by other factors. The situation is particularly acute in the Greater Toronto Area (GTA).

In response, the government has introduced a number of measures to combat increasing claims costs and, at the same time, to reduce the cost to drivers of escalating automobile insurance premiums. Insurers have become more aggressive in fighting fraud through civil actions and in employing new technology in claims adjustment.

As part of the government’s response to the concern over rapidly escalating costs, the 2011 Ontario Budget announced that a Task Force would be established to determine the scope and nature of automobile insurance fraud and make recommendations about ways to reduce it.

The Ontario Auto Insurance Anti-Fraud Task Force was appointed on July 29, 2011, and is directed by a Steering Committee of five members, independent of government. Our mandate is set out in Appendix 1. In essence, we were assigned two tasks:

- assess, as best we can, the extent and nature of fraud in the Ontario automobile insurance system; and
- recommend actions available to government and other stakeholders to reduce the incidence of fraud for the benefit of insurance policyholders.

Those in the auto insurance system, as well as the government, have a responsibility to play an active role in combating auto insurance fraud in Ontario. In order to actively involve these interested parties, three Working Groups of selected stakeholders and representatives of the government are assisting the Steering Committee in developing recommendations to prevent fraud. The Working Group members were selected to represent their professions as a whole, and not special interest issues.
The three major factors that can influence the existence and extent of fraud are opportunity, arising from the structure of the system and its regulation; incentives, which will increase in the absence of robust prevention, detection, investigation and enforcement strategies; and lack of consumer awareness. The Working Groups were established to focus on these major factors. Their mandates cover:

- prevention, detection, investigation and enforcement;
- regulatory practices in the automobile insurance system; and
- consumer engagement and education.

The terms of reference of the three Working Groups are set out in Appendix 2.

The Steering Committee’s final report is due by fall 2012.

This interim report sets out some preliminary observations and information about automobile insurance fraud, the evolution of the Ontario automobile insurance sector over the past two decades and actions currently underway to combat fraud. We propose some further measures that we believe could be implemented relatively quickly to attain positive results, and we set out the actions we intend to take through the balance of our mandate.

We have benefited considerably in our work from the presentations and comments made to our committee. These include insurance industry representatives, health care providers, experts in law enforcement and regulation and other interested individuals. We hope this interim report will make clear the directions we intend to pursue, so those with an interest in these issues can continue to assist us in dealing effectively with this important issue.

The issues related to the auto insurance industry are complex and many of the participants in the system have strong and legitimate points of view that reflect their particular perspective. Our goal is to understand these perspectives, but to take a broader view, rooted in the public interest and in the need to find balance that best serves the interests of all users of the auto insurance system. We have tried consistently to present our initial findings in as objective and unbiased way as we can. Some of the analysis has never been attempted before and will be quite challenging. But we are optimistic that the work we have set out to do will make a positive difference.
The Ontario Auto Insurance System and Its Evolution

Automobile insurance has been mandatory in Ontario since 1979. Before then, vehicle owners could purchase an automobile insurance policy or self-insure by paying into what is termed an “Unsatisfied Judgment Fund.” Self-insured drivers were liable for their negligent acts and the Fund stepped in only where an at-fault driver was unable to fully compensate a not-at-fault person injured in an automobile accident.

Currently, insurers, brokers, agents and certain providers of services to those involved in vehicle collisions are strictly regulated. Others in the system are not. For example, the government determines the terms of insurance coverage, regulates what insurers may charge policyholders and pay to health care providers, and oversees insurers’ conduct in the marketplace.

Since 1998, the Financial Services Commission of Ontario (FSCO), the successor to the Ontario Insurance Commission, has regulated compliance with the Insurance Act, and accompanying regulations. The Minister of Finance is responsible for proposing changes to the Act and its regulations.

Other participants in the system are unregulated or less strictly regulated. These include tow truck drivers, auto body repair shops, and rehabilitation clinics.

This section sets out the main features of Ontario’s regulated insurance market, and how those features have changed over the past two decades. The Task Force notes that there has been a legitimate and constant tension between the objective of treating injured persons in a fair and effective way, while containing the total cost of insurance for policyholders. It has been a continuing challenge for Ontario governments to maintain a balance that will be affordable for all Ontario drivers and adequate for those injured in accidents.

We conclude this section with some general observations about the system and comments on how we believe these observations should guide our work.
The Current System

The current system is a hybrid. It provides mandatory coverages that include a mandatory level of accident benefits for drivers, passengers, pedestrians and cyclists injured as a result of the use of a motor vehicle, regardless of who is to blame. These are known as no-fault benefits. Additional coverage limits may be purchased. Insurance policies also include both mandatory and optional levels of coverage for damage to the policyholder’s vehicle and property, plus protection for those who would be held liable in court for causing injuries and damage. Only those with “serious and permanent injuries” have the right to sue another motorist for loss of income, the cost of medical care not provided by government programs and for causing pain and suffering. All insurers must offer the same basic and optional accident benefits.

The advantage of a hybrid system is that all individuals who are injured can be treated right away by claiming no-fault benefits. Those who are more severely injured may recover additional costs in court, to the extent that they were not at-fault. The challenge is getting the balance right between court (or tort) compensation and no-fault benefits with appropriate controls, while keeping premiums affordable for the vast majority of Ontario residents who will drive for years, even decades, without becoming involved in an automobile collision or becoming injured. Ontario’s reforms over the last 20 years have adjusted this balance several times with varying results.
### Ontario’s Automobile Insurance Benefits

<table>
<thead>
<tr>
<th>Mandatory Coverages</th>
<th>Optional Coverages</th>
</tr>
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| **Third-Party Liability**  
  - Pays for claims as a result of lawsuits.  
  - Minimum coverage by law is $200,000.  
  - Court awards for pain and suffering include mandatory deductible amounts.  | **Collision**  
  - Coverage for repairs to an insured vehicle when the insured driver is at fault |
| **Statutory Accident Benefits Schedule (SABS)**  
  - Provides benefits if a person is injured in an accident, regardless of who caused the accident.  
  - Includes medical and rehabilitation, income replacement, attendant care and death and funeral coverages.  | **Comprehensive**  
  - Pays for losses from theft, fire and non-collision damage.  |
| **Direct Compensation**  
  - Covers damage to an insured vehicle to the extent that another driver was at fault for the accident.  | **Optional Accident Benefits**  
  - Can include higher limits for standard Accident Benefits coverages or coverages such as housekeeping and caregiving.  |
| **Uninsured Automobile Coverage**  
  - Protects drivers from damage caused by an uninsured motorist.  | **Other Optional Coverages**  
  - Such as coverage for the cost of a rental vehicle while an insured vehicle is being repaired and full replacement cost for a relatively new vehicle.  |

The key issues at play have been:

- the amount and rules governing mandatory statutory accident benefits coverage available to Ontario motorists;
- the caps on what may be paid for the assessment and treatment of injuries;
- the impairment severity threshold that must be met to be eligible for access to court-awarded compensation;
- whether court-awarded damages for pain and suffering should include deductible amounts and, if so, how great those deductibles should be; and
- the avenues available to an injured person to dispute an insurer’s denial of benefits.
Insurance Costs and Rate Setting

The Rate Approval Process

The premiums that insurers charge to policyholders are regulated by FSCO. The process works in the following way.

Insurers propose rates based on their own historic claims costs, by accident year and by coverage, and generally adjust rates annually based on updated claims information. Proposed rates are based on an estimate of what should be charged for the period that a policy is in effect. Accordingly, no allowance is made to recover past losses. The premium is determined by taking into account expected future claims costs, operating expenses, investment income and a provision for profit.

Industry data is commonly used by insurers to estimate cost trends for the period rates will be in effect. Insurers look at their own historic and expected costs to determine what rates they should charge, either to be profitable or remain competitive with other insurers in the market.

Insurers group drivers with similar risk characteristics and similar expected claims costs for the purpose of setting rates. Consumers are charged different rates depending upon their risk characteristics. Risk classification elements include:

- territory or location;
- classification (age; gender; marital status; annual mileage; distance driven to and from work);
- driving record (number of years licensed; number of years without an at-fault accident);
- vehicle rate group;
- deductible; and
- liability limit.

Government regulations prohibit insurers from using certain risk-classification elements in their systems. Prohibited elements include:

- income level;
- employment history;
- credit rating;
- entitlement to other benefits; and
- claims where the person was not at fault or only 25 per cent at fault.
Insurance Costs and Rate Setting
Rate Change Example

The following is an example of how a consumer could be charged different rates from year to year.

Bill owns a 10-year old mini-van, which he drives to and from work. He has chosen a $2 million limit for his third-party liability coverage but no optional benefits under his Accident Benefits coverage.

Any number of events could cause Bill’s auto insurance rates to change. For example, Bill could:

- be involved in a motor vehicle collision for which he is deemed to be at-fault, causing insurers to classify him as a riskier driver;
- reduce his third-party liability limit to $1 million, reducing the maximum amount an insurer would have to pay under that coverage; or
- get a new job that requires him to drive twice as far to get to work, increasing the amount of time he spends driving in his vehicle.

Any of these events could change a risk classification element used by an insurer to determine what rates to charge Bill. For example, if Bill was at-fault in a motor vehicle collision he would be grouped with other drivers that had been at-fault in a collision. Insurers would likely have higher rates for drivers in that group.

Insurers are required to file any proposal for rate changes with FSCO for approval. Filings include the claims experience and expense justification for rate changes. Filings are reviewed against standardized actuarial and financial benchmarks. The Financial Services Commission does not set rates. It either approves proposed changes or not, in which case the existing rates remain in effect.

When approving rates, FSCO takes into consideration the insurance company’s actuarial analysis, FSCO’s own actuarial analysis and other information relevant to the application for the proposed rates. Changes are reviewed in the context of the company’s position and practices in relation to the existing rates and practices in the marketplace. The decision by FSCO is based on a balancing of interests to ensure that approved rates are just and reasonable.
While consumers would like to pay as little as possible for their insurance, insurers require an appropriate return on investment to raise capital from investors and to remain solvent during a period of unexpected losses. Losses and a withdrawal of investor capital can lead to higher prices and less choice for consumers. As part of its review of rate filings, FSCO considers the financial solvency of an insurer.

