ONTARIO AUTOMOBILE ANTI-FRAUD TASK FORCE

STEERING COMMITTEE STATUS UPDATE

JULY 2012

July 23, 2011

Mr. Steve Orsini
Deputy Minister
Ministry of Finance
Office of the Deputy Minister
7 Queen's Park Crescent
Toronto, ON
M7A 1Y7

Dear Deputy Minister:

Please find attached a status update report from the Ontario Automobile Insurance Anti-Fraud Task Force Steering Committee.

We are pleased to transmit this report to you, for distribution to the Minister of Finance. The report describes the progress made by the Task Force and others in the auto insurance system since our Interim Report was made public in December, 2011, and puts forward several potential recommendations for public feedback before we submit our final report.

The Task Force has been supported by officials in the Ministry of Finance, the Ministry of Community Safety and Correctional Services, the Ministry of the Attorney General and the Financial Services Commission of Ontario. While the continued support and advice from these officials has been valuable, this report reflects our own conclusions on the matters the government has directed us to review.

Respectfully Submitted,

Frederick W. Gorbet
Chair, Steering Committee

Margaret Beare

George Cooke

James Daw

Bob Percy

ONTARIO AUTOMOBILE ANTI-FRAUD TASK FORCE

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EXECUTIVE SUMMARY

The Steering Committee of the Ontario Auto Insurance Anti-Fraud Task Force is seeking public comment on a number of potential recommendations before we submit our final report to the government in the fall of 2012.

We have already heard many suggestions, both before and after issuing our preliminary report last December. These helpful comments, combined with our own research and discussions, have led us to certain conclusions. First and foremost is that all of us — consumers, insurers, health care practitioners, lawyers, paralegals, tow truck operators, body shops, law enforcers and regulators — have a role to play in combating fraud in the auto insurance system. We are now asking you to focus your attention on public policies that would help reduce the extent of organized and premeditated fraud by making it more difficult to commit and hide.

Estimating the amount of fraud has proven difficult. We do know that there was a startling and unexplained increase in claims for Accident Benefits from 2006 to 2010, primarily in the Greater Toronto Area. A comprehensive review of the history of attempts to quantify all insurance fraud (including opportunistic, premeditated, and organized) produced a wide range of potential estimates, from $770 million to $1.6 billion in 2010. Despite the lack of precision in these estimates, information we have gathered leads us to believe that new rules and regulatory powers are warranted to protect the premium-paying public and the reputations of ethical service providers.

Measures already introduced by the government, such as a $3,500 limit on the treatment and assessment of most minor injuries, may have helped to reduce the flow of money to unnecessary and/or fraudulent treatments. Comprehensive year-end statistics for 2011 are not yet publicly available, although early figures indicate a reduction in claims. However, a flood of requests for the mediation of claims of undetermined merit at the Financial Services Commission of Ontario's (FSCO) Dispute Resolution Services has postponed a final determination of the effectiveness of these policy changes. Regardless of any reduction in costs that may result, there is nothing to suggest the changes will permanently reduce the appetite to make unwarranted or illegal claims.

We are certainly encouraged by the open discussion of the issues and actions taken by various parties in the system. Insurers, for example, are better equipping themselves to cooperate with each other to detect highly suspicious claims for Accident Benefits and bodily injury settlements. Using the latest computer analysis techniques, it is possible to quickly detect connections between claimants, vehicles and service providers by pooling and analysing data from several insurers and several years at once. This allows the identification of suspicious activity. For example, one incident that had previously escaped the attention of insurers essentially involved the same three individuals reporting the same injuries after three alleged collisions, involving three different cars, three different drivers, and three different insurers, all within a short period of time.

Tests this year using three different software programs have led insurers for the majority of Ontario drivers to agree to form a new company. This company would charge its owners for the cost of operation and employ state-of-the-art software to do a rapid analysis of new claims that would highlight the most suspicious among them. This would trigger further research by insurance adjusters and investigators, while allowing efficient processing of claims that are not suspicious. The most suspicious claims could be handed over to regulators or other investigative authorities.

In addition, the Insurance Bureau of Canada (IBC) is negotiating an arrangement that would draw tips on insurance fraud from the 24-hour, multilingual call centres maintained by the Ontario Association of Crime Stoppers. IBC has also worked with the Canadian Police Knowledge Network to develop an online course to help frontline officers identify and investigate staged collisions.

FSCO, the regulator for the auto insurance system, is also proceeding with anti-fraud initiatives:

- Representatives of FSCO, Health Claims for Auto Insurance (HCAI) and select health regulatory colleges have worked to develop the Professional Credential Tracker (PCT). This tool helps health care practitioners prevent their identities from being stolen by fraudulent health care facilities. Practitioners using the PCT will see which facilities are using their professional credentials to bill insurers and report any suspicious activity to their health regulatory college.

- The Superintendent of FSCO will soon be able to impose monetary penalties for unfair or deceptive acts or practices as a result of legislation that was recently passed.
- Discussions with officials at the Workplace Safety and Insurance Board (WSIB), who are also working to confront fraudulent billing practices and benefit claims, could open opportunities for FSCO and WSIB to share data.

The government has also commissioned studies, separate and apart from the work of the Task Force, to deal with other issues affecting the cost of insurance and the treatment of persons injured in collisions. We support establishing new science-based approaches for treating and assessing injuries. These will help form a solid foundation for Ontario to move forward by ensuring that appropriate treatment is provided by the appropriate practitioners.

Yet more change is required, and the public knows it. An opinion poll conducted earlier this year found that a majority of respondents was aware that fraud is a problem for auto insurers, and would support government action to address the problem. Insurers and medical practitioners agree. So we are leaning toward recommendations that would widen the regulatory net, put more power into the hands of regulators and insurers to deal with highly suspicious claims, educate consumers to help them avoid unsavoury practices, and stop the flow of dollars into the wrong hands

We invite comments on the following potential recommendations, which are further elaborated in this report and its appendices.

Regulation of health clinics

The Steering Committee has concluded that licensing and regulation of auto insurance business practices of health clinics is appropriate and necessary. We are also considering extending any regulatory scheme to commercial providers of independent medical assessments. We have not yet settled on a specific model. It would be helpful to receive comments on the following:

- Should there be restrictions placed on the ownership of clinics and what kind of transparency by the owners should be required?
- We are not proposing to regulate professional credentials nor methods of treatment but we do want to increase accountability. We are considering a requirement that clinics designate a regulated health practitioner to be held responsible for the integrity of the clinic’s business practices.

- We are considering requiring that the designated regulated health care practitioners regularly confirm that appropriate business practices are being followed.
- We are seeking input on a range of appropriate sanctions for improper behaviour.

Regulation of the towing industry

We have heard concerns that some members of this industry may be participating in paid referrals or improper billing practices that inflate insurance costs. We are considering options that include: better consumer education, harmonized municipal licensing requirements, and provincial business licensing and regulatory standards. We have also been impressed with voluntary initiatives that have been introduced in Halton Region. We would appreciate views on whether these or other “market-based” models could provide an effective alternative to additional regulation, and if so, what would be required to make them more widespread.

Enhanced authorities for FSCO

We are considering enhanced authorities for FSCO — to authorize it to regulate the business practices of health care treatment and assessment facilities; to permit it to require information and investigate market conduct with respect to a broader range of participants in the business of auto insurance; and to assess whether the definition of Unfair or Deceptive Acts or Practices should be expanded and whether the penalties for their breach are adequate deterrents.

Tightened controls on delivery of Accident Benefits

We have reviewed several proposals from insurers. We agree that health care providers and assessment facilities should not submit bills for treatments, goods or services without obtaining a signature from the patient to confirm these were actually received. Neither they nor legal advisers should ask claimants to sign forms before the recommended items or services have been listed on those forms. We are considering whether insurers should be able to interview claimants a second time under oath, if there are issues that could not have been anticipated at the time of the first interview. We are also proposing that insurers be allowed to bill claimants $500, as a form of cost-recovery, if claimants fail to attend a medical examination requested by the insurer without providing timely notice or a reasonable explanation for not appearing at the agreed time and place.

We also believe that insurers need to change some of their practices. For example, we think that notices that must now be sent to injured claimants every 60 days should include more than the total sum of invoices paid on their behalf. Claimants should receive itemized statements, so that they can look for errors or deliberate misstatements that could exhaust their entitlement to benefits prematurely.

Consent and disclosure of personal information

Insurers are subject to federal law when it comes to protecting the privacy of their policyholders. While this protection is appropriate and necessary, the existing law could in some circumstances impede broad-based investigative techniques aimed at detecting fraud. New federal legislation proposed in Bill C-12 could be helpful.

Another option that is being examined in Ontario is to consider whether the consent provisions embedded in applications for auto insurance and applications for benefits in the event of a collision might be amended in a way that would be consistent with privacy legislation but provide greater certainty about the ability to share information for the purpose of detecting and preventing fraud. FSCO is considering changes and we are working to develop an approach that will allow consultations with the industry before we conclude our Final Report.

Providing insurers with broader civil immunity

We are considering whether to recommend that existing civil immunity provisions in the *Insurance Act* be broadened to protect insurers from civil suits for reporting to regulators or the police when they have suspicions of fraudulent behaviour by their own policyholders

Learning moments and website

Insurers, regulators and law enforcement agencies could all benefit from consumers being better informed and more alert to the potential for fraud within the auto insurance system. To that end, our working group on consumer education and engagement has identified a number of timely occasions for providing consumers with key messages. We are proposing that an entire website be devoted to informing those injured in vehicle collisions about the benefits available for different types of injuries, how to claim benefits and how to detect and report suspicious or inappropriate behaviour at collision scenes, clinics and offices of legal representatives.