Exhibit 1, shows the average level of automobile insurance premiums in Ontario from 1985 to 2010, adjusted for inflation. The chart demonstrates quite clearly a cyclical pattern in premiums, with higher costs to insurers, leading to pressure to increase premiums faster than average inflation in Canada and to government-introduced reforms to the system to help take pressure off costs. The pattern repeats, with premium-induced policy responses occurring in 1990, 1996, 2003 and 2010.

The balance of this section reviews the evolution of the system through the various premium cycles shown in Exhibit 1. It should be stressed that throughout this report, when we discuss the costs of insurance, we are not talking about costs to the government and taxpayers but costs that will be passed on to drivers through higher premiums.
The Evolution of the System: 1990 to 2003

In 1990, Ontario responded to increasing costs due to rising levels of litigation, court awards and out-of-court settlements by introducing substantive no-fault accident benefits. The government also made automobile insurance benefits, payable only after all other benefits, such as the Ontario Health Insurance Plan (OHIP) and group medical insurance, were used. These changes were intended to avoid significant premium increases that would otherwise have occurred.

At the same time, access to tort damages for both economic and non-economic loss was limited to those with injuries that were “permanent,” “serious” and “physical” in nature. This definition of eligibility was referred to as the “verbal threshold” The terms of the threshold have since been altered, and have become the focus of numerous legal disputes. In addition, the province instituted mediation and arbitration processes to resolve disputes outside the court system.

Other measures to reduce automobile insurance costs included replacing OHIP subrogation with an annual insurer assessment of health system costs. OHIP subrogation is the recovery of costs from insurance companies or at-fault parties for OHIP services provided to individuals injured in an automobile accident.

In 1994, the NDP government of Ontario, which had campaigned in 1990 on a platform that included introducing government-run automobile insurance, introduced a substantial expansion of statutory accident benefits. For example, the attendant care benefit under statutory accident benefits more than tripled to $10,000 from $3,000 per month. The right to sue for economic losses was eliminated but the right to sue for compensation for pain and suffering was expanded. The new “verbal threshold” referred to serious, although not necessarily permanent impairments of an important physical, mental or psychological function.

This expansion of no-fault benefits to an upper limit of $1 million for medical and rehabilitation services, with no aggregate cap on attendant care benefits, led to a rapid increase in costs.

In 1996, the then Conservative government reintroduced the right to sue for economic loss in cases of serious injury. To constrain costs and provide some premium relief the mandatory accident benefit coverage was reduced for non-catastrophic injuries to $100,000, although consumers had the option to buy $1 million in medical, rehabilitation and attendant care coverage. To help control costs, the regulator was granted authority to set fee schedules for health care providers. Providers of rehabilitation services were required to submit a treatment plan and seek an insurer’s approval before starting therapy.
The Evolution of the System: 2003 to 2010

Premiums stabilized after the 1996 cost containment measures were put into place. However, in 2000 the cost of both accident benefits and tort settlements began to climb at an increasingly rapid rate, leading to higher premiums.

As a result, in 2003 a number of significant amendments were made to the automobile insurance system, including:

- introducing a Pre-approved Framework (PAF) guideline for the treatment of whiplash injuries, which accounted for the majority of automobile insurance medical and rehabilitation claims. A limit was set on the amount that could be billed without prior approval, but guidelines were introduced to provide quicker and more certain access to treatment. (No prior approval was required for treatments that were within the PAF guidelines.);
- reducing the maximum hourly rate by 30 per cent for health care providers by order of the Superintendent of FSCO;
- expanding the right to sue for excess health care expenses;
- doubling the sum deducted from court awards for pain and suffering; and
- directing the Superintendent of FSCO to review and report back to the Minister of Finance on the operation of the automobile insurance system at least every five years — with respect to statutory accident benefits, court proceedings and dispute resolution mechanisms.

The 2003 reforms were followed by a reduction in premiums from 2004 through 2007, but premiums began increasing again in 2008.

In addition, the dispute resolution system, in its current form has become unsustainable. (See accompanying box.)
The History of Dispute Resolution in Ontario’s Automobile Insurance System

Since 1990, FSCO has provided a dispute resolution service. Its objective was to provide a quick and fair method of resolving disputes between injured persons and insurers. The first stage is an informal mediation process, which is free to the person claiming benefits, and a fee charged to the insurer once the case has been assigned to a mediator. If the attempt at mediation is not successful, the person claiming benefits may choose to apply for FSCO arbitration or to have the matter determined in court. The parties may also jointly refer the issues in dispute to a private arbitrator. As is the case in court, an arbitrator’s decision will be binding on both parties, but a FSCO arbitrator’s decision may be appealed to the Director of Arbitrations (or his/her delegate) on a question of law. There is no provision for an appeal to the court of a FSCO arbitrator’s decision.

In addition, the parties may apply for variation or revocation of an arbitration or appeal order on one of three material grounds: a material change in the circumstances of the insured person; evidence that was not available at the arbitration or appeal stage has become available; an error in the arbitration or appeal order (for example, the order does not correspond to the reasons for the decision). Depending on the nature of the request for revocation or appeal, it may be decided by either the same adjudicator or another.

The appeal decision of the Director (or his/her delegate) may be subject to judicial review by the Divisional Court.

Since 2006–07, FSCO’s mediation service has experienced a 136 per cent increase in applications, from 13,053 applications that year to 30,748 in fiscal 2010–11. This surge in demand has resulted in a backlog that has been growing for several years. As of September 1, 2011, there were 27,375 files awaiting assignment to mediators. An applicant will typically wait 10 months to be assigned a mediator.

Continued
It would appear a combination of factors have led to the backlog:

- Industry practices in the handling and processing of statutory accident benefit claims are leading to more disputes;
- More claimants, represented by legal professionals, are disputing decisions made by insurers;
- More complex accident benefits have expanded the issues or coverages that can be mediated;
- There are more questions about the legislative and regulatory changes including recent amendments to statutory accident benefits; and
- Economic conditions are creating financial pressures.

The Evolution of the System: 2010 Forward

Changes implemented in September of 2010 flowed in large measure from the first five-year review mandated by the government and submitted to the Minister of Finance in March of 2009. They were also driven by rapidly increasing costs that were once again putting pressure on premiums. In considering the cost increases leading to rate pressures in 2010, both the government and the industry believed that a high and rapidly growing rate of fraudulent behaviour was an important factor. The next section of this report provides cost, and other information that makes it clear why this view was widespread.
The further measures that were introduced in November 2010 and again in July 2011 were taken in this context. They addressed both the increasing cost of the system and its complexity.

The September 2010 reforms:

- introduced a strong element of choice for consumers to tailor their coverages according to their insurance needs;
- provided a standard or mandatory minimum medical and rehabilitation coverage of $50,000 (reduced from $100,000) and included assessment costs under that new $50,000 limit. (The option of $100,000 or $1 million in coverage is available at an additional cost.);
- provided a new standard or mandatory minimum attendant benefit coverage of $36,000 (reduced from $72,000);
- made caregiver, housekeeping and home maintenance expense coverage optional;
- capped the costs for assessments at $2,000 per assessment whether initiated by an insurer or health care practitioner;
- capped treatment coverage for a list of minor injuries at $3,500, while providing a right to more spending in limited cases; and
- required insurers to provide claimants with statements every two months that would list the amount of remaining coverage for certain accident benefit coverage.

Early data on the effect of these reforms show that they appear to be stabilizing costs and moderating premium increases. Also in September of 2010, FSCO initiated two important processes that are still underway and that will have a significant impact on the evolution of Ontario’s automobile insurance system.

First, FSCO launched a consultation process regarding potential medical science-based changes to the definition of “catastrophic impairment” within the Statutory Accident Benefits Schedule (SABS) regulation. This was an attempt to, once again, draw an appropriate and fair boundary between automatic compensation under the SABS and the right of an injured person to seek greater compensation through the court system. An expert panel was appointed and began meeting in December 2010. This Panel has submitted its recommendations to the Superintendent of FSCO, who is currently preparing a report to the Minister of Finance.
Second, in response to the March 2009 five year review, the government asked FSCO to develop a new Minor Injury Treatment Protocol, which updates Ontario’s approach to treating soft tissue injuries and reflects current medical science. It is anticipated that, once this treatment protocol is in place, insurers and health care providers will be provided with evidence-based direction regarding effective treatment of minor injuries. A Request for Proposal for a consultant to undertake this research was published on November 23, 2011.

**Additional Measures in 2011**

In addition to setting up the Anti-Fraud Task Force, the government introduced other measures in 2011, including:

- a FSCO Bulletin in March 2011 that highlighted the rights and responsibilities of insurers to challenge questionable or abusive claims.

  The SABS amendments that became effective in September 2010 gave insurers additional ways to manage abusive or fraudulent claims, including measures for verifying invoices and expenses. The Bulletin reminded insurers that the use of these tools is necessary to ensure automobile insurance benefits are delivered effectively and efficiently.

- amendments to the SABS to include provisions that enhance the ability of insurers’ to get confirmation of invoices received for goods and services provided to claimants.

  Prior to these amendments, insurers were required to pay an invoice submitted by a service provider within 30 days of receipt. Now an insurer can request that a provider of goods and services supply additional information to assist the insurer in assessing its liability for the payment. Invoices for goods or services provided to persons injured in automobile accidents can be submitted by clinics without the provider’s knowledge. Allowing insurers to request additional information will help them determine whether the goods or services being invoiced have actually been provided or are potentially fraudulent.
• an amendment to the Insurance Act to eliminate the ability to apply for accident benefits for injuries incurred on public transit vehicles when no collision has occurred.

Persons injured on municipal public transit buses and streetcars are eligible for statutory accident benefits. Typically, claims for benefits result from bumps and falls while entering and leaving vehicles, standing in aisles, and getting in and out of seats. Often these injuries are not reported at the time of the incident, but may be reported days or weeks later. The driver often has no knowledge of the incident, and public transit authorities are unable to verify whether the claimant was in fact a passenger of the vehicle. As a result, transit authorities have received an increasing number of questionable or fraudulent claims. The Toronto Transit Commission reported a 62.5 per cent increase in accident benefit payments between 2004 and 2007. During the same period, Mississauga Transit reported an increase in accident benefit payments of 133.3 per cent.

• introducing mandatory use of the Health Claims for Auto Insurance (HCAI) invoice processing system.