Mandatory disclosure by insurance companies

One of the benefits of Ontario's competitive insurance market is the variety of choice available. But consumers could benefit from knowing more before they choose an insurer. So we think insurers should provide more disclosure to the public about how they select and supervise their preferred providers of services — including independent medical examinations.

Resource implications for FSCO

A significant number of the recommendations we are considering are directed to FSCO as the regulator of the auto insurance system. In particular, recommendations regarding the regulation of health care treatment and assessment facilities and expansions to FSCO's investigative authority — if implemented — would carry significant resource implications. It is necessary that FSCO be provided with the requisite staff and expertise to assume these new regulatory activities. In this regard we suggest that the government consider allowing FSCO to hire new staff as necessary, particularly since the insurance sector would be absorbing the additional costs associated with new resources.

Overall, the changes we are considering should result in net savings to the system from a reduction in the cost of fraudulent insurance claims. Those practitioners and clinic operators who are the most competent and scrupulous would enjoy a larger share of the available business. And injury victims would receive better care.

Over the coming months we will continue to refine and develop the issues identified above. Our target is to make recommendations to the government and others, where appropriate, in fall 2012.

We look forward to engaging in a dialogue with interested parties regarding these important issues. Input can be submitted to the Task Force by emailing autoinsurance@ontario.ca.

INTRODUCTION

As part of the government's response to rapidly escalating automobile insurance 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 Task Force was appointed in July, 2011. It is directed by a five-person Steering Committee that is independent of government. Its final report to the Minister of Finance is due in the fall of 2012.

In December 2011 the Task Force released an Interim Report. That report described the evolution of the Ontario automobile insurance system from 1990-2010, set out some preliminary conclusions of the Task Force with regard to the extent and nature of auto insurance fraud, made some recommendations for early action and described, for interested parties and the broader community, the agenda that the Task Force proposed to pursue through the balance of its mandate.

This Status Report provides an update on our work since the Interim Report. It has three main purposes:

- to report on steps that have been taken since the release of the Interim Report — by government, by industry, by law enforcement, by the regulator and by others — to implement measures aimed at reducing auto insurance fraud;
- to report the results of the research into auto insurance fraud that has been commissioned by the Task Force; and
- to provide a more detailed outline of the recommendations that the Task Force is considering for its Final Report — as a basis for feedback and input from interested parties.

Before turning to these three areas, we provide — as context for this Status Report — a brief summary of the Interim Report and some general observations of the Steering Committee.[1]

[1] The Structure of the Task Force is set out in Appendix 1. There are many public servants and representatives of interest groups who have contributed to the work of the Task Force, through its three Working Groups and through meetings of the Task Force. The five-person independent Steering Committee thanks those contributors for their inputs and advice, but wants to make clear that the opinions, conclusions and recommendations of this Report are those of the Steering Committee alone.

Highlights of the Interim Report

The Interim Report[2] set out four key observations which reflected the evolution of automobile insurance in Ontario over the past two decades and which would inform the future work of the Task Force.

1. Changes to Ontario's insurance system have historically aimed at a balance between controlling costs to reduce pressure on premiums, and ensuring that collision victims receive fair, adequate and timely assistance. Exhibit 1 from the Interim Report, reproduced here as Appendix 2, highlights the relationship between automobile insurance premiums and government system reforms from 1985 through 2010. Automobile insurance is mandatory for Ontario drivers. When costs go up, premiums go up and as Exhibit 1 shows (and the Interim Report describes in some detail) governments have responded to increasing costs and premiums by making changes to the auto insurance system through successive reforms.
2. The design of the system, and changes to the rules and procedures governing its operation, can create opportunities for fraud. As the Interim Report suggested, it appears that organized and premeditated auto insurance fraud in Ontario likely increased substantially from 2006 through 2010, particularly in the Greater Toronto Area.
3. The Task Force's mandate is focused on the extent and impact of fraud and what the government and other interested parties should do about it. It is not part of its mandate to review the adequacy or appropriateness of the current automobile insurance system except to the extent that the system facilitates fraud.
4. Although the mandate is focused, recommendations cannot be made in a vacuum. It is important that the Task Force understand, as best it can, the system, the tensions within it, and the impact potential actions will have on collision victims who need the protections and assistance they expect the system to provide.

At the time of the Interim Report the Task Force was not sufficiently informed to make a quantitative estimate of the extent of auto insurance fraud in Ontario. It did conclude that the figure of $1.3 billion that has been used to describe the cost of auto insurance fraud in Ontario for some time cannot be considered a verifiable measure of the current extent of fraud.

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[2] The Interim Report is available at http://www.fin.gov.on.ca/en/autoinsurance/interim-report.html

Although not able to measure the extent of fraud, the Interim Report conceptually defined auto insurance fraud in three categories[3]:

> **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;
>
> **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
>
> **Opportunistic Fraud:** an individual pads the value of his or her auto insurance claims by claiming for benefits or other goods and services that are unnecessary or unrelated to the collision that caused the claim.

The Interim Report carefully reviewed trends in claims cost data and information gathered from industry stakeholders and regulators. This review led to the following conclusions:

- auto insurance claims costs, specifically Accident Benefits claims costs, increased dramatically from 2006 to 2010, and this increase in costs had a direct impact on auto insurance premiums.
- a large and unexplained gap exists between changes in Accident Benefits claims costs and changes in factors that would have been expected to influence those costs; this 'unexplained gap' amounted in 2010 to an average of $300 per insured motor vehicle in Ontario[4].
- the most dramatic increase in costs has occurred in the Greater Toronto Area, where the 'unexplained gap' in 2010 amounted to an average of $700 per insured motor vehicle[5].
- anecdotal evidence suggests that fraudulent activity, and in particular, premeditated and organized fraud may have accounted for a substantial portion of the 'unexplained gap'.

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[3] For a more detailed description of the three categories of fraud and some examples, see the Interim Report, pp. 43-46.

[4] Interim Report, page 23.

[5] Interim Report, page 24.

The Interim Report also set out some major issues that the Task Force would be examining in the coming months, including:

- the licensing and/or regulation of health clinics;
- other possible gaps in regulation;
- the establishment of a dedicated fraud investigation unit;
- the development of a consumer engagement and education strategy; and
- the creation of a dedicated website with information for Ontario auto insurance claimants.

The Interim Report noted that this list was not exhaustive and that as research and discussions with interested parties continued, other issues would likely be brought to its attention and priorities regarding this initial list might change.

DEVELOPMENTS SINCE THE INTERIM REPORT

Since last December, the Task Force has continued to hear from interested parties[6] and the Working Groups have engaged in a focussed assessment of the agenda set out in the Interim Report.

It is obvious that issues surrounding the operation of the automobile insurance system in the province are many, complex, interrelated, and high profile. They affect all Ontario drivers in the pocketbook, through high premiums. They also directly impact those unfortunate enough to be involved in serious collisions through uncertainty about how, and how quickly, their claims will be dealt with. In addition, when insurance payouts from staged collisions are viewed as profit-making ventures, the safety of the driving public is put at risk.

[6] A list of individuals and groups who made presentations to the Task Force Steering Committee and its Working Groups is set out in Appendix 7.

The December report of the provincial Auditor General on Automobile Insurance pointed to the impact that fraud was having on premiums, but also pointed out issues involved in rate-setting and in the dispute resolution services provided by the Financial Services Commission of Ontario (FSCO).[7] Over the past several months, FSCO has announced changes to provide more efficient management of its dispute resolution services[8] and four separate Private Members' Bills have been introduced in the Ontario Legislative Assembly dealing with rate-setting and with aspects of fraud prevention.[9]

As well, the Ontario Standing Committee on General Government began a study of auto insurance practices and trends with the purpose of developing recommendations on how to make auto insurance rates more affordable. The study has now been referred to the Standing Committee on Finance and Economic Affairs.

[7] The provincial Auditor General report is available online: http://www.auditor.on.ca/en/reports_en/en11/301en11.pdf

[8] FSCO is keeping the public up to date regarding changes to dispute resolution processes at http://www.fsco.gov.on.ca/en/drs/Pages/mediation-backlog-initiatives.aspx

[9] Bill 41, introduced by MPP Amrit Mangat, targets fraud directly. Bills 43 and 71, introduced by MPP Mario Sergio, and Bill 45, introduced by MPP Jagmeet Singh, introduce new rate-setting rules for the auto insurance system. Bill 45 lost on recorded division on June 7, 2012. On March 7, 2012, Bill 43 carried on First Reading. On March 22, 2012, Bill 41 carried through Second Reading and has been referred to Committee. On April 26, 2012, Bill 71 carried through Second Reading and has been referred to Committee. The bills can be viewed in their entirety at the Legislative Assembly of Ontario website (www.ontla.ca).

Standing Committee on General Government
Request for Claims Information and FSCO Response

The Standing Committee on General Government held two days of hearings on the auto insurance system, which included a presentation from FSCO. Following the FSCO presentation, the Standing Committee requested information on claims costs from the first six months of 2011 so that it could better understand the impact of the September 2010 auto insurance reforms.

We have reviewed the information provided to the Committee by FSCO but are not drawing conclusions from it. In its response to the Committee, FSCO identified many issues to consider when reviewing the data, which we believe are valid reasons not to make conclusions regarding claims costs trends at this time. These issues included:

- claims costs from the first half of 2011 may still change significantly based on decisions related to the September 2010 reforms, such as the Minor Injury Guideline, that are still in dispute;
- there has not been a full year of claims experience based only on coverage levels from after the September 2010 reforms (the preliminary 2011 data provided by FSCO is from a mixture of coverage levels);
- it is too early to tell how the reforms impacted bodily injury claims costs because there is a two year time period in which bodily injury claims can be reported;
- claims costs are seasonal, meaning that data for the first half of 2011 cannot easily be extrapolated to apply to a full year; and
- in the past, innovative auto insurance system participants have been able to find ways to take advantage of the system and increase costs.