In Ontario, HCAI is used as a central electronic system to transmit specific automobile insurance health claims forms. Although it is not a direct fraud prevention tool, the information stored in HCAI has the potential to help detect fraudulent activity. In the 2011 Ontario Budget, the government announced it would be working with the insurance industry to use HCAI to detect potentially fraudulent activity. Progress on this initiative is described later in this report.
Health Claims for Auto Insurance (HCAI) — Evolution of Tracking Costs

Health Claims for Auto Insurance is an insurance industry-funded central electronic system that must now be used to transmit specific Ontario automobile insurance health claim forms to automobile insurers and to obtain approval for payment. It is administered by HCAI Processing, a not-for-profit organization. The following health claim forms must be submitted to insurers through the HCAI system by health care providers:

- Treatment and Assessment Plan (OCF-18)
- Auto Insurance Standard Invoice (OCF-21)
- Treatment Confirmation Form (OCF-23)

The HCAI system permits insurers to record decisions on each of the above forms and allows health care providers to check the status of the insurers’ decisions.

The HCAI system became mandatory February 1, 2011 for all health providers and facilities participating in the automobile insurance system. Use of the HCAI system will allow for the creation of a database, the development of standard data reports, and better understanding of the medical and rehabilitation goods and services paid for by automobile insurers.

Assessment and Implications For Our Work

In reflecting on the evolution of the automobile insurance system over the past two decades, there are four key observations that we believe should inform our work going forward.

1. There is a clear dynamic that drives change in the system: cost increases in claims lead to pressure on premiums. Because insurance is mandatory and because governments regulate rates, these premium pressures result in efforts to contain costs. Changes will inevitably affect the balance between reducing pressures on rates and ensuring that accident victims receive fair, adequate and timely assistance.

2. As a result, the hybrid system has not only changed a lot since it was introduced two decades ago, it continues to evolve and is, in many respects, very complex. The design of the system, and rules and procedures governing its operation, create opportunities for fraud.
3. Our mandate is limited. This Task Force is not reviewing the adequacy or appropriateness of the current automobile insurance system. Indeed, as noted above, there are additional exercises underway with respect to catastrophic injury and Minor Injury Guidelines and FSCO will continue to report on the operation of the system at least every five years. Our focus is on fraud, its extent and impact, and what the government and other interested parties should do about it. As we explain below, there is reason to believe that fraud has recently played a significant role in cost increases in the system.

4. Finally, while our mandate is limited, we cannot make our recommendations in a vacuum. Context is key. Therefore it is important that we understand the system, the tensions within it and how potential actions will impact accident victims who really do need the protection and assistance they expect the system to provide. Our recommendations must strive to ensure that actions taken to minimize fraud in the system do not unduly affect legitimate claimants and should, where possible, improve their access to the protection and benefits they need.
Observations About Auto Insurance Fraud

Overview
It is early days in the work of the Task Force, and at this time we are not prepared to make a quantitative estimate of the extent or distribution of auto insurance fraud in Ontario. What we have done to date, however, is examine trends in claims costs data and information gathered from industry stakeholders and regulators. This section of our report presents data, together with anecdotal evidence, that suggest that fraud — though it cannot be precisely quantified — is extensive, increasing and having a substantial impact on auto insurance premiums.

Key Findings of this Section

- Auto insurance claims costs, specifically Accident Benefits claims costs under the SABS, have increased dramatically in a very short period of time.
- A large and as yet unexplained gap exists between changes in Accident Benefits claims costs and changes in factors that are expected to influence those costs.
- The most dramatic increase in costs has occurred in the Greater Toronto Area (GTA).¹
- Anecdotal evidence provided to the Task Force suggests that fraudulent activity, and in particular, “premeditated” and “organized” fraud, is increasing.

¹ The Task Force has limited its definition of the GTA to two Statistical Territories used by the General Insurance Statistical Agency (GISA). These territories include the City of Toronto, Peel Region, parts of York Region (including Newmarket, Vaughan, Richmond Hill and Markham) and parts of Durham region (including Pickering, Ajax, Whitby and Oshawa).
**Auto Insurance Costs**

Note: The definitions and sources of all data used in this section are set out in Appendix 3 of the report.

An examination of available data on automobile insurance claims shows that the financial cost of claims is increasing at a very high rate. Exhibit 2 shows the increase in overall auto insurance claims costs in Ontario from 2006 to 2010. The data show that overall claims costs rose by $3 billion, or about $450 per registered vehicle.

![Exhibit 2](image)

As explained in the previous section, auto insurance in Ontario is made up of several different types of coverage, such as Third Party Liability and Accident Benefits. In order to understand the reasons behind the large increase in overall claims, the Task Force reviewed claims costs for each of the types of coverage provided by an auto insurance policy in Ontario.
The coverage that exhibited the most dramatic growth in costs was Accident Benefits.\textsuperscript{2} Exhibit 3 shows the increase in Accident Benefits costs from 2006 to 2010. Accident Benefits costs more than doubled from 2006 to 2010, increasing by 118 per cent. Of the $3 billion increase in total claims costs, $2.4 billion or 80 per cent came from Accident Benefits costs.

Analyzing regional Accident Benefits claims costs shows the majority of the 118 per cent increase in costs shown in Exhibit 3 came from increases in the GTA. In fact, although the GTA accounts for just over one-third of the insured vehicles in Ontario it accounted for more than 80 per cent of the increase in Accident Benefits claims costs in recent years.

\textsuperscript{2} Exhibit 16 compares changes in specific types of Accident Benefits claims costs and changes in claims costs for other types of auto insurance coverage.
Exhibit 4 shows the growth of Accident Benefits claims costs in the GTA from 2006 to 2010. The “per vehicle” figures in Exhibits 2 and 3 were based on the nearly 6.6 million vehicles insured in Ontario, whereas the “per vehicle” figure in Exhibit 4 is based on the 2.4 million vehicles insured in the GTA.

Of the $2.4 billion increase in Accident Benefits costs in Ontario through this period, $2 billion occurred in the GTA, amounting to $800 per vehicle insured in the GTA in 2010.

The increase of $2.4 billion in Accident Benefits costs in Ontario from 2006 to 2010 cannot be explained by factors that would normally be expected to lead to increased costs. The Task Force reviewed several of the factors that would be expected to either increase or decrease auto insurance claims costs. Exhibit 5 is a diagram of these “cost factors” and how they changed between 2006 and 2010.
What can be seen from Exhibit 5 is that something is causing Accident Benefits costs (and therefore overall auto insurance claims costs) to grow at an alarmingly fast rate while many of the normal factors that influence these costs either decrease or increase only slightly. The bulk of the increase in Accident Benefits came from the “severity” of claims costs, as opposed to the “frequency” of claims. The implication is that the cost of an average claim was significantly higher in 2010 than it was in 2006. But looking at the factors that influence severity, as presented in Exhibit 5, indicates that the severity of injuries suffered by automobile accident victims actually decreased by six per cent from 2006 to 2010.

The remainder of this subsection provides a closer examination of the relationship between the cost factors identified and more detailed data on Accident Benefits claims.

The majority of claims costs incurred under the Accident Benefits coverage in Ontario’s auto insurance system cover either the treatment or assessment of injuries resulting from a motor vehicle collision.
Exhibit 6 shows the remarkable divergence between changes in Accident Benefits costs and changes in private health care expenditures in Ontario. More specifically, it compares:

- the actual change in Accident Benefits costs in Ontario; and
- the change in Accident Benefits costs that would have occurred if the costs had changed at the same rate as private health expenditures in Ontario.  

### Key Facts:

- Accident Benefits costs were just over $2 billion in 2006 and nearly $4.5 billion in 2010.
- In 2010, Accident Benefits costs would have been $2 billion less if they had grown at the same rate as private health expenditures in Ontario.
- $2 billion in unexplained Accident Benefit costs represents approximately $300 for each of Ontario’s 6.6 million personal automobiles.

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3 Private sector expenditures include health insurance claims paid by insurance firms; private spending on health-related research, equipment and construction; and out-of-pocket health care spending by individuals.
As shown in Exhibits 3 and 4, the increases in Accident Benefits costs from 2006 to 2010 were concentrated in the GTA. Exhibit 7 applies the framework from Exhibit 6 to the GTA, showing that if private health expenditures changed at the same rate across Ontario, the unexplained portion of costs that grew faster than private health expenditures would be more than $700 per insured vehicle in the GTA.

**Exhibit 7**

Accident Benefits Costs Growing Much More Rapidly than Private Health Expenditures in the GTA

<table>
<thead>
<tr>
<th>Year</th>
<th>GTA Accident Benefits Costs</th>
<th>Expected GTA Costs Based on Private Health Expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>$1.0 BILLION</td>
<td>$700 per GTA Vehicle</td>
</tr>
<tr>
<td>2007</td>
<td>$1.5 BILLION</td>
<td></td>
</tr>
<tr>
<td>2008</td>
<td>$2.0 BILLION</td>
<td></td>
</tr>
<tr>
<td>2009</td>
<td>$2.5 BILLION</td>
<td></td>
</tr>
<tr>
<td>2010</td>
<td>$3.0 BILLION</td>
<td></td>
</tr>
</tbody>
</table>

Key Facts:

The gap shown in Exhibit 7 shows how quickly Accident Benefits costs grew in the GTA compared to private health expenditures in all of Ontario. The Task Force also analyzed regional data from urban areas in Ontario other than the GTA and rural Ontario. The following table shows that although Accident Benefits costs have grown more quickly than private health expenditures across Ontario the most significant increases are concentrated in the GTA.
### Accident Benefits Costs Growing Quickly in the GTA (2006 to 2010)

<table>
<thead>
<tr>
<th>Region</th>
<th>Increase in Accident Benefits Costs ($M)</th>
<th>Expected Increase Based on Private Health Expenditures ($M)</th>
<th>Gap per Insured Vehicle in Region</th>
</tr>
</thead>
<tbody>
<tr>
<td>GTA</td>
<td>$1,967</td>
<td>$236</td>
<td>$715</td>
</tr>
<tr>
<td>Non-GTA Urban</td>
<td>$306</td>
<td>$113</td>
<td>$95</td>
</tr>
<tr>
<td>Rural</td>
<td>$158</td>
<td>$106</td>
<td>$24</td>
</tr>
</tbody>
</table>

To explore further why there appears to be such a large gap between actual Accident Benefits costs and the costs that might be “normally” expected given private health expenditures, the Task Force examined the factors that drive insurance claims costs.

Insurance claims costs are driven by two factors:

- claims frequency, or how often claims occur. Greater frequency leads to a greater number of claims paid by insurers, therefore increasing claims costs and leading to higher premiums for consumers; and
- claims severity, or how large claims are. Greater severity leads to the average cost of a claim increasing, therefore increasing claims costs and leading to higher premiums.

Costs may also be driven by government reforms to the auto insurance system that cause either claims frequency or severity to change. The charts in this section use information from either 2006 to 2009 or 2006 to 2010. The September 2010 reforms likely had some effect on costs in the last quarter of 2010. Other than the 2010 reforms the government did not make any major changes to the auto insurance system between 2006 and 2010. The 2010 reforms did not, therefore, have a major impact on the information presented in the following exhibits.

The Task Force examined several factors that could normally be expected to increase either claims severity or frequency.
Claims Frequency

Claims frequency is a measure of how often claims occur. It is intuitive that auto insurance claims frequency would be increased by two main factors:

- an increase in the number of motor vehicle collisions leading to injuries in a given year. These are defined as “Personal Injury Collisions” in the Ministry of Transportation’s Ontario Road and Safety Annual Report (ORSAR); and
- an increase in the number of individuals injured in motor vehicle collisions in a given year.4

Auto insurance claims consist of claims under several different types of coverage provided by a standard auto insurance policy, such as Accident Benefits. Accident Benefits claims frequency is generally measured by the number of claims per 100 vehicles insured. For example, if there are 100 vehicles insured in Ontario and five Accident Benefits claims occur in a given year, the claims frequency for that year is five claims per 100 vehicles.

Exhibits 8 and 9 show how the claims frequency factors relate to actual Accident Benefits claims frequency in Ontario. Both charts show gaps between the actual Accident Benefits claims frequency and the expected frequency given changes in the main factors.

Exhibits 8 and 9 also reflect Ontario-wide data from 2006 to 2009. The Task Force does not have the data necessary to make a regional comparison between claims frequency and either personal injury collisions or injuries resulting from motor vehicle collisions. We did, however, find the regional trends in Accident Benefits claims frequency to be worth noting in this report:

- for Ontario as a whole: 14 per cent increase;
- for the GTA: 28 per cent increase;
- for urban Ontario other than the GTA: unchanged; and
- for rural Ontario: eight per cent decrease.

4 These “frequency factors” are both reported by the Ministry of Transportation in ORSAR. Due to the complex nature of some of the types of injuries that can be suffered by motor vehicle collision victims, the Task Force does not expect these numbers to be completely accurate indicators of auto insurance claims frequency. It is intuitive, however, that the frequency of automobile insurance claims should be closely and fairly consistently related to the number of motor vehicle collisions resulting in personal injury or the number of individuals injured in those motor vehicle collisions.
Exhibit 8 shows the gap between actual Accident Benefits claims frequency and personal injury collisions. Both lines start at the actual Accident Benefits claims frequency from 2006, then diverge based on the actual rates of change for each variable between 2006 and 2009.

**Key Facts:**

- In 2009 there were 3,500 fewer personal injury collisions than in 2006.
- The number of Accident Benefits claims per 100 vehicles insured in Ontario increased by 14 per cent over that same time.
Exhibit 9 shows the gap between actual Accident Benefits claims frequency and the number of individuals injured in motor vehicle collisions. Similar to Exhibit 8, both lines start at the Accident Benefits claims frequency in 2006, then diverge based on the actual rates of change for each variable between 2006 and 2009.

**Key Facts:**

- In 2009, 6,400 fewer people were injured in a motor vehicle collision than in 2006.
- As noted in Exhibit 8, the number of Accident Benefits claims per 100 vehicles increased by 14 per cent over that same time.
- Both the number of personal injury collisions and the number of injuries caused by motor vehicle collisions declined from 2006 to 2009. However, Accident Benefits claims frequency increased by 14 per cent.
Claims Severity

Claims severity is a measure of the average cost of claims. There are two main factors that influence the average cost of Accident Benefits claims:

- inflation, or the increase in the cost of treating the same injury from year to year; and
- the extent or severity of the injury suffered by the collision victim.5

Accident Benefits claims severity is measured by claims costs per insured vehicle. For example, if there are 10 vehicles insured in Ontario and insurers pay a total of $1,000 in Accident Benefits claims in a given year, the Accident Benefits claims severity for that year is $100 per vehicle insured.

To measure inflation, the Task Force used Ontario Health Care Consumer Price Index (CPI). The Health Care CPI measures how health care prices change from year to year.

To measure the extent or severity of injuries suffered by motor vehicle collision victims, the Task Force used information on injury severity from ORSAR, which includes data on the following categories of injuries:

- fatal — person killed immediately or within 30 days of the motor vehicle collision;
- major — person admitted to the hospital, either for treatment or observation;
- minor — person went to hospital and was treated in the emergency room but was not admitted; and
- minimal — person did not go to the hospital when leaving the scene of the collision.

The Task Force used the total number of injuries that resulted in motor vehicle collision victims going to the hospital (fatal, major and minor injuries) as a measure of injury severity in Ontario.

Exhibits 10 and 11 show how the claims severity factors described above relate to the actual Accident Benefits claims severity in Ontario.

5 Similar to the “frequency factors” described above, the Task Force does not expect these “severity factors” to perfectly predict auto insurance claims severity. We do believe that general trends in the factors should be relatively similar to general trends in the auto insurance system.
Similar to the claims frequency charts above, both Exhibits 10 and 11 show “gaps” between what actually happened and what would be expected given changes in the main factors.

The charts in Exhibits 10 and 11 reflect Ontario-wide data from 2006 to either 2009 or 2010. The Task Force does not have the data necessary to make a regional comparison between claims severity and either personal injury collisions or injuries resulting from motor vehicle collisions. We did, however, find the regional trends in Accident Benefits claims severity to be worth noting in this report:

- for Ontario as a whole: 106 per cent increase;
- for the GTA: 168 per cent increase;
- for urban Ontario other than the GTA: 50 per cent increase; and
- for rural Ontario: 26 per cent increase.
Exhibit 10 shows the gap between actual Accident Benefits claims severity and the inflation in health care prices paid by consumers between 2006 and 2010.

Both lines start at the Accident Benefits costs per vehicle insured in 2006, then diverge based on the actual rates of change for each variable between 2006 and 2010.

**Key Facts:**

- The Ontario Health Care CPI increased by seven per cent from 2006 to 2010, while Accident Benefits claims severity increased by more than 100 per cent.
- If Accident Benefits claims severity had followed the same rate of change as Ontario Health Care CPI, claims costs per vehicle insured would have been $325 lower in 2010.
Exhibit 11 shows the gap between actual Accident Benefits claims severity and the change in the number of minor, major and fatal injuries caused by motor vehicle collisions from 2006 to 2009.

As in Exhibit 10, both lines start at the Accident Benefits cost per vehicle insured in 2006, then diverge based on the actual rates of change for each variable between 2006 and 2009.

**Key Facts:**

- The number of minor, major and fatal injuries caused by motor vehicle collisions in Ontario declined by six per cent from 2006 to 2009.
- Accident Benefits claims severity increased by 94 per cent over that same time.
- If Accident Benefits claims severity had followed the same rate of change as the number motor vehicle collision injuries resulting in hospital visits, claims costs per vehicle insured would have been $330 lower in 2009.
Geographic Differences: GTA Versus the Rest of Ontario

As noted, there are significant gaps between actual changes in Accident Benefits claims frequency and severity and the changes to frequency and severity one would normally expect based on available data.

Differences exist between overall claims costs in different areas of Ontario. Costs in the GTA are generally greater than those in rural Ontario, so it is expected that insurance claims costs would follow that trend and that there would be a cost differences between regions. However, the gap between the GTA and the rest of Ontario has been growing dramatically in recent years and, once again, the extent of the gap is not readily explained by available data, such as growth in cost differences.

In 2006, the Accident Benefits claims cost per vehicle in the GTA was slightly more than double what it was in rural Ontario. In 2010 the GTA cost per vehicle was well over four times that of rural Ontario.

Exhibit 12 shows changes in Accident Benefits claims costs in the GTA, urban areas other than the GTA and rural Ontario. So that population growth does not affect the data, claim costs per insured vehicle are used. A growing gap clearly exists between Accident Benefits costs in the GTA and costs in other areas of Ontario.

<table>
<thead>
<tr>
<th>Exhibit 12</th>
</tr>
</thead>
</table>

Accident Benefits Claims Costs Have Grown Rapidly in the GTA

- Rural
- Non-GTA Urban
- Greater Toronto Area

<table>
<thead>
<tr>
<th>Year</th>
<th>Rural</th>
<th>Non-GTA Urban</th>
<th>Greater Toronto Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>2007</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>2008</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>2009</td>
<td>$0</td>
<td>$0</td>
<td>$1,500</td>
</tr>
<tr>
<td>2010</td>
<td>$0</td>
<td>$0</td>
<td>$1,500</td>
</tr>
</tbody>
</table>
Geographic Differences: Ontario Versus Other Provinces

Our analysis to date has focused on what has happened to Accident Benefits in Ontario compared with what one might expect to happen, given certain recognized factors that drive cost increases.

Another way of looking at the Ontario experience is to examine what has actually happened here compared with other provinces with similar auto insurance systems.

The following three exhibits provide a snapshot of growth in Accident Benefits, Accident Benefit Severity and Accident Benefit Frequency in five Canadian provinces where insurance is provided by private insurance companies.

Even within provinces with privately delivered auto insurance there is significant variance in the coverage provided by auto insurance policies. For example, the standard limit for no-fault medical and rehabilitation benefits varies from $10,000 to $50,000 among provinces, meaning that costs related to Accident Benefits coverage will vary significantly as well.