Source: FSCO submission to the Clerk of the Standing Committee on General Government on May 30, 2012.

Clearly, broad segments of the community are seized with these issues and that is a good thing. There is no perfect design that will satisfy the often-conflicting objectives of providing quick and reasonable care to claimants, ensuring premiums are affordable, supporting a competitive insurance market that provides choice to consumers, and being fraud-proof and abuse-resistant. One of the key conclusions that we have come to is that all the players in the system — consumers, industry, health care practitioners, lawyers, paralegals, tow truck operators, body shops, law enforcement, regulators and governments — have a role to play in combating fraud in the auto insurance system.

Fraud has many consequences. It drives up costs and increases premiums. It creates additional workload, pressure and uncertainty within the industry — raising questions about which claims are credible and diverting attention and resources away from providing necessary assistance to legitimate claimants. It results in increases in the mediation and arbitration of claims that clog the FSCO dispute resolution system and lead to delays and uncertainty for all. And the actions of some can cast clouds of suspicion over the many ethical and legitimate providers of services to the auto insurance industry.

We are encouraged by the positive reactions to our Interim Report and the synergies that are being created among different actors in the system. We have observed the strengthening of existing partnerships and the willingness to create new ones to combat fraud. We are encouraged and impressed by the willingness to share knowledge and best practices, and by the good will and constructive suggestions that are being made to us as we proceed with our work.

The balance of this section reports on actions that have been taken to combat fraud since the Interim Report was released, and on the results of the research studies the Task Force commissioned.

Actions taken to reduce fraud since the Interim Report

Surveying consumer attitudes toward fraud

Our Interim Report recommended that the insurance industry measure the current state of consumer engagement and education. As a result of this recommendation, the Insurance Bureau of Canada (IBC) gave the Task Force an opportunity to provide input regarding the questions consumers were asked in a survey conducted by Pollara. One thousand Ontarians were asked about their thoughts and experiences related to auto insurance fraud.[10] A majority of the consumers surveyed:

- are aware of auto insurance fraud
    - Eight in ten of those surveyed believe insurance fraud is a frequent or occasional occurrence in Ontario.
    - Six in ten believe that fraud is influential or very influential on increasing the price of auto insurance.
- are supportive of initiatives to reduce auto insurance fraud
    - Support for six potential anti-fraud initiatives tested by Pollara ranged from 64% to 77%.
- trust their insurance company, broker or agents as sources of advice about auto insurance claims
    - Over 75% of those surveyed would contact their insurance company, broker or agent for information about making a claim related to an injury suffered in a collision.
    - Approximately two thirds of individuals who had made an auto insurance claim in the past five years stated they tend to trust insurance brokers and agents (compared with 53% of individuals who had not made a claim in the past five years).

The results of the poll have been useful input to the Task Force and its deliberations, and will provide a baseline that can be used in measuring the success of future consumer engagement and education initiatives.

[10] The Pollara results are available at: http://www.ibc.ca/en/Insurance_Crime/index.asp

Recent Ontario Government initiatives

The *2012 Ontario Budget* included several positive commitments and proposals related to Ontario's auto insurance system. In the *Budget*, the government:

- committed to working with the Task Force and addressing recommendations made in the Interim Report. For example, FSCO has addressed our recommendation for the Superintendent of FSCO to create a guideline addressing the issue of insurers being invoiced for medical devices at prices considerably higher than their normal retail values.
- proposed legislative amendments to provide the Superintendent of FSCO with the power to impose administrative monetary penalties for contraventions of legislation and regulations. We are especially encouraged by this initiative as we recommended the implementation of administrative monetary penalties in our Interim Report (see below for further information about administrative monetary penalties).
- identified several steps the government will take to further modernize FSCO and Ontario's insurance regulation framework. While these steps are directly targeted at improving overall regulation of the auto insurance system, they will also enhance FSCO's ability to address major issues, such as fraud. For example, the government is proceeding to:
    - engage in a review of the automobile insurance dispute resolution system; and
    - strengthen the Superintendent's authority regarding Unfair or Deceptive Acts or Practices.

Administrative Monetary Penalties: A Brief Overview

In the Task Force Interim Report, we recommended the following:

> *"the government should provide the Superintendent [of FSCO] with the power to impose administrative monetary penalties for contraventions of legislation and regulations, as discussed in the 2011 Ontario Budget."*

Administrative monetary penalties (AMP's) are civil fines that a regulator, instead of a court, imposes on someone that has committed unlawful activity. Once they are implemented, AMP's will encourage regulatory compliance within the insurance industry and provide FSCO with a quick enforcement tool that is flexible and targeted.

For example, if the Superintendent of FSCO is satisfied that a company is not complying with the *Insurance Act*, the Superintendent could impose an AMP on the company. The level of the AMP would depend on the seriousness of the company's behaviour but could be up to a maximum fine of $200,000. The company could choose to appeal the decision to impose an AMP if it felt the penalty was unfair or unjustified.

The Superintendent currently has the power to impose AMP's on two types of financial services institutions – mortgage brokers and credit unions. AMP's are also used by other regulators in Ontario and other jurisdictions.

We noted in the Interim Report that as of October 14, 2011, the Superintendent of FSCO is requiring CEO's of auto insurance companies to attest, personally and annually, that the Statutory Accident Benefits Schedule 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.[11] This new requirement was also referred to in the *Budget* and we understand that FSCO is now working on its first cycle of follow-up activities, which will involve meetings with individual insurers, associated with the attestations.

[11] Interim Report, page 49.

Ongoing enforcement

Since the Task Force began its work, the media have reported on a number of criminal court cases in the Greater Toronto Area in which auto insurance fraud and criminal organization offences have been alleged. Most, if not all, of these cases are before the courts at some stage of the criminal justice process. The Task Force members observe, on the basis of these media reports, that complaints of auto insurance fraud are being pursued. Police investigations are occurring, charges are being laid and prosecutions are proceeding through the criminal justice system. In some cases, the media have reported that the investigation involved cooperative efforts among the insurance industry, FSCO and police services.

The Criminal Law Division of the Ministry of the Attorney General has for several years instituted best practices with respect to major case management. Major cases include large and complex fraud cases, such as some auto insurance fraud allegations.

There are 54 Crown offices in Ontario. The geographic location of an alleged crime will generally determine which Crown's office is responsible for its prosecution. Each jurisdiction within Ontario has a local Crown counsel who is responsible for the supervision and oversight of major cases. This responsibility includes an ongoing assessment of the reasonable prospects of a conviction and whether it is in the public interest to continue with the prosecution. Large complex cases, such as automobile insurance frauds, are assigned as soon as practicable to a Crown counsel who remains with the case until its conclusion, absent exceptional circumstances

The means of providing oversight for large complex cases may vary among jurisdictions within the province, depending on local needs and circumstances. Two of the largest and busiest Crown jurisdictions within the GTA (Toronto and Peel) have taken the additional step of providing ongoing legal support upon request to the fraud/financial crimes unit of their police service in the investigation of such cases.

As well, Ontario has instituted a Major Case Advisory Group that provides resources and assistance across the province for large complex prosecutions.

With respect to education and training, the Ministry of the Attorney General provides ongoing education to Crown counsel on a wide range of criminal offences, including fraud and other types of financial crime. For example:

- in May, 2012, the Ministry hosted a two-day Financial Crimes Workshop in the GTA for Crown counsel that included a presentation on the investigation and prosecution of auto insurance fraud;
- the 2011 Fall conference included training on recent amendments to the sentencing provisions for fraud in the Criminal Code of Canada; and
- the 2011 Crown Summer School included a course on Complex Prosecutions.

Partnerships among organizations

Auto insurance fraudsters may target other benefit paying systems, such as the Workplace Safety and Insurance Board (WSIB) or the Ontario Health Insurance Plan (OHIP) in addition to auto insurance companies. Regulators inside and outside of the auto insurance system should share information and coordinate investigations so that fraudsters cannot continue to abuse different benefit paying systems in Ontario.

We have had several discussions with WSIB to better understand opportunities for coordination between WSIB and FSCO. We are extremely encouraged by the willingness of both organizations to share information about their current practices regarding fraud and how those practices could be improved by coordination with each other.

By building on this positive progress in the coming months we hope to facilitate ways in which FSCO and WSIB can learn much from each other to reduce fraud. In particular, we also believe that increased information sharing between WSIB and FSCO could result in more fraud prevention.

Just as regulators and other government organizations must collaborate on fraud prevention, organizations from outside the government must also work together. IBC's Pollara survey found that Ontarians are not sure who to contact if they want to report auto insurance fraud. With that in mind, we invited the Ontario Association of Crime Stoppers to meet with our Consumer Engagement and Education Working Group to discuss how Crime Stoppers has been successful in encouraging individual Ontarians to report suspicious activity.

After observing our Working Group's interest in how the Crime Stoppers model could be used by the insurance industry, IBC engaged Crime Stoppers outside of the Task Force setting. Discussions are under way to create a working Memorandum of Understanding (MOU) between the two organizations that would designate Crime Stoppers as the official tip line for reporting insurance crime. This would provide the insurance industry with Crime Stoppers' high recognition factor and strong reputation, as well as delivering the advantage of Crime Stoppers' 24-hour multi-lingual service. We welcome this cooperation and are hopeful that it can lead to more consumers becoming engaged in the fraud prevention process and further collaboration between groups interested in reducing fraud.

HCAI anti-fraud tools

Health Claims for Auto Insurance (HCAI) is an electronic system for transmitting auto insurance claim forms between insurers and healthcare facilities in Ontario. HCAI's anti-fraud potential has been recognized by many different groups, including the government, health care practitioners and the insurance industry. We created an HCAI Anti-Fraud Working Group to bring these groups together to consider ways that HCAI might be used to combat fraud.