Exhibits 13 to 15 track the changes in Accident Benefits costs in the “private sector provinces.” We have included only provinces that have more than 100,000 vehicles insured in 2010 and also have private auto insurance systems. In order to show only changes in costs, the starting point for each province is 100 in 2006 — the number then changes based on the percentage change in each province for each year. The data show substantially higher growth rates for accident benefit costs, severity and frequency in Ontario than in any of the other provinces considered.
Exhibit 13

Overall Accident Benefits Claims Costs Have Grown More Rapidly in Ontario than Elsewhere in Canada

Provinces Indexed to 100 in 2006

Exhibit 14

Accident Benefits Claims Severity Has Grown More Rapidly in Ontario than Elsewhere in Canada

Provinces Indexed to 100 in 2006
Exhibit 15

Accident Benefits Claims Frequency Has Grown More Rapidly in Ontario than Elsewhere in Canada

Provinces Indexed to 100 in 2006

2006 2007 2008 2009 2010

Ontario
Nova Scotia
New Brunswick
Alberta
Newfoundland and Labrador

Trends within the Accidents Benefits Coverage

The Accident Benefits coverage contains several different benefits for victims of auto insurance collisions. The following benefits were all part of the standard Accident Benefits coverage for Ontarians until the September 2010 reforms:

- medical and rehabilitation benefits, which cover the cost of reasonable and necessary medical and rehabilitation expenses, such as physiotherapy;
- attendant care benefits, which pay for an aide or attendant to look after an insured if they have been seriously injured in a motor vehicle collision;
- income replacement benefit, which replaces 70 per cent of income up to the coverage limit if an insured cannot work due to a motor vehicle collision;
- caregiver benefit, which reimburses an insured person for expenses incurred in hiring someone to care for their dependants if they were providing full-time care and no longer can due to a motor vehicle collision (now an optional benefit after the September 2010 reforms); and
housekeeping and home maintenance expenses, which pay for reasonable and necessary additional expenses for someone to complete an insured’s usual duties if the insured is unable to do so due to a motor vehicle collision (now an optional benefit after the September 2010 reforms).

In reviewing data on the costs of certain types of benefits within the Accident Benefits coverage over the past few years, the Task Force found several unexplained trends. The Task Force also examined the difference between trends in types of Accident Benefits coverage and trends in types of coverage that respond to claims for physical damage to insured vehicles.

Exhibit 16

Physical Damage Claims Costs Have Remained Relatively Unchanged While Accident Benefits Costs Have Increased Significantly

In considering Exhibit 16, the difference in the increase from 2006 to 2010 in physical damage costs, compared with Accident Benefits costs, is striking.

Exhibit 16 shows increases in the costs of specific types of Accident Benefits. The chart also shows that “Examination and Assessment” costs have grown at a dramatically faster rate than costs for the medical treatment of injuries.

Continued
### Key Facts:

- Examination and assessment costs include costs for examinations requested by an insurer, as well as those that are part of a treatment plan developed by a health care practitioner.\(^6\)

- Since 2006, Medical benefit costs have grown 105 per cent, while examination and assessment costs have grown by 288 per cent.

- In 2006, insurers spent $1.90 in medical and rehabilitation treatment costs for motor vehicle collision victims for every $1 spent on examining and assessing their injuries.

- In 2010, insurers spent less than $1.20 in medical and rehabilitation treatment costs for motor vehicle collision victims for every $1 spent on examining and assessing their injuries.

- The September 2010 reforms had a significant impact on the types of Accident Benefits coverage shown in Exhibit 16. For example:
  - caregiver and housekeeping benefits were made optional;
  - the standard or mandatory minimum amounts of attendant care and medical and rehabilitation benefits were reduced; and
  - the cost of assessments was capped at $2,000 per assessment.

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\(^6\) The data available to the Task Force do not distinguish between these two types of examinations. However we will be attempting to find further information on this issue during the balance of our mandate.
Other Information

Over the past four months, the Steering Committee and its Working Groups have seen several presentations regarding auto insurance fraud and many have indicated that fraud is an increasing problem in Ontario. Although no precise measurements on the impact of auto insurance fraud are available, anecdotal evidence suggests that a problem does exist in Ontario’s auto insurance system:

- Ontario’s system for resolving disputed claims requires each disputed claim to go through mediation. From 2006 to 2010, applications for mediation received by FSCO have increased by 136 per cent. Changes in the auto insurance system have caused an increasing and significant number of auto insurance claims to become disputed.

- The Task Force has received information from many individuals representing different areas of the auto insurance system (from health care providers to claims adjusters to consumers). The information and comments provided have ranged from expressions of interest in the work of the Task Force to recommendations regarding specific anti-fraud measures. Some of these communications were from individuals commenting on their own experience with fraud, and their own knowledge of the extent of fraud in the system.

- The number of civil actions taken by insurers against medical rehabilitation and assessment clinics allegedly involved in auto insurance fraud grew dramatically in late 2010 and 2011.

- Trends in the transactional database for Accident Benefits claims, Health Claims for Auto Insurance (HCAI) show an unexplained and growing increase in the number of health care facilities registered to submit invoices to insurers (see Exhibit 17).
Exhibit 17 shows figures related to the use of HCAI by health care facilities in Ontario. Health care facilities use HCAI to bill insurers for treatments provided to injured motor vehicle collision victims.

Key Facts:

- On February 1, 2011 HCAI became mandatory for use by insurers and health care facilities.
- The number of facilities registered to bill insurers using the HCAI system has grown by nearly 40 per cent once it became mandatory.
- The number of forms submitted through HCAI decreased by 45 per cent from March 2011 to September 2011. Providers are submitting fewer forms covering longer periods of time and more treatments as they become more familiar with the HCAI system.
Insurance Fraud Scheme One: Ariana’s Story

A major auto insurer shared an example of an organized fraud scheme with the Task Force. The story involved one of the insurer’s policyholders, who came forward to confess her involvement in the fraudulent scheme. The names of the individuals involved have been changed to address privacy considerations.

The policyholder that came forward to share her story is a university student named Ariana. Ariana was approached by Natalie, an acquaintance at school, with the offer of a free car in exchange for her participation in a plan.

Setting up the Fraud

The fraud organizer picked Ariana up at school and took her to purchase a policy from the insurer. He pretended to be her brother, answering most of the questions in order to purchase the policy and using his credit card to pay the initial insurance premium. Ariana was told that they had to purchase the insurance before she would be given the car.

Shortly after the insurance was purchased, the organizer contacted Ariana again to advise her that the vehicle had been involved in an accident and that she had to attend the collision reporting centre to make a report. He provided all of the accident details to the collision reporting centre officer, while Ariana sat in the background.

Making the Claim

The organizer then drove Ariana to a rental car company where they rented a vehicle in her name. After picking up the rental vehicle, he drove Ariana to a doctor’s office. Ariana had not been involved in an automobile collision, but prior to meeting with the doctor she was coached on how to respond to the doctor’s questions regarding the “injuries” she had sustained.

The doctor referred Ariana to a physiotherapy clinic, which the insurer believes was involved in the scheme. Ariana attended the clinic on three occasions, and received only one treatment for 15 minutes. Meanwhile, medical bills were submitted to the insurer in Ariana’s name for treatments that she supposedly had received.

In addition, two other occupants were reported as passengers in Ariana’s vehicle at the time of the accident. They also submitted claims to Ariana’s insurer. Ariana later confirmed with her insurer that she had never met either of these passengers.

Conclusion

Ariana made the decision to come forward to her insurer regarding the scheme she had unwittingly helped facilitate. Her story is an example of anecdotal evidence provided to the Task Force regarding the nature of organized auto insurance fraud schemes in Ontario.
Insurance Fraud Scheme Two: The Fender Bender

A major auto insurer provided the Task Force with an example of a seemingly minor motor vehicle collision resulting in claims for hundreds of thousands of dollars’-worth of auto insurance coverage. This example of fraud and abuse in the system was also presented at the Insurance Bureau of Canada’s Regulatory Affairs Symposium on October 27, 2011.

The vehicle pictured above was involved in a collision. Damage to the vehicle was limited to scratches on the back right bumper.

As a result of the collision, two claimants submitted more than 100 Accident Benefits claims forms to the insurer, including 42 Application for Approval of Assessment forms and 66 Treatment Plans.

Some of the forms submitted included claims for medical assistive devices. The total cost submitted for one of the devices was over ten times its retail price.

The total cost of the claims submitted to the insurer was $214,929.01.
Estimating the Cost of Fraud

Part of the Task Force’s mandate is to determine the scope and nature of auto insurance fraud in Ontario.

Although, as noted above, we have heard anecdotal stories about fraud from many individuals, we have also heard from others that claims of fraud have been exaggerated by the insurance industry. In particular, skepticism has been expressed regarding the dollar amounts that have been attributed to fraud by industry spokespersons.

A figure of $1.3 billion has been used to describe the cost of auto insurance fraud in Ontario for some time. We have attempted to understand the basis for that calculation and have concluded that the $1.3 billion figure cannot be considered a verifiable measure of the extent of fraud at this time.

At this stage in our mandate, the Task Force is not able to indicate with any precision what percentage of the gaps in claims frequency, severity and overall costs can be attributed to fraud. It may even turn out to be the case that a precise measurement of the cost of fraud in Ontario cannot be calculated with confidence. In order to determine whether or not such measurement can be made, the Task Force will be overseeing comprehensive and objective research and analysis on the scope of auto insurance fraud in Ontario.

We briefly describe this research in the next section of this report. We expect it to be challenging. Fraud is extremely difficult to measure and may take many forms:

- Organized Fraud
  - several participants with different roles within Ontario’s auto insurance system create an organized scheme designed to generate cash flow through a pattern of fraudulent activity;
  - the organized scheme may involve the creation of claims through either staged collisions or completely fabricated accidents created through fraudulent paperwork;
  - individual claimants are not the organizers of these schemes;
  - the schemes may involve white collar professionals whose credibility is seldom challenged, as well as other facilitators who guide victims to specific participants in the scheme;
- organized schemes use several different methods to defraud insurance companies, including staging collisions with innocent drivers and stealing the identities of health care professionals or auto collision victims; and

- the organizers of a scheme may use sophisticated techniques such as money laundering to avoid suspicion from authorities.

**Organized Fraud Example**

Organized auto insurance fraud schemes may operate in many different ways. Some may focus on creating claims through staged accidents, while others focus on taking advantage of legitimate claimants. Each scheme will involve several individuals or organizations working towards a common goal — profiting from Ontario’s auto insurance system.

“Ariana’s Story” from the “Observations About Auto Insurance Fraud” section is an example of an organized auto insurance fraud scheme.

- Premeditated Fraud
  - a participant within Ontario’s auto insurance system consistently charges insurers for goods or services not provided or provides and charges for goods and services that are not necessary;

  - the participant is involved in a pattern of fraudulent activity, possibly at the expense of motor vehicle collision victims or possibly with their complicity; and

  - the fraud is committed independently and the participant is not dependent on a larger organization.
Premeditated Fraud Example

Premeditated auto insurance fraud is committed by an individual participant in Ontario’s system with no connection to a broader, more organized scheme.

Both the vehicle repair shop and the individual health care practitioner in the following examples are not involved in larger fraud schemes. They will, however, take advantage of their position in the auto insurance system by engaging in a pattern of fraudulent behaviour designed to increase the amount they can charge insurers.

Example One — Vehicle Repair Shop

A vehicle repair shop may intentionally increase the amount of work needed to repair vehicles brought in for repairs after collisions. A vehicle may be brought to the shop with minor damage but be presented to an insurer with significantly more damage.

By inflicting further damage on the vehicle before it is inspected by an insurer, the shop increases the value of the goods and services it will provide to the claimant. The cost of these goods and services will ultimately be paid by the claimant's insurer.

Example Two — Health Care Practitioner

A major auto insurer shared an example showing how this premeditated type of fraud might be committed by a health care practitioner when assessing injuries suffered by accident victims.

In this instance, the insurer found that a practitioner, instead of developing an individualized assessment request for each victim, was submitting the same assessment request without changing the information. In at least one case, the practitioner neglected to add the victim’s name to the request, leaving a blank space instead. Without the victim’s knowledge, the practitioner submitted requests recommending certain treatments to the insurer.
• Opportunistic Fraud
  o an individual pads the value of their auto insurance claims by claiming for benefits or other goods and services that are unnecessary or unrelated to the collision that caused the claim.

**Opportunistic Fraud Example**

Opportunistic fraud occurs when individual claimants inflate the value of their claim. Unlike those involved in organized or premeditated schemes, the individual committing opportunistic fraud does not consistently engage in a pattern of fraudulent behaviour.

For example, an individual making an auto insurance claim may inflate the value of personal goods damaged in a collision. An individual may also continue to remain away from work for several days after their recovery from the collision is complete. The individual could continue to collect income replacement benefits as part of their Accident Benefits coverage despite being able to return to work.

In our research, we will be attempting to determine the relative magnitude of these three types of fraud. We believe that each type could be a significant issue in Ontario’s auto insurance system.
Concluding Observations

While we are not prepared at this stage to make a quantitative estimate of the extent of fraud in the Ontario auto insurance system, the rapid and unexplained increase in Accident Benefits costs, together with the anecdotal evidence we have heard, have convinced us that fraud is a large and growing factor in the Ontario marketplace. We also believe, given the numbers we have seen, that it is reasonable to conclude at this time that:

- there is an unexplained and widening gap between the cost of Accident Benefits claims and numbers that we would normally expect to move in parallel with Accident Benefits costs. The magnitude of the differences between the actual changes in costs and the factors that would be expected to influence these costs (see Exhibits 8 through 11) cannot be explained to our satisfaction with available data. We hope that our research will provide greater precision with respect to what is causing the gap as our work proceeds.

- the cost increase appears to be concentrated in the GTA. Although the data do not permit us to analyze geographical breakdowns with the same “frequency” and “severity” detail that we can for the province, there is no question that the vast majority of the unexplained increase in Accident Benefit costs is occurring in the GTA. The “unexplained” gap per registered vehicle in the GTA, estimated to be $700 in Exhibit 7, is much higher than the ‘unexplained’ gaps of $300 to 350 per registered vehicle for Ontario as a whole (see Exhibits 6, 10 and 11).

- the fastest-growing parts of auto insurance fraud are premeditated and organized fraud rather than opportunistic fraud. This conclusion is based on the shape of the growth curve in the unexplained gaps from 2006 to 2010. It will be extremely difficult to provide precise estimates of fraud, let alone break these estimates down into organized, premeditated and opportunistic. There is, however, little reason to believe that opportunistic fraud would have grown so quickly in such a short period of time. And there is much anecdotal evidence that premeditated and organized fraud have grown rapidly in recent years.
Actions To Combat Fraud Are Ongoing

As pointed out, the automobile insurance system is not standing still. Fraud is recognized as an important issue, and those responsible for the integrity of the system are taking action. Our three Working Groups have been tracking a number of initiatives that have been introduced and are under development for introduction in the short term.

In this section, we briefly review some of the initiatives that have been taken, and we recommend additional actions that we believe can be implemented relatively quickly and that would assist and enhance efforts to reduce fraud.

Actions Now Underway

Some important measures have recently been introduced. We recognize and endorse these initiatives, and we believe that many of them will provide a foundation that can be further built upon as we go forward.

In the area of Prevention, Detection, Investigation and Enforcement:

- the Insurance Bureau of Canada (IBC) has worked with York Regional Police to develop a “Staged Accident Investigation” optional e-learning package for police officers;

- the Task Force has created an Ad Hoc Working Group to investigate a proof-of-concept use of the HCAI system, that would allow health practitioners to access the system through their regulatory colleges to verify whether their billing identification numbers have been used without their authorization. This Working Group is chaired by FSCO and includes representatives of HCAI, the insurance industry, government departments, regulated health professionals, and the health regulatory colleges; and

- a group of insurers has developed an anti-fraud initiative, on a pilot basis, that combines claims data from those insurers and analyzes them with a highly sophisticated tool to identify suspicious patterns through the use of predictive modelling. The pilot project has been designed as a proof-of-concept exercise and appears to have the potential to be very effective.
In the area of Regulatory Practices:

- the Superintendent of FSCO has issued a guideline on the HCAI system to address various billing concerns, including frequency of invoicing, incomplete invoices, duplicate invoices, and submission of invoices for non-approved goods and services;
- the Superintendent also issued a revised Minor Injury Guideline (MIG) released on October 19, 2011 that clarifies MIG billing issues;
- the Superintendent has issued a Bulletin requiring that effective July 1, 2012 all invoices for treatment include the treatment plan number which will make it easier for adjusters to reconcile invoices to treatment plans, and make it easier to identify duplicate invoices or bills for unapproved treatment; and
- as of October 14, 2011, the Superintendent is requiring the CEO’s of automobile insurance companies to attest, personally and annually, through a formal document, that the SABS cost controls they have in place, including those to address fraud and abuse, are effective, reviewed on a regular basis, and ensure that legitimate claimants are treated fairly and in accordance with the law.

In the area of Consumer Engagement and Education:

- FSCO has redesigned its anti-fraud webpage and has created and distributed anti-fraud content, including a brochure directed specifically to health care practitioners;
- some insurance companies and brokers have developed mobile apps designed to deliver pertinent information to policyholders in times of emergency; and
- both the Insurance Brokers Association of Ontario (IBAO) and IBC have increased their efforts to develop and distribute anti-fraud information directly to consumers using various media channels.

Scope For Further Action Now

Many of the issues that have been brought to our attention are complex and require further analysis and investigation. We note some of these in the next section to provide a road-map of the direction we plan to take. But we believe that there are some additional measures that can and should be undertaken as quickly as possible. These have been identified by the Working Groups and recommended to us.
In the area of Prevention, Detection, Intervention and Enforcement:

- the e-learning package developed by IBC and York Regional Police Service should be made more generally available to other police services through the Canadian Police Knowledge Network;
- written material regarding staged collisions and automobile insurance fraud should be developed for and included in Basic Constable Training materials;
- the advanced level traffic training given at the Ontario Police College could be enhanced to promote the use of staged collision experts in seminars and to increase the profile given to staged collisions and automobile insurance fraud; and
- the Ad Hoc Working Group examining HCAI issues, referred to above, should consider additional ways that HCAI might be used to monitor system behaviour for patterns that may be associated with fraud.

In the area of Regulatory Practices:

- the Superintendent of FSCO should create a guideline to address the issue of insurers being invoiced for medical devices at prices considerably higher than their normal retail value; and
- the government should provide the Superintendent with the power to impose administrative monetary penalties for contraventions of legislation and regulations, as discussed in the 2011 Ontario Budget.

In the area of Consumer Engagement and Education:

- the industry can enhance its efforts to educate consumers about fraud, using targeted communication strategies across all media platforms, including actively promoting the distribution and use of mobile apps that give policyholders key information in times of emergency; and
- the Task Force intends to work with the industry to undertake surveys and focus groups that can help measure the current state of consumer engagement and education, so as to provide baseline measures against which improvement can be measured down the road.
What We Propose To Do In The Rest Of Our Mandate

Research

A key part of the Task Force’s mandate is to provide research on auto insurance fraud to the government. We will be pursuing as much research as necessary and in the most efficient manner possible to support the recommendations the Task Force may wish to make to the government. To ensure that the process is transparent, we will be working with the government to make the research available to the public.

Currently, the Task Force’s research is focused on two main areas:

- the scope and nature of auto insurance fraud in Ontario; and
- effective auto insurance fraud prevention strategies in other jurisdictions with similar auto insurance systems.

As the work of the Task Force progresses and new issues are identified, additional research may be pursued.

Scope and Nature of Fraud

Determining the scope and nature of auto insurance fraud in Ontario is one of the Task Force’s primary objectives. To us, the most important aspect about the scope and nature of fraud is its impact on Ontarians. Fraud can have a financial impact, through increased costs and premiums, a public safety impact, through staged accidents endangering drivers, and a health status impact, through inappropriate or excessive treatment.

In addition to fraud’s direct impact on consumers, there is an enforcement concern that has an indirect impact on Ontarians. If the extent and nature of auto insurance fraud in Ontario is as great as some of the individuals who have given presentations to the Task Force suggest, then it could be a lucrative criminal enterprise that might be funding additional criminal activity.
The Task Force will also attempt to gather information on more detailed aspects of the scope and nature of fraud, including:

- the costs of organized, premeditated and opportunistic fraud;
- estimates of various types of fraud, including not only accident benefits where costs have risen dramatically, but also fraud related to physical damage to vehicles;
- the geographic distribution of fraud within Ontario; and
- the extent of the migration of staged accident rings to Ontario and their impact on Ontario’s drivers.

Because fraud comes in many different forms and operates outside Ontario’s legal economy, determining its nature and scope presents a considerable challenge. Measuring the scope of this problem is underway and will continue.

Past attempts to measure the cost of auto insurance fraud have been based on “closed claims studies”. In a closed claim study, an investigator must review hundreds of auto insurance claims to determine whether or not they involved elements of either organized or opportunistic fraud. The results of the review are then extrapolated to all claims in Ontario.

Although this methodology can provide valuable insights, closed claims studies place a significant amount of importance on the subjective judgments of individual investigators. On balance, we believe there are preferable new approaches to estimate the extent of fraud.

The Insurance Bureau of Canada is currently working with KPMG and IBM, companies experienced in both advanced data analytics and cost measurement of other underground activities, to estimate the cost of auto insurance fraud in Ontario. Other issues related to the scope and nature of fraud, such as the prevalence of organized fraud compared to premeditated and opportunistic fraud, may also be addressed by IBC’s work.