Cooperation between the different members of the HCAI Working Group has helped facilitate three different anti-fraud initiatives:

1. Professional Credential Tracker
    - The Professional Credential Tracker (PCT) helps health care practitioners prevent their identities from being stolen by fraudulent health care facilities. Practitioners using the PCT will see which facilities are using their professional credentials to bill insurers and report any suspicious activity to their health regulatory college.
    - The PCT has successfully undergone two phases of testing (see below). Further testing of the PCT by two more major groups of health care practitioners is being pursued through discussions with the appropriate regulatory colleges.

HCAI Professional Credential Tracker
Initial Testing Results

The initial phase of Professional Credential Tracker (PCT) testing was done through a sample group from the College of Audiologists and Speech-Language Pathologists of Ontario. A second phase involved a sample group from the College of Psychologists of Ontario.

The sample groups were surveyed after the conclusion of each testing phase. The survey of the sample group involved in the second phase of testing revealed that:

- At the end of the testing period, 14% of the participants reported finding that their credentials were being used at clinics they did not recognize.
- More than 90% of the participants stated that they would run a report from the PCT at least once a year.
- More than 95% of the participants stated that the PCT report was either “very” or “somewhat” easy to understand.
- Nearly two-thirds of the participants included positive comments about the PCT initiative in their feedback.
- Only 22% of the participants had an accurate understanding of their information on the use of their credentials prior to using the PCT.

2. Personal Identification Number Development

    - Creating a Personal Identification Number (PIN) for regulated health care practitioners using HCAI will increase HCAI’s anti-fraud potential. A PIN would also make the Professional Credential Tracker easier to use and more accessible for individual practitioners. The HCAI Anti-Fraud Working Group has recognized the value of adding PIN capability to HCAI and is currently developing a project plan that will require sources of funding to be identified prior to implementation.

3. Business-to-Business Statements

    - HCAI business-to-business statements summarize invoicing activity between an insurer and a health care facility in a given month. The statements allow insurers and health care facilities to identify any suspicious anomalies in their monthly invoicing activity.

- Business-to-business statements have been fully implemented by HCAI. Statements listing invoices submitted in a given month, who they were submitted by, and what services were covered are now being sent to insurers and health care facilities.

In the Interim Report we recommended that the HCAI Anti-Fraud Working Group consider additional ways for HCAI to be used as an anti-fraud tool. We are encouraged by the progress made on our recommendation and by the collaborative efforts among the insurance industry, health care practitioners and government within the HCAI Working Group that have made that progress happen.

Industry actions

Investment in technology has not been limited to further developing HCAI as an anti-fraud tool. We noted in the Interim Report that a group of companies had developed an anti-fraud initiative, on a pilot basis, that uses highly sophisticated data analytics to identify potentially fraudulent claims.

The insurance industry has made encouraging progress on this initiative since the Interim Report was made public. The project has moved past its pilot phase and has added more companies to its list of participants. The companies are now working with IBC on an implementation strategy that will allow the technology to reach its full potential as an anti-fraud tool. The plan is to develop and implement an industry-wide solution, which will be supported by IBC's Investigative Services Division and other financial service organizations, to detect and prevent insurance fraud through the use of sophisticated analytical tools that would identify fraudsters that target multiple insurers.

Insurers plan to provide claims information into a database which is then scored using social network analysis and predictive models to help identify suspicious links between claims made with different insurers. Information suggesting fraudulent activity will then be confirmed through further investigation by IBC in partnership with member insurers.

We support this initiative and believe that it has great potential to identify organized and premeditated fraud in a timely way. We discuss further aspects of this below, when we consider the results of the research that has been conducted on the extent of fraud, and issues we are pursuing to assist detection of fraud.

The industry has also increased its efforts to engage and educate consumers about insurance fraud. For example, IBC used Fraud Prevention Month (March) to initiate an anti-fraud campaign involving coverage in broadly distributed industry and community media; participation in industry panels and community events; news releases and social media content.

We are encouraged by the industry's demonstrated commitment to reducing fraud and the partnerships formed to achieve this goal.

Police training

York Regional Police, IBC, and the Canadian Police Knowledge Network (CPKN) have joined to develop an online training course for frontline officers. This course — *Identifying Staged Collisions* — uses videos to illustrate common types of staged collision scenarios and describes the various signs, indicators, and behaviours that may characterize a staged collision. CPKN and IBC have together sponsored a period of free access to the course for all Canadian police officers until Dec. 31, 2012, after which a moderate fee will be charged to recover costs.

As well, the Ontario Police College, in consultation with the Ontario Traffic Council, developed and launched a new "Traffic Officers Course" in March 2012. This course addresses a range of issues, including staged collisions and fraud investigations involving motor vehicles and was developed to assist front line officers and patrol supervisors. IBC has made a presentation to the first group of students.

Fraud-related research commissioned by the Task Force

We report here on three major pieces of research that we have commissioned. Two have recently been completed and one is still under way. They are all helping to inform our work.

Scope of fraud research

As we indicated in our Interim Report, IBC engaged KPMG Forensic to conduct a study aimed at estimating the extent of auto insurance fraud in Ontario. This study was provided to the Task Force and is available online.[12]

[12] http://www.ibc.ca/en/Insurance_Crime/index.asp

For many years, and in many contexts, observers have commented that the cost of auto insurance fraud in Ontario is $1.3 billion annually. In our December 2011 report we commented that we could find no basis to give us confidence in the credibility of that number, and we welcomed the KPMG study as an opportunity to provide a fresh view of the extent of the problem. We also engaged Ernst & Young to provide the Task Force with an independent assessment of the KPMG methodology and results.[13]

The KPMG study concluded that "there is insufficient information to provide a precise and statistically based estimate of auto insurance fraud in Ontario." The study did, however, provide a wide range for the scope of fraud. It estimated that the cost could range from 9-18% of annual claims costs, which in 2010 would have amounted to between $769 million and $1.56 billion. KPMG calculated the impact of this estimate of fraud on the average auto insurance premium in the province to be between $116-236 in 2010.[14]

The approach taken by KPMG was to review information available from a broad range of sources, including studies conducted by others in Ontario, Canada, the United States, the United Kingdom, and Australia. KPMG also reviewed three different proof-of-concept projects recently conducted by groups of insurers to apply sophisticated data analysis techniques to samples of auto insurance claims to identify suspected cases of fraud. The KPMG study assesses the available information, and outlines the very real difficulties of deriving a single, meaningful and credible estimate of the extent of fraud.

[13] Ernst and Young's assessment is also available at http://www.fin.gov.on.ca/en/autoinsurance/forensic-ey.html

[14] KPMG Report, p. 58

KPMG primarily used the data analytics studies, which combine claims information from participating companies with highly sophisticated tools that can identify suspicious patterns between claims, to develop an estimate of the extent of organized fraud in Ontario. Their report notes that these studies were undertaken by insurers to test the use of fraud identification technologies in their businesses, and not for research purposes. Although the data analytics studies were not designed as fraud research projects, KPMG was able to extrapolate results from two of the three studies to estimate the scope of organized fraud. However, it is important to stress that design limitations, in KPMG's view, made the extrapolations consistent underestimates of the true extent of organized fraud. While recognizing this problem of underestimation, as well as the importance of providing some quantification, KPMG noted that, on the basis of its review of these studies, organized fraud in Ontario was at least in the range of $175-275 million in 2010. KPMG concluded, with respect to the data analytics studies that:

> "…(they) provide a well-structured and significant review of claims data resulting in a quality, if understated, estimate of organized auto insurance fraud in Ontario."[15]

In making its conclusion regarding organized fraud, KPMG noted many specific reasons why the range it found was likely an understated estimate of organized fraud's scope in Ontario.[16] These included:

- The studies were established with specific protocols that excluded certain types of claims from being reviewed for suspicious patterns. For example, one study did not include claims information that had already been identified as suspicious by insurance company investigators.
- Data analytics studies are most effective when using data from an entire industry. The studies used by KPMG only had access to information from a subset of companies within the Ontario auto insurance industry.
- The studies were limited to auto insurance claims information. Information from other types of insurance, such as property insurance, would have improved the ability of the data analytics tools to find suspicious patterns.

[15] KPMG Report, p. 53.

[16] KPMG Report, pp. 52–53.

As noted above, Ernst & Young was also engaged to provide an independent assessment of KPMG's work. Ernst & Young has completed a preliminary assessment of KPMG's report in which it also agrees that organized fraud is likely greater than the range estimated by the data analytics studies used by KPMG.

In addition, Ernst & Young indicated that KPMG's report may significantly underestimate the extent of overall auto insurance fraud in Ontario because it does not specifically address premeditated fraud, which, as Ernst & Young noted, could range between $130 to $260 million per year. Combining this estimate of premeditated fraud with KPMG's understated estimate of organized fraud, creates a value of organized and premeditated auto insurance fraud in Ontario of between $305 to $535 million per year (which itself should also be viewed as an underestimate).

Ernst & Young also indicated that they believed KPMG's estimate of opportunistic fraud in relation to non-injury claims could be refined.

As a result, Ernst & Young's report indicated that if these issues were addressed in a comprehensive manner, the resulting estimate of the cost of auto insurance found by KPMG would not be unreasonable. We will be receiving a more comprehensive final report from Ernst & Young, which we will encourage the government to make public, before we submit our final recommendations.

Jurisdictional research

In order to better understand how other jurisdictions were dealing with auto insurance fraud, the Task Force engaged Deloitte to conduct a series of jurisdictional scans. These covered anti-fraud practices in six key jurisdictions outside of Ontario — Alberta, British Columbia, Florida, Massachusetts, New York and the United Kingdom. The jurisdictional scans were confined to identifying and briefly reviewing publicly available information. The scans were focussed on the work of the three Task Force Working Groups. Each Working Group developed a series of specific questions regarding its own mandate[17] and Deloitte used these questions as guidance in assessing available material in the relevant jurisdictions.