The Task Force welcomes this project as a potentially valuable exercise. The Insurance Bureau of Canada, through its access to claims information collected from the majority of companies offering auto insurance in Ontario, is uniquely positioned to conduct a comprehensive study on the cost of fraud in Ontario.
The Task Force, however, is mindful of the challenges facing attempts to establish the exact cost of fraud and of the public’s concern about bias on the part of the insurance industry in estimating the size of the fraud problem. The Task Force will therefore engage an independent third party to review and report on the integrity of IBC’s methodology and conclusions.

This independent third party will review how IBC, KPMG and IBM intend to estimate the cost of fraud. They will provide feedback to IBC and report to the Task Force’s Steering Committee on the proposed methodology. The intent is to ensure the final estimate is as accurate and unbiased as possible. At the conclusion of the IBC/KPMG/IBM project, the third party will also report to the Task Force on whether or not it believes the estimated cost of fraud is comprehensive and objective.

As well as informing the Task Force on IBC’s approach to estimating the cost of auto insurance fraud in Ontario, the third party will also undertake additional research, including:

- identifying any aspects of the scope and nature of auto insurance fraud that are not addressed satisfactorily by IBC’s report; and
- providing a summary of the approaches used in studies of the nature and scope of auto insurance fraud in other jurisdictions.

**Strategies in Other Jurisdictions**

Many jurisdictions outside Ontario are also dealing with the issue of auto insurance fraud. The approaches taken by these jurisdictions could provide valuable insight to the Task Force regarding anti-fraud strategies that could be effective in Ontario.

The Task Force will be pursuing three research projects in order to gain a better understanding of anti-fraud strategies in other jurisdictions. Each project will explore the subject area of the three Task Force Working Groups:

- Prevention, Detection, Investigation and Enforcement;
- Regulatory Practices; and
- Consumer Engagement and Education.

This jurisdictional research will help educate the Task Force and provide ideas to be discussed and analyzed by the Working Groups.
Some Major Issues for Consideration

This report has identified several steps that have been taken to combat auto insurance fraud, and has recommended some additional initiatives that we believe can be implemented relatively quickly with beneficial effects.

In the balance of our mandate, we intend to pursue a number of other issues that we believe may assist considerably in reducing the incidence of auto insurance fraud, but that are complex and require more analysis, input and consideration than we have been able to devote to them over the past four months.

We list below some of the major issues that have come to our attention and that we believe merit further consideration. We have not concluded on any of these issues, but by presenting them at this stage we hope to inform a dialogue that will assist us in moving forward in assessing them.

There are five major issues that we have asked the Working Groups to examine in more depth:

1. The licensing and/or regulation of clinics

Some other jurisdictions require clinics providing health care services, including those that treat auto accident victims, to be regulated or licensed (owners and/or operators) to varying degrees. For example, in September 2011 Hillsborough County, Florida, passed an ordinance requiring the licensing of any medical clinic that provides treatment or therapy to patients claiming injury due to an automobile accident. In Ontario, where there is no such requirement we have observed an extraordinary increase in the number of clinics submitting forms through HCAI over the past 18 months (see Exhibit 17). At present, very little is known about such facilities. We intend to consider whether a licensing and/or regulatory regime would make sense and, if so, what type of regime might be best suited to Ontario.

There is a spectrum of possible responses to this issue, ranging from the status quo, to licensing only, to licensing plus some form of regulation, to licensing, regulation and periodic audit. There are also issues about who would have the authority and accountability for any licensing or regulatory activity and how it would be exercised.

We have asked the Working Group on Regulatory Practices to pursue this issue over the coming months.
2. Other possible gaps in regulation

There may be other gaps in regulation worth considering. For example:

- should there be a more rigorous and comprehensive regulatory regime for tow-truck drivers?
- are there effective ways to address issues that have been brought to our attention with respect to “referral fees” to individuals that sound a lot like “kickbacks?”
- does FSCO have adequate legislative/regulatory authority to penalize those who are breaking the rules, including the ability to levy penalties on insurance companies (which it now regulates)?
- should FSCO have additional legislative/regulatory authority over others in the system (which it does not now regulate)?
- are there gaps or shortcomings in statutes and/or penalties outside of FSCO’s authority that, if addressed, could significantly prevent and deter fraud?
- do insurance companies have the proper tools to address fraud, including the ability to properly manage the relationship with their claimants?

Further investigation of this issue will focus on the insurance company/claimant relationship in the areas of:

- barriers to communication between claimants and insurers during the claims process;
- tools insurers have to obtain neutral medical assessments of a claimant’s injuries; and
- how rules governing the auto insurance claims process (for instance, how a misrepresentation of facts is treated) can affect the handling of claims.

The Working Group on Regulatory Practices will also be considering these issues.

3. The establishment of a dedicated fraud investigation unit

Both the US and the UK have dedicated insurance fraud investigation organizations. We have had a presentation from the US National Insurance Crime Bureau and have been impressed with the approach it has taken to combating insurance fraud and the progress that it has made in doing so. We hope to learn more about the UK experience through our jurisdictional research described above.
We will consider whether a dedicated investigation unit makes sense for Ontario and, if so, how it might best be structured and operate. There are a number of issues related to this consideration that will have to be examined, including:

- our findings on the scope and extent of auto insurance fraud;
- the relationship of any such organization to the industry;
- the governance structure, transparency and accountability of such an organization;
- relationships between an investigative unit and enforcement authorities;
- privacy implications; and
- accountability and resources.

We have asked the Working Group on Prevention, Detection, Investigation and Enforcement to consider these issues over the coming months. An eventual recommendation will be based upon assessment of need as well as feasibility.

4. Developing a consumer engagement and education strategy

Consumers with little to no knowledge about Ontario’s auto insurance system are taken advantage of by fraud organizers. They may risk their own personal safety by participating in a staged motor vehicle collision for a small amount of compensation or simply have their identity stolen after agreeing to sign claims forms provided to them. Actively engaging these consumers so that they become aware of the impacts of fraud and the role they can play in preventing it from occurring will be an important part of any anti-fraud strategy.

We hope to learn more about successful consumer engagement and education strategies in Ontario and other jurisdictions while considering:

- the value in developing a coordinated strategy supported by several auto insurance system participants;
- current barriers that exist to effective communication between insurance companies and their claimants;
- possible opportunities for anti-fraud messages to be inserted into existing consumer engagement initiatives inside and outside Ontario’s automobile insurance system; and
- the best way to reach the different communities that make up the diverse cultural mix of Ontario.
5. Developing a single web portal for Ontario auto insurance claimants

A single web portal could be effective in providing consumer education and engagement information to Ontario drivers and automobile accident injured claimants.

More specifically, such a web portal could be a source of clear and useful information to all Ontario auto insurance claimants on the type of treatments they should expect for their specific injury. For example:

- the portal would be a source of consumer information and education on approved protocols for treatments on specific auto related injuries;
- these protocols would be endorsed by the relevant colleges for the health care practitioners involved, and will require working closely with health care practitioners, the insurance industry and relevant Ontario government ministries;
- having ready access to validated protocol information would help make Ontario drivers injured in an accident more informed consumers of services provided by health care practitioners; and
- the web portal would also provide the opportunity for coordination of consumer engagement and education initiatives between the different parts of the auto insurance system — particularly between insurers, health care practitioners, and Ontario government ministries.

We have asked the Working Group on Consumer Engagement and Education to consider these issues over the coming months.

None of these issues are simple. All are important. And there will be others that arise in the course of our work, or are brought to our attention. The list above is, therefore, not intended to be exhaustive. But by outlining some of the higher profile issues we intend to examine, we hope to catalyze interested parties to provide information that can assist us in coming to sensible and effective conclusions.
Information Gathering

The Task Force and its Working Groups have benefited from a number of informative and instructive presentations from and discussions with interested parties regarding auto insurance fraud. The presenters have included Ontario law enforcement officials, representatives of insurance companies, insurance fraud investigators, health care providers and individuals involved in community outreach programs in the GTA.

These presentations have been extremely helpful to the Task Force. The information presented and the discussions generated have significantly helped our understanding of auto insurance fraud and the overall auto insurance system in Ontario. The Task Force will continue to meet with interested parties to gather further information and discuss possible anti-fraud strategies throughout the balance of its mandate.

Contacting the Task Force

We have also received input from many individuals inside and outside the insurance industry, through our email address. We welcome further such input and invite interested parties to submit information by emailing autoinsurance@ontario.ca.
Appendix 1: Steering Committee Terms of Reference

Background

The Auto Insurance Anti-Fraud Task Force (the “Task Force”) was announced in the Government of Ontario’s 2011 Budget. The Government has set out two key objectives for the Task Force:

- Determine the scope and nature of auto insurance fraud in Ontario; and
- Make recommendations regarding:
  - Prevention, detection, investigation and enforcement;
  - Regulatory practices in the auto insurance system; and
  - Consumer engagement and education.

Purpose of the Steering Committee

The Steering Committee will provide research and advice on auto insurance fraud to the Minister of Finance. Towards this end, the Committee will collaborate with working groups of auto insurance stakeholders, regulators and government representatives to develop the Committee’s recommendations for a comprehensive anti-fraud strategy.

The Committee will submit its reports and recommendations to the Deputy Minister of Finance, who will share these materials with the Deputy Minister of Community Safety, the Deputy Minister of Correctional Services and the Deputy Attorney General.

The Committee’s recommendations will focus on auto insurance fraud prevention, detection, investigation and enforcement, as well as regulatory practices and consumer education in Ontario’s auto insurance system. Recommendations may also be made on other issues identified by the Committee through its research.

The Committee’s recommendations and reports will not involve specific cases of auto insurance fraud or alleged auto insurance fraud.
Functions of the Steering Committee

The Chair of the Committee will:

- Report to the Deputy Minister of Finance on all Task Force matters, including:
  - Steering Committee reports and recommendations.
  - Task Force Working Group reports and recommendations.
- Direct research and analysis on the scope and prevention of auto insurance fraud in Ontario and other jurisdictions, leading to interim and final reports submitted by the Committee.
- In prior consultation with the Deputy Minister of Finance, form Task Force Working Groups, develop terms of reference documents to guide the work of those groups and appoint a Chair of each group formed.
- Develop an interim report summarizing the progress made by the Task Force Working Groups, and by the Committee, towards the development of final anti-fraud recommendations.
- Submit a final report containing the recommendations of the Committee supported by input from the Task Force Working Groups.
  - Any quantitative or qualitative findings on the scope of general insurance fraud in Ontario developed through the Committee’s research on auto insurance fraud will be included in the final report.