[17] The three Working Groups focused on Consumer Education and Engagement; Prevention, Detection, Investigation and Enforcement; and Regulatory Practices.

Deloitte presented three reports to the Task Force, one related to the substance of each of the three Working Groups. The executive summaries of each report are publicly available on the Ministry of Finance website.[18]

Research on the licensing/regulation of clinics

In the Interim Report we identified the licensing/regulation of health clinics in the auto insurance system as a major issue the Task Force would review. To assist us in this effort, we have engaged Willie Handler and Associates, an advisory firm with considerable expertise on Ontario's auto insurance system. An interim report[19] has informed our evolving position on the licensing and regulation of facilities that provide health-related services to auto insurance claimants and insurance companies. The next section of this Report sets out our current thinking on this issue, for consideration and comment.

[18] The three executive summaries are available at:

http://www.fin.gov.on.ca/en/autoinsurance/juris-pdie.html

http://www.fin.gov.on.ca/en/autoinsurance/juris-rp.html

http://www.fin.gov.on.ca/en/autoinsurance/juris-cee.html

[19] http://www.fin.gov.on.ca/en/autoinsurance/regulatory-model.html

STATUS OF ONGOING ISSUES

Introduction and Context

The Interim Report presented a list of major issues to be considered by the Task Force. The list was an outline of some higher profile issues to be examined, rather than an exhaustive agenda. Raising these issues in a public report encouraged interested parties to provide us with relevant and helpful information. We look forward to continuing this dialogue as we develop recommendations to be included in our Final Report.

The status report below draws heavily on the conclusions and recommendations of the three Working Groups that have been assisting the Steering Committee. We appreciate the advice and input of the many public servants, representatives of organizations and individuals who are assisting us. Their participation has been not only valuable but essential to our work. It is important to emphasize, however, that the conclusions and recommendations in this report are those of the five independent members of the Steering Committee, and we take full responsibility for them.

The material below is presented as a basis for further input, as we move towards our Final Report in the fall of 2012. We are anxious to have submissions from interested groups and individuals on the issues and directions we identify, and we intend to provide an opportunity for presentation and discussion of this report in the coming weeks.

The issues below and our thinking about how to deal with them are influenced by an overall set of conclusions about auto insurance fraud that we share, and we believe it will be helpful to set out specifically some of the main elements that are shaping our approach. These are:

- Auto insurance fraud is a serious issue in Ontario and it has grown in scope over the past several years. KPMG's study reported that fraud could cost between $769 million and $1.56 billion annually. We believe that organized and premeditated fraud have contributed to a recent growth in insurance claims costs that has been concentrated in the GTA. KPMG's study estimated the cost of organized fraud to be at least $175-$275 million in 2010, based upon very conservative assumptions.

- The cost of fraud is having an appreciable impact on premiums, and organized aspects of auto fraud (such as staged collisions) also threaten public safety.
- Our work should be focused primarily on reducing the extent of organized and premeditated fraud. Opportunistic fraud is also important, but the limited number of studies that exist confirms our intuitive view that opportunistic fraud tends to be relatively constant over time and across jurisdictions[20]. While it appears to be substantial, we believe that it is most effectively dealt with through consumer engagement and education, the design of the auto insurance product, the use of evidence-based approaches to treating collision victims and individual companies developing and implementing their own anti-fraud policies.
- Organized and premeditated fraud is different. It goes beyond the opportunistic padding of legitimate claims to fabricating new claims or billing insurers for medical services that were never provided to a claimant. To deal with organized and premeditated fraud effectively requires a coordinated approach among companies and new anti-fraud tools. Our focus is on providing a framework for that coordination and the tools to do the job.
- While it is important to diligently investigate suspected fraud and prosecute where appropriate, it is more effective in the short term to implement measures that can reduce the economic incentive to act fraudulently. This involves ensuring that we have in place a system where organized and premeditated fraud can be detected quickly and, where investigations warrant, effective action can be taken to interrupt the flow of income to fraudsters.
- The product design of auto insurance can also influence the extent to which fraud and misuse takes place, particularly where eligibility requirements for benefits may be overly dependent upon subjective criteria. In this regard the Task Force thinks it is important for the government to continue to pursue changes to the auto insurance system based on scientific and medically-based evidence.

These broad conclusions inform our thinking about the issues and the recommendations we will ultimately make. In considering the following update on individual issues we ask the reader to keep in mind this overall thrust of our approach.

[20] See, for example, KPMG Report at p. 59.

Licensing and regulation of health clinics

We are convinced that a licensing and regulation regime for health clinics treating auto insurance claimants is appropriate and necessary. We have received relevant presentations from individual health care practitioners, the Alliance of Community Medical and Rehabilitation Providers, the Coalition Representing Health Professionals in Automobile Insurance Reform and the Federation of Health Regulatory Colleges of Ontario (FHRCO).

We are considering whether the regulatory regime we recommend for health clinics should also apply to other commercial enterprises that provide independent medical assessments (IMEs) to insurers or to claimants.

While we have not concluded on a specific model to recommend, we are in broad agreement on certain basic objectives and operational characteristics that should guide our decision.

We see four objectives that a licensing/regulatory regime should achieve: transparency; accountability; verification; and sanctions.

> **Transparency:** We do not feel it is necessary to restrict ownership of a clinic to a regulated health professional (RHP), but ownership of a clinic operating in the auto insurance assessment or treatment business should be transparent. It may be desirable to institute a "fit and proper"[21] test for clinic ownership, possibly along the lines of that now required for the right to charter and own a regulated financial institution. Transparent ownership will also make apparent issues of conflicts of interest (real or potential). For example, should lawyers or paralegals representing auto insurance claimants be allowed to own rehab clinics? Should doctors who refer patients for rehab be allowed to refer patients to clinics they own and, if so, what disclosure regime should be instituted to ensure that claimants are well informed about potential conflicts? An important consideration in a licensing regime is how such conflicts should be treated.

[21] Generally, "fit and proper" tests are used to assess the suitability of prospective owners of regulated financial institutions. These tests include an examination of the applicant's past record as a business person, the soundness of their business plan and the reasons why they wish to get into the particular line of business. They also seek to assess that applicants have the necessary integrity and fitness of character. These tests help ensure that key shareholders are not a source of weakness to the regulated institutions. See Reforming Canada's Financial Services Sector, Finance Canada (1999), http://www.fin.gc.ca/finserv/docs/finservrept_e.pdf , p. 16.

Transparency also extends to business practices. In particular, with regard to independent medical examinations (IME's) we are considering whether the regulatory regime for assessment providers should mandate disclosure of the schedule of fees paid to regulated health professionals for providing assessments.

Accountability: The regime we will propose will seek to regulate business practices of licensed clinics, to deter fraud and identify it where it occurs. We are not proposing, as part of this initiative, to recommend regulating the professional credentials or methods of regulated health practitioners (RHPs) providing assessments or treatments. This is already done by the regulatory colleges. We do understand, however, from our discussion with FHRCO, that the colleges are resource-constrained and tend to focus their limited resources more on regulating issues that go directly to patient care and safety, rather than the business practices of RHPs. We believe that the recommended regime should have a clear accountability focus – with a designated individual responsible for the integrity of the business processes within the clinic. It has been proposed to us that this might not necessarily be the owner but might be a designated RHP where the owner is not a RHP.

Verification: We would expect the owner or a designated health professional to attest regularly to the integrity of the business practices of licensed clinics. We would also expect records to be kept and available for inspection that would allow such attestations to be audited and verified.

Sanctions: Where business processes are inadequate there should be a range of sanctions available. These could include cease and desist orders, suspension of billing rights through HCAI, restricting an individual's right to own a clinic, and pursuing criminal or civil charges where warranted.

We are considering whether FSCO should be responsible for implementing and overseeing whatever licensing/regulatory regime is recommended. As we move forward with this initiative we are mindful of the need to strike a balance that does not overburden sole practitioners, small clinics, and those clinics whose major activity is not in the area of auto insurance. We welcome suggestions on how to make such a regime as efficient as possible for all concerned, without losing overall effectiveness.

Other possible gaps in regulation

In the Interim Report we identified a number of other regulatory areas that we intended to pursue. These were generally grouped into three areas:

i) regulation of the towing industry;

ii) the scope of FSCO's regulatory authorities with regard to insurers; and whether they should be broadened to include other actors in the auto insurance sector; and

iii) regulations regarding the relationship between insurers and claimants.

Regulation of the towing industry

Since the Interim Report was made public we have continued to gather information about the towing industry and the role it plays in Ontario's auto insurance system. We have found that oversight and enforcement activities around tow truck operations in Ontario are inconsistent across the province, creating uncertainty for consumers and opportunities for fraud organizers, and for tow-truck operators themselves, to exploit. Issues raised include the participation of some tow truck operators in the creation or manufacture of false claims, exorbitant towing fees, and inappropriate referral practices (such as paid referral fees for directing consumers to particular health care, automotive body shop, or legal service providers). Concerns have also been raised about the public safety aspects of some tow trucks competing to be first at the scene of a collision.

The Task Force asked the Regulatory Practices Working Group (RPWG) to examine options that would reduce the potential for practices that may fraudulently inflate insurance costs, while recognizing the important role the towing industry plays in quickly clearing damaged vehicles from roadways, thereby preventing secondary collisions and congestion.

The RPWG established an ad-hoc inter-ministerial committee to help gather information and conduct analysis on the towing industry. The RPWG is continuing research and analysis around the value of greater regulation and a number of regulatory and non-regulatory approaches, including:

- options to address practices that may fraudulently inflate insurance costs;
- broader regulatory options that address not only auto insurance concerns but road safety and consumer protection issues; and
- market-based options.