A detailed set of proposed deliverables and possible timelines can be found in Appendix A.

Composition of the Steering Committee

The Committee will consist of up to five members, including one Chair, appointed by the Minister of Finance. The Chair will set the agenda of Committee meetings in collaboration with the other members of the Committee.
Proceedings of the Steering Committee

The Committee will meet on a regular basis, and as often as may be required by the Minister of Finance, so that the Committee’s reports and advice may be delivered to the government in accordance with timelines set by the Minister of Finance.

Government representatives, at their own discretion, may observe and participate in any meetings of the Committee and the Task Force Working Groups.

Remuneration and Administrative Arrangements

The Ministry of Finance will provide the Committee with administrative and related support services, as required.

The Chair and selected members of the Committee will be paid on a per diem basis and reimbursed for reasonable travel and incidental expenses as provided for by Order in Council O.C. 1316/2011.

Confidentiality

All materials produced by the Committee and the Task Force Working Groups, including reports/recommendations, remain the property of the Ministry of Finance and will be kept confidential and released publicly only with the approval of the Minister of Finance.

Background research reports prepared for the Committee’s work will be made available to the public by the Ministry of Finance.

Communications

All press releases, statements and other communications on behalf of the Committee will be made by the Ministry of Finance.
Steering Committee Terms of Reference: Appendix A

Steering Committee Deliverables and Timelines

- The Steering Committee will report to the Deputy Minister of Finance on all Committee and Task Force Working Groups matters. Reports will be confidential and released only with the approval of the Minister of Finance.

- The times listed below may be adjusted by the Minister of Finance in consultation with the Chair of the Committee.

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<tr>
<td>Interim Research Report</td>
<td>Late Fall 2011</td>
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<tr>
<td>Final Research Report</td>
<td>Spring 2012</td>
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<tr>
<td>Interim Progress Report</td>
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<td>Final Recommendations Report</td>
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Steering Committee Terms of Reference: Appendix B

Auto Insurance Anti-Fraud Task Force: Proposed Structure

Auto Insurance Anti-Fraud Task Force: Organizational Structure

Government of Ontario
Ministry of Finance
Ministry of the Attorney General
Ministry of Community Safety and Correctional Services

Task Force Steering Committee

Steering Committee Chair:
Fred Gorbet
Former Deputy Minister of Finance
Member of the Order of Canada

Consumer Representative:
James Daw
Business Journalist

Justice Representative:
Deputy Chief Bob Percy
Deputy Chief of Operations,
Halton Regional Police Service

Academic Advisor:
Margaret Beare
Professor of Law and Sociology,
York University

Industry Representative:
George Cooke
President and CEO,
The Dominion of Canada
General Insurance Company

Task Force Working Groups

Prevention, Detection, Investigation and Enforcement
MOF | MAG | MCSCS | FSCO
IBC | CADRI | Justice Representative

Consumer Engagement and Education
MOF | MAG | MCSCS | FSCO
IBC | CADRI | IBAO | Consumer Representative

Regulatory Practices
MOF | MAG | MCSCS | MOHLTC | MCS | FSCO
Law Society | IBC | CADRI | PACICC | FHRCO
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<td>CADRI</td>
<td>Canadian Association of Direct Response Insurers</td>
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<tr>
<td>FHRCO</td>
<td>Federation of Health Regulatory Colleges of Ontario</td>
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<tr>
<td>FSCO</td>
<td>Financial Services Commission of Ontario</td>
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<td>IBAO</td>
<td>Insurance Brokers Association of Ontario</td>
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<td>Insurance Bureau of Canada</td>
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<td>Law Society</td>
<td>Law Society of Upper Canada</td>
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<td>MAG</td>
<td>Ministry of the Attorney General</td>
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<td>MCS</td>
<td>Ministry of Consumer Services</td>
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<td>MCSCS</td>
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<td>MOHLTC</td>
<td>Ministry of Health and Long-Term Care</td>
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<tr>
<td>PACICC</td>
<td>Property and Casualty Insurance Compensation Corporation</td>
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Appendix 2: Working Group Terms of Reference

Background

The Government of Ontario has initiated an Auto Insurance Anti-Fraud Task Force (the “Task Force”). The Task Force is charged with determining the scope of auto insurance fraud in Ontario and making recommendations to the Government of Ontario regarding the following areas:

- Prevention, detection, investigation and enforcement;
- Regulatory practices in the auto insurance system; and
- Consumer engagement and education.

The Task Force will be led by a Steering Committee composed of external stakeholders. The Steering Committee Chair will be independent from the insurance industry and the Government of Ontario.

The Steering Committee will submit its reports and recommendations to the Deputy Minister of Finance. An Assistant Deputy Ministers Table (the “ADM Table”) consisting of senior government officials from the Ministry of Finance (“MOF”), Ministry of Community Safety and Correctional Services (“MCSCS”) and Ministry of the Attorney General (“MAG”), will observe and consult with the Steering Committee.

Working groups of stakeholders and representatives of the Government of Ontario will assist the Steering Committee in developing auto insurance fraud prevention recommendations.

Purpose of the Working Groups

The Auto Insurance Anti-Fraud Task Force Working Groups (the “Working Groups”) will develop policy recommendations aimed at reducing auto insurance fraud in Ontario while maintaining a fair and competitive auto insurance marketplace. Each Working Group will be focused on a distinct subject area (see Appendix A).

The Steering Committee will consider recommendations made by the Working Groups when developing its reports and recommendations for the Deputy Minister of Finance.
Functions of the Working Groups

The Steering Committee, in consultation with the Deputy Minister of Finance, will appoint a Chair to lead each of the Working Groups. The Chairs of the Working Groups (the “Chairs”) will submit a final report on fraud prevention recommendations to the Steering Committee based on the deliberations of each Working Group.

The Chairs will also provide regular reports on the progress of each Working Group to the Steering Committee.

The Working Groups may also be a source of informal input for the Steering Committee’s report on anti-fraud measures that can be implemented early.

Composition of the Working Groups

The Steering Committee will request participation in the Working Groups from relevant stakeholder and government organizations. These organizations may appoint one individual to each applicable Working Group, subject to the approval of the Steering Committee.

With the prior consent of the appropriate Working Group Chair, a substitute representative may attend Working Group meetings from time to time on behalf of the individual appointed.

The Steering Committee may choose to add or remove a stakeholder organization from the Working Groups at any time.

The Chairs may establish subcommittees for the purposes of specific policy analysis.
Final Report of the Working Groups

The final report of the Working Groups will include, but not be limited to, recommendations regarding any applicable information found in the final research report of the Steering Committee.

Recommendations will be voted on by the members of the appropriate Working Group prior to being forwarded to the Steering Committee. Recommendations will be forwarded in a final report of the Working Groups if agreed upon by consensus of the Working Group members. Consensus is deemed to have been reached when 80 per cent of the members of the appropriate Working Group agree with a recommendation. Consensus, even when not at 100 per cent members’ agreement, shall be represented in the final report to the Steering Committee with unified support.

Multiple or modified recommendations may only be forwarded to the Steering Committee when consensus is not reached on a certain issue.

Only the Working Group Chair and the Working Group members or their substitutes may vote. Members of the Steering Committee will not participate in votes conducted by the Working Groups.

Proceedings of the Working Groups

The Working Groups will meet on a regular basis so that advice may be delivered to the Steering Committee in accordance with timelines set by the Minister.

Designated representatives of the ADM Table and substitutes for members of the Working Groups may also attend meetings.

Members of the Steering Committee may choose to attend meetings of the Working Groups at their own discretion.

Administrative Arrangements

MOF, in collaboration with MAG, MCSCS and FSCO, will provide the Working Groups with administrative and related support services as required.
Communications

All press releases, statements and communications on behalf of the Working Group will be made through MOF in collaboration with the Steering Committee, MAG, MCSCS and FSCO.

Confidentiality

All materials produced by the Working Group, including reports and or recommendations remain the property of MOF and will be kept confidential and released publicly only with the approval of the Minister of Finance.

Individual members of the Working Groups and any substitutes attending meetings on their behalf will sign a confidentiality agreement in a form provided by the Minister of Finance.
Appendix 3: Data Sources

This annex provides a list of the sources used for each of the Exhibits in this section. The primary data source used by the Task Force is the General Insurance Statistical Agency (GISA). GISA acts as a statistical agent on behalf of eight participating regulatory authorities across Canada, including FSCO.

More information on GISA can be found on its website at http://www.gisa.ca.


Exhibit 4  GISA: Accident Benefits Claims and Adjustment Expenses Incurred, 2006 to 2010 (Statistical Territory 717: Metropolitan Toronto and Markham, Richmond Hill, Vaughan, Peel Districts, and Statistical Territory 710: Oshawa, Aurora, Newmarket, Orangeville Districts).

Exhibit 5  Data derived from other exhibits.


Canadian Institute for Health Information (CIHI): Private Health Expenditure in Ontario, 2006 to 2010. Private Health Expenditure information for 2009 and 2010 is based on values forecasted by CIHI.

Exhibit 7  GISA: Accident Benefits Claims and Adjustment Expenses Incurred, 2006 to 2010 (Statistical Territory 717: Metropolitan Toronto and Markham, Richmond Hill, Vaughan, Peel Districts, and Statistical Territory 710: Oshawa, Aurora, Newmarket, Orangeville Districts).

Canadian Institute for Health Information (CIHI): Private Health Expenditure in Ontario, 2006 to 2010. Private Health Expenditure information for 2009 and 2010 is based on values forecasted by CIHI.
Exhibit 8  Data Received from the Financial Services Commission of Ontario (FSCO): Claims Frequency per 100 Earned Vehicles (Accident Benefits), 2006 to 2009.

Exhibit 9  Data Received from FSCO: Claims Frequency per 100 Earned Vehicles (Accident Benefits), 2006 to 2009.


Exhibit 12  Data Received from FSCO: Claims Cost per Earned Vehicle (Accident Benefits), 2006 to 2010.


Exhibit 16  Data Received from FSCO: Claims Costs by Coverage Type, 2006 to 2010.

Exhibit 17  HCAI: Total Forms Submitted and Active Health Care Facilities, 2006 to 2010.