Within each of these categories, a limited number of specific proposals have been identified for further consultation and discussion. These are described in Appendix 3.

Enhanced authorities for FSCO

The first and most effective line of defence against organized and premeditated fraud is to be able to quickly and effectively cut off the access of fraudsters to the flow of money. We believe that FSCO is well-positioned to do this and, with enhanced authorities and resources, could be more effective than it now is.

We are encouraged that the Government has asked the Legislative Assembly to provide authority to FSCO to levy administrative monetary penalties. As noted above, we also are considering recommending that FSCO have the authority to license/regulate the business practices of clinics providing auto insurance related health care services and commercial providers of independent medical assessments, and to enforce administrative sanctions related to access to HCAI in appropriate circumstances. There are also some additional areas that we are continuing to assess.

First, we are assessing if the range of authorities is prescribed with sufficient clarity that there is no ambiguity about FSCO's scope of authority. Current legislation refers to those "engaged in the business of insurance" and, under some interpretations can be read to mean entities and individuals who supply services to insurance companies. It would seem appropriate to clarify the language to provide greater certainty about who FSCO can require to provide information, examine and penalize for unfair or deceptive acts or practices. We believe that the net should be wider rather than narrower, and intend to make recommendations in this regard in our Final Report. Along the same lines, we are reviewing the scope of the information that the Superintendent can obtain.

Appendix 4 contains a brief description of a number of the regulatory provisions that we are considering in this regard, and on which we would welcome comments.

Second, we will be reviewing the acts and practices that are currently defined as “unfair or deceptive”, as well as the powers and authorities of the Superintendent to investigate them and impose appropriate sanctions. The unfair or deceptive acts or practices (UDAP) provisions apply to persons providing goods or services payable under Ontario’s insurance system. This includes health care and goods and service providers, legal service providers, and auto towing, storage, and repair service providers. UDAP prohibitions that apply to goods and service providers (except legal service providers authorized under the Law Society Act, namely lawyers and paralegals) include: charging for goods or services not provided; requesting, accepting or paying referral fees; and unreasonably excessive charges compared to prices charged for similar goods and services. Additional UDAP provisions that apply to health care goods and service providers and all legal service providers (including those authorized under the Law Society Act) include: use of unapproved insurance forms; and failure to disclose a conflict of interest where required (see Appendix 5 for details).

We would appreciate feedback on whether the unfair or deceptive acts or practices provisions should apply more broadly, for example, consistent application to legal service providers, including those who are authorized under the *Law Society Act* such as lawyers and paralegals.

We want to ensure that the range of practices is as comprehensive as it should be and that penalties associated with these practices are appropriate disincentives. Appendix 5 contains a description of some of the regulatory provisions that we are considering in this regard.

Third, we generally feel that FSCO should be taking a more active role in investigating and prosecuting offences under its legislation. This approach to enforcement should also apply to the use of administrative sanctions. In addition to adequate and appropriate resources, a more active approach will require the receipt of timely information about suspicious claims or unlawful activity. As noted above, the industry is establishing an organization that will work with claims data from individual insurance companies to identify suspicious cases that may indicate organized or premeditated fraud. We will be looking for ways to ensure that FSCO has adequate and timely access to this information, so it can take effective action. We are also impressed with the framework for investigation and prosecution that the Workplace Safety and Insurance Board (WSIB) has put in place, and we are looking at ways to promote the sharing of relevant information about suspected unlawful activity among FSCO, WSIB and possibly OHIP as well.

Regulations governing relations between insurers and claimants

Claimant awareness and behaviour can play a role in combating fraud. A well informed claimant is more likely to advocate on their own behalf and also rebuff attempts to be drawn into fraudulent and abusive situations.

The Interim Report indicated that we would examine a number of recommendations put forward by the insurance industry to assist in deterring and dealing with fraud. These related to relationships between insurers and claimants. The RPWG has considered the list put forward by the industry and the Steering Committee has reviewed and, in some cases, modified the conclusions of the RPWG.

At this point, we would be prepared to recommend regulatory changes in six areas, as set out and briefly discussed below. We are prepared to give further consideration to others that may be suggested.

1. *Require claimants to confirm attendance at treatment facilities*

Insurers have reported being billed for treatments that never took place. In some circumstances the claimant or injured person was unaware this occurred. The Statutory Accident Benefit regulation could be amended to require health care providers and assessment facilities to ask claimants to sign a form each time they receive a treatment. Copies of the forms would have to be kept on file and made available for inspection by a representative of the insurer at the time of audit.

2. *Require claimants to confirm receipt of goods and services billed to insurers*

Insurers have reported being billed for goods and services that were never provided. In some circumstances the claimant or injured person was unaware this occurred. The Statutory Accident Benefits regulation could be amended to require providers of goods and services to ask claimants to sign a form when they receive goods such as an Obus Forme back rest or an orthotic shoe insert. Copies of the forms would have to be kept on file and made available for inspection by a representative of the insurer at the time of audit.

3. *Require claimants to attend up to two examinations under oath upon request of insurer*

Insurers sometimes have difficulty substantiating a claim without additional information that only the claimant could provide. The current regulatory regime requires only one examination under oath and in many cases this examination takes place very early and is directed at establishing which insurer is the responsible insurer where there is more than one company involved and doubt about the facts. Insurers have suggested that once treatment has commenced it would be desirable to allow for a second examination under oath if an issue arises that could not have been anticipated at the time of the first examination, or where the first examination had to wholly be used to establish which insurer was responsible for a claim. As a matter of due process, it is important that additional criteria be established around this proposal to ensure that claimants are treated fairly during the administration of these examinations under oath.

4. *Require a claimant to pay their insurer a $500 fee for missing a medical examination as requested*

Insurers are billed when claimants fail to attend a medical examination arranged by the insurer at an agreed time and place. It has been reported that some legal representatives have told their clients not to attend, and to not give notice. The Statutory Accident Benefits regulations could be amended to require the claimant to pay a fee of $500 toward the cost of the missed appointment when the person has missed an appointment, without giving reasonable notice or without offering a reasonable explanation for failing to give notice in time. It would be up to the insurer, not FSCO, to give the claimant timely and adequate warning of the potential charge, and to collect the money.

5. *Strengthen enforceability of the Cost of Goods Guideline by making direct reference to its application in the Statutory Accident Benefits Schedule (SABS)*

The current SABS does not include a direct reference to the *Cost of Goods* Guideline. For enforceability and as a technical matter, the SABS should refer directly to the Cost of Goods Guideline.

6. *Make it an unfair or deceptive act or practice to request a claimant or injured person to sign a claim form that has been left blank or incomplete*

Insurers report that claimants are at times asked to sign claim forms before the items to be billed to the insurer have been entered. The claimants are often unaware that it is against the rules for them sign what amounts to a blank form. When they do sign, it is easier to exaggerate, misrepresent or fraudulently bill for treatments or for goods and other services without their knowledge. A change in rules would make it a violation under rules governing unfair or deceptive acts or practices to present a blank or incomplete form for signature.

7. *Require insurers to include an itemized list of expenses in the benefit statement sent to claimants every two months.*

The SABS requires insurers to send claimants a benefit statement every two months. Adding an itemized list of expenses to the benefit statement would allow claimants to review specific expenses incurred under their claim and identify any suspicious information. Insurers could also include information about how a claimant can report suspicious activity so that they stop the misuse of their benefits by fraudsters.

Establishment of a dedicated fraud investigation unit

The Interim Report suggested that we would consider whether a dedicated investigative unit, to pursue criminal charges, would make sense for Ontario. As indicated above, we are convinced that the most effective and quickest way to combat auto insurance fraud is through actions to curtail the flow of revenue to organized and premeditated fraudsters. The increased use of sophisticated technology to analyze a large volume of claims information from multiple insurers is a very powerful detection tool for identifying possible cases of organized and premeditated fraud.

We believe that it may well be more effective to focus our enforcement recommendations on provincial offences. We expect that the measures we are considering with regard to FSCO's investigative and enforcement capabilities, and with regard to using HCAI access as a tool to fight fraud, will do exactly that. There are also some additional issues that we believe should be addressed with regard to privacy and insurers' potential liability for reporting highly suspicious claims, about which we will elaborate in the next section.

We understand that the government does not direct police in operational matters and that police conduct an independent investigation and exercise independent discretion with respect to whether they have reasonable and probable grounds to support the laying of criminal charges. We are encouraged by the recent actions that have been taken by Ontario law enforcement, and by the cooperation with industry that has apparently played a role in some of these actions. We believe that further initiatives can strengthen the cooperation that now exists and that such measures can be implemented relatively quickly and effectively.

There are two particular areas that have been identified as having potential to assist the investigation of criminal acts. The first has to do with the transfer of evidence from investigators in insurance companies, IBC, or FSCO to law enforcement, and the second relates to the involvement of provincial Crown counsel.

Transfer of evidence to law enforcement

The industry has identified police resources as a challenge in reporting alleged insurance fraud to police for investigation as police must prioritize cases based on a number of criteria. However, there are examples of areas within police services that provide specialized supports for such types of crime. The OPP Anti-Rackets Branch is responsible for the investigation of major organized crime, which may include organized crime rings that perpetrate auto insurance fraud. The Anti-Rackets Branch has linkages with other police services and Crown counsel who are available to provide pre-charge legal advice, upon request. Certain large police services may also have units that deal with such crimes. For example, the Toronto Police Service has a Financial Crime Unit; Peel Regional Police has a Fraud Bureau and the Royal Canadian Mounted Police (RCMP) has the Commercial Crime Section which investigates major fraud.

Police may also utilize joint forces investigations between police services for specific investigations that cover several jurisdictions. Additionally, the OPP, the Toronto Police Service and other police services participate in a Combined Forces Special Enforcement Unit (led by the RCMP) to investigate organized crime.

Through the synergies created by the Task Force, and in particular, the Working Group on Prevention, Detection, Investigation and Enforcement, police forces in the province (including the OPP) can explore the feasibility of working together to illustrate best practices so that the transfer of appropriate evidence in such cases can be facilitated. A strategy could be contemplated that would improve the evidence provided to police for investigations, while improving the identification of major criminal fraud rings. Such a strategy could:

- enhance public and media awareness of the issues associated with auto insurance fraud;
- support cross-force and cross sector joint force collaboration involving police and IBC, in identifying and investigating major fraud rings in areas where fraud is most severe;
- provide a tactical priority driven roll out of enforcement that will target the largest and most severe criminals and groups involved in auto insurance fraud;
- wind down at the end of three years, with the dissemination of best practices to police, stakeholders, and public; determine next steps; and,
- take full advantage of any new industry-established data analytics organizations in identifying major rings, narrowing the investigative focus while improving the evidence provided to police in the pursuit of criminal investigations.

We believe it would be very helpful if police forces, particularly in the GTA and with the cooperation of the OPP, would explore the feasibility of developing a joint force collaboration strategy to create public awareness, develop a law enforcement response and provide tactical priority-driven enforcement. We hope that in our final report we are able to report that such an initiative is under way.

Continuity of provincial Crown counsel

Insurance industry representatives have urged that the government establish an insurance fraud investigation and prosecution bureau with designated Ministry of the Attorney General prosecutors to promote consistency of Crowns for the entirety of a case.

Our system in Ontario is not designed or resourced to provide such ‘dedicated’ Crown counsel, except in rare and special circumstances. Crown counsel and police have separate and distinct roles in the investigation and prosecution of crime. The separation of the investigative and prosecutorial roles of the state is an important safeguard to ensure impartiality and fairness in the administration of criminal justice.

The Criminal Law Division of the Ministry of the Attorney General has for several years instituted best practices with respect to major case management, which would include large and complex fraud cases, such as some auto insurance fraud allegations. Where there is a reasonable prospect of conviction and it is in the public interest to proceed, such cases are assigned to a Crown early, and efforts are made to retain the assigned Crown counsel until the prosecution is completed, absent exceptional circumstances. While we do not believe that ‘dedicated’ Crown counsel are required or essential, we do recognize that investigations take time, that Crown counsel are available to provide pre-charge advice to police when necessary, and that once charges are laid the continuity of Crown counsel is important. We urge the Ministry of the Attorney General to continue to ensure continuity wherever possible and particularly in large, complex fraud cases.

Related issues: privacy and civil immunity

A critical requirement for effective investigation and enforcement of organized and premeditated fraud is early identification of suspicious cases. We have noted at several points the power of data analytics to identify rings when fraudsters target more than one insurance company. Data analytics have been used successfully as a fraud identification tool for some time in the United States and the UK, and KPMG’s research report recognizes that three proof-of-concept exercises in Ontario have yielded extremely positive results. We believe that it is highly desirable for the industry to move forward quickly and decisively to put in place the organization, governance and management to make effective use of this powerful anti-fraud tool.

There are a number of challenges that the industry is addressing, including the desirability of ensuring that the pooled data-base is as comprehensive as possible. Ideally, all insurers would opt to participate.

There are also some public policy issues that need to be addressed to make this fraud identification tool as effective as possible.

The first is privacy legislation and the possibility of finding appropriate ways to allow the pooling of data to identify fraud, while still respecting essential aspects of personal privacy. This has been a serious concern in the proof-of-concept exercises and has limited the participation in those exercises and the effectiveness of them. Bill C-12, which would amend the federal privacy legislation (the *Personal Information Protection and Electronic Documents Act*), contains provisions that would be very helpful in facilitating broad participation in fraud detection exercises. The Bill has had first reading in Parliament and moving it forward would provide a helpful degree of certainty.

An option that is being examined in Ontario is to consider whether the consent provisions embedded in applications for auto insurance and applications for benefits in the event of a collision might be amended in a way that would be consistent with privacy legislation but provide greater certainty about the ability to share information for the purpose of detecting and preventing fraud. FSCO is considering changes and we are working to develop an approach that will allow consultations with the industry before we conclude our Final Report.

The second issue is civil liability. Industry representatives have expressed a concern that disclosure of suspicious activity to other insurers, regulatory agencies such as FSCO and to law enforcement may expose them to civil liability. The industry has requested that consideration be given to enhancing civil immunity provisions when dealing with highly suspicious claims.

Ontario's *Insurance Act* already provides civil immunity protection in relation to disclosures and statements to certain named entities. Section 446 provides:

> **446.** A person who in good faith makes an oral or written statement or disclosure to the Tribunal, the Superintendent, an employee of the Commission or any other person acting under the authority of this Act that is relevant to the duties of the person to whom the statement or disclosure is made shall not be liable in any civil action arising out of the making of the statement or disclosure.

The jurisdictional scan completed by Deloitte identified several jurisdictions where immunity provisions existed. None of these provided blanket immunity but they did provide protection in a broader range of circumstances than is contemplated in Section 446 of the *Insurance Act*. We are considering a recommendation that Section 446 of the Act be reviewed with a view to broadening its scope by adding a new subsection that could provide that immunity from disclosure to prescribed persons or entities with regard to fraudulent insurance activity.

An additional benefit of a greater degree of immunity might be the facilitation of police investigations. Police have reported to the Prevention, Detection, Investigation and Enforcement Working Group that, in addition to the resource constraints associated with taking on large, complex fraud investigations, there may also be a lack of substantiated evidence to support opening an investigation. For example, writing warrants and/or production orders can be very resource intensive and require evidence that we have been told insurance companies are sometimes unwilling to provide to police because of concerns that this may expose the company to civil liability. Enhancing civil immunity provisions within the *Insurance Act* could address this concern.

Development of a consumer engagement and education strategy

Informed consumers are vital to fraud prevention in Ontario's auto insurance system. Collision victims with a clear understanding of their auto insurance policy and what to expect when involved in a collision are decidedly less vulnerable to exploitation by fraudsters. Actively engaging consumers so that they can detect and avoid being used in a fraudulent scheme will be an important part of our overall anti-fraud strategy.

We intend to recommend in our Final Report that the key partners in Ontario's auto insurance system — including government, industry and regulators — introduce and support a comprehensive consumer-focused strategy. The strategy will aim to educate consumers and engage them more actively in auto insurance decisions that affect them, including ways to understand and combat auto insurance fraud.

The elements of this comprehensive strategy are being developed by the Working Group on Consumer Engagement and Education. The strategy would consist of three key elements:

i) providing essential information at critical times;

ii) making available a specialized website to assist all Ontario drivers, but particularly auto insurance claimants; and

iii) requiring insurance companies to disclose information that may assist consumers when choosing their insurer.

Each of these is discussed below.

Essential information at critical times

The Working Group has identified a number of “learning moments” for drivers, when they are most likely to absorb essential information about auto insurance and auto insurance fraud. These moments include, for example:

- reporting collisions;
- having a vehicle towed;
- visiting a Collision Reporting Centre;
- receiving the now-mandatory 60-day benefit statement issued by insurers to claimants;
- purchasing or renewing an insurance policy;
- receiving or renewing a driver’s licence or vehicle registration; and
- other identified times when consumers are looking for information and would be receptive to receiving it.

It is important to educate consumers about what it is they can do when they encounter what appears to be fraudulent behaviour. The Working Group is looking at existing channels for interested consumers to communicate concerns, As well, the industry is pursuing possible partnerships with existing organizations to pool efforts to facilitate “whistle-blowing” by individuals in Ontario. In addition, there are other options to enhance whistle-blowing through legislation or regulation. For example, Bill 41, introduced by MPP Amrit Mangat, contains legislative provisions intended to protect whistle-blowers from retaliation. The bill has carried Second Reading in the Legislature and we will continue to monitor its progress as it is considered by the Standing Committee on General Government.

This element of the strategy, when fully developed, will identify these opportunities, the nature of the information that could be effectively delivered and the delivery mechanism. A working draft of a matrix that illustrates how this element of the strategy is evolving is attached as Appendix 6.

As this element of the strategy continues to evolve, specific content will be developed for the key learning moments identified by the Working Group. The content should be developed with two key considerations in mind:

- the dedicated website being developed by the Working Group must be integrated into content created to engage and educate consumers at key learning moments.

- consumer engagement and education approaches used at key learning moments in Ontario's auto insurance system should be sensitive to the diverse population of the Greater Toronto Area (GTA).

Dedicated website

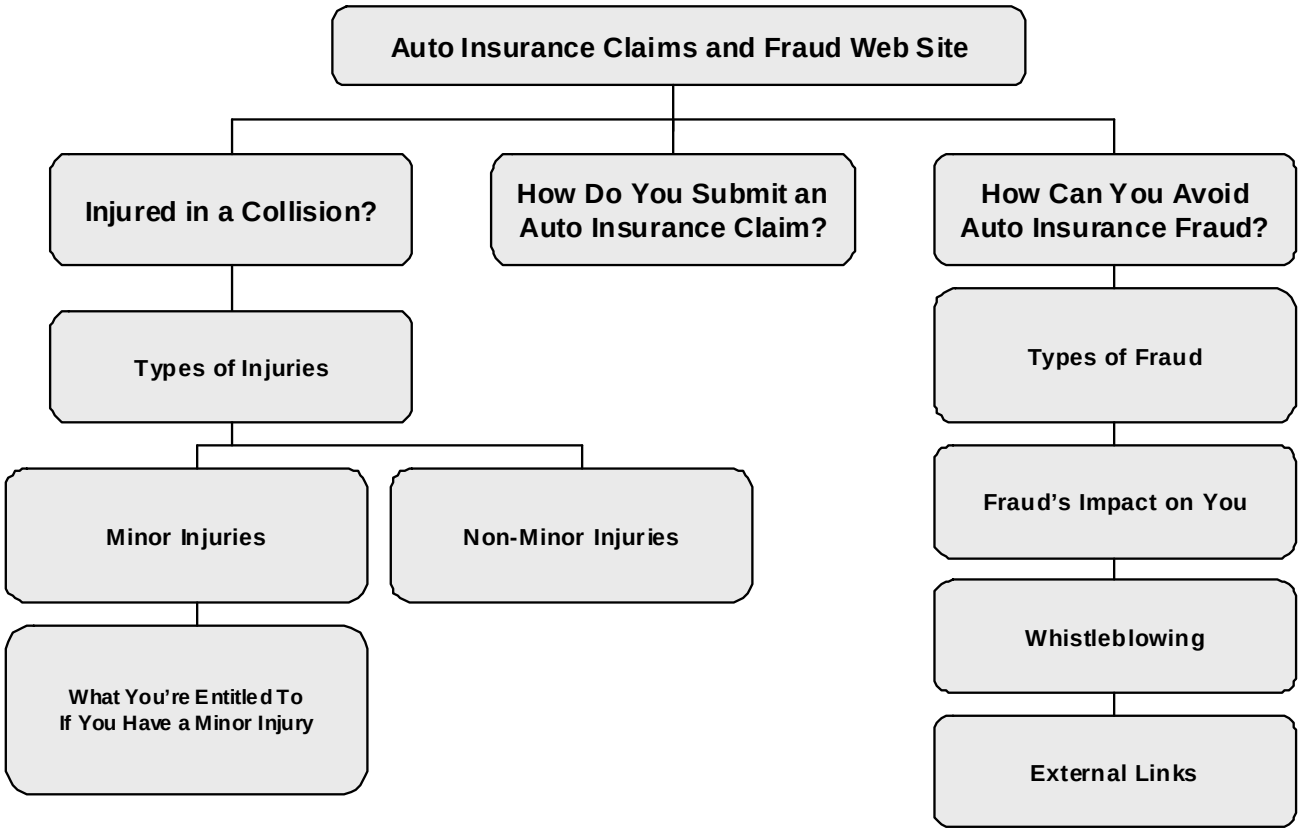
The second element of the broad strategy will be the implementation and maintenance of a dedicated website. In the Interim Report, we asked the Working Group to review the idea of creating a website that could provide important information to Ontario drivers and collision victims.

The Working Group has developed a draft site map that outlines potential information that could be provided on such a site. The site map is based on the Working Group's objectives of providing consumers with information about:

- what to do if they've been involved in an collision;
- what to expect if they've been injured in an collision; and
- the information they require to avoid and prevent fraud as they go through the claims process and recover from an injury.

The website would link consumers to existing and relevant information available on government, insurance industry and other appropriate websites, as well as provide new information where required. In order to drive traffic and promote the site, any communications materials developed under the broad communication strategy would link to this site or provide information about it. The diagram below provides a schematic of the type of content that the site could contain.

POTENTIAL AUTO INSURANCE WEB SITE CONTENT



A number of key questions are now being considered by the Working Group, specifically:

- where the site should be located;
- who would be responsible for creating and maintaining its contents; and
- what costs would be associated with it.

We welcome feedback from industry organizations that provide information to consumers and from consumers themselves regarding the Working Group's approach to this issue. The Steering Committee has asked the Working Group to make recommendations on these issues to the Task Force by the end of July.

Regulatory disclosure obligations

As part of the consumer engagement and education strategy we are considering recommending mandatory disclosure by companies of certain information that will assist consumers in their purchasing decisions. It is currently relatively easy for consumers to make price comparisons when shopping for auto insurance. However, there is little consumer-friendly information available to find out how a company would handle a claim should they need to make one.

We are considering requiring companies to disclose information on their website that would help potential customers understand how a company's claims process would work. At a minimum, we are considering new requirements for disclosure on company websites regarding:

- complaint-handling procedures;
- whether they have preferred providers that they deal with for services such as independent medical assessments, health care, towing services, auto repair shops, and others who might be providing claimant services in the event of a collision; and
    - where they do have preferred providers, that they identify them on their website and disclose the criteria and internal processes they use to select preferred providers;
    - where they do not have preferred providers, identify the criteria and processes they use to select providers who will be involved with the claim, including in particular those who provide independent medical assessments to the company.

As we continue to stress, fraud affects everyone and we believe that each of us has a role to play in helping to combat it. Information is essential to allow consumers the ability to play that role. The type of information we are considering requiring will help consumers in their purchase decision and in better understanding what they might expect should they be involved in a collision. It will also help all involved with the industry identify "best practices" and, hopefully, over time raise the bar in a way that makes it more difficult for organized and premeditated fraudsters.

We welcome comments on this proposed initiative and, in particular, suggestions for additional disclosure that might be helpful.

Our Final Report will contain recommendations for the implementation of the Consumer Engagement and Education Strategy outlined above, including our views about accountability for implementation, resourcing, and the necessity for periodic evaluations of the strategy to ensure that it is well focussed and providing value.

Other Issues

This section reports on a number of other issues that have been brought to our attention over the course of our work.

Collision Reporting Centres and reporting forms

Under the *Highway Traffic Act*, individuals involved in a motor vehicle collision that results in injuries and/or damage are required to report to the nearest police service. Police services are required to collect this information for the Registrar of Motor Vehicles.

A driver involved in a collision where the damage is more than $1,000 may report the collision to a Collision Reporting Centre (CRC), a facility created to help motorists report collisions when their vehicle has been damaged but no physical injuries have been suffered.

Ontario has two Collision Reporting Centre models - those run by police services and those run by a private company, Accident Support Services International (ASSI), which collects the required information when a police service has delegated the requirement to collect information. Private insurers pay a fee to ASSI for access to the Collision Reports and ASSI is required to comply with privacy legislation in the sharing of information with insurers.

CRCs run by ASSI use a number of tools to help detect auto insurance fraud, including a database called Collision Reporting and Occurrence Management System (CROMS). CROMS retains information about vehicle ownership, drivers' licences, and liability cards as well as digital photos and measurements of reported collisions.

While CRCs operated by police services do not have access to CROMS, ASSI has indicated its willingness to make CROMS available to all police services free of charge. We understand that each police service would need to determine whether it needs CROMS and how feasible it would be to use it. This would involve an assessment of legal, policy and financial implications, but we are encouraged by ASSI's willingness to share this important anti-fraud tool and encourage all parties to continue working together to enhance the effectiveness of CRCs in combating fraud.

The Task Force has also been informed that the Ministry of Transportation (MTO) has a project under way which will eventually replace paper-based collision reporting forms with a new e-Collision system, designed to accept statements from witnesses, drivers, and police officers as well as a variety of documents, including photos and diagrams. The project, expected to be complete in fall 2012, will accommodate electronic transfer of collision reports and provide a web application for interested police services to use in-station and, in future, in-car for direct entry of collision data. The objective is to provide a flexible electronic reporting system that can meet the needs of many stakeholders and allow more extensive data capture of information about the collision than the current paper based forms allow. MTO has been working with police services and stakeholders in the development of this tool.

Abuse of the Repair and Storage Liens Act

The Task Force received a submission from Mr. Lawrence Gold, discussing abusive use of rights under the *Repair and Storage Liens Act* (RSLA) to place a lien on stored vehicles in order to charge excessive fees. Our understanding is that the Ontario Bar Association has a RSLA reform committee that intends to make recommendations to the government later this year with respect to possible changes in the Act.

Independent medical examinations

The Task Force received a number of submissions regarding the credentials and qualifications of individuals providing independent medical examinations (IME's) to both claimants and insurance companies. The general thrust of these submissions was to deplore a perceived lack of objectivity and scientific basis for assessments, particularly those dealing with soft tissue injuries and chronic pain. We heard that the adversarial nature of the system encourages "advocacy" rather than "objectivity" by assessors and that this is the case for both claimant and insurance-company assessors.

Recommendations made to the Task Force covered a broad range of topics, including:

- requiring independent medical examiners to obtain formal training and credentials in order to offer such services;
- the formation of a new academic institute dedicated to both scientific integrity and clinical excellence which, among other tasks, could develop standards for IME's;
- standardized forms for completion of IME's and new attestations by assessors with respect to their qualifications and objectivity.

Although we believe that standards of competency and accountability are good things, the broad questions of qualifications, standards and competencies of independent medical assessors are beyond the scope of our mandate and we do not feel competent to make recommendations in this regard.

We believe that our recommendations with respect to the regulation of companies providing IME's and with respect to industry disclosure about how assessors are chosen will provide more transparency and accountability in the system. We are also considering, as part of this regulatory framework, requiring an attestation from an organization performing IME's that all medical examiners are qualified and operating within their scope of competency.

Resource implications for FSCO

Throughout this report we have discussed anti-fraud policies that would expand FSCO's role in Ontario's auto insurance system, but we are aware that any expansion of FSCO's role would be ineffective without the necessary resources. New anti-fraud initiatives will not achieve meaningful results without adequate levels of funding and staff to implement them.

A significant number of the recommendations we are considering are directed to FSCO as the regulator of the auto insurance system. In particular, recommendations regarding the regulation of health care treatment and assessment facilities and expansions to FSCO's investigative authority – if implemented – would carry significant resource implications. It is necessary that FSCO be provided with the requisite staff and expertise to assume these new regulatory activities. In this regard we suggest that the government consider allowing FSCO to hire new staff as necessary, particularly since the insurance sector would be absorbing the additional costs associated with new resources.

NEXT STEPS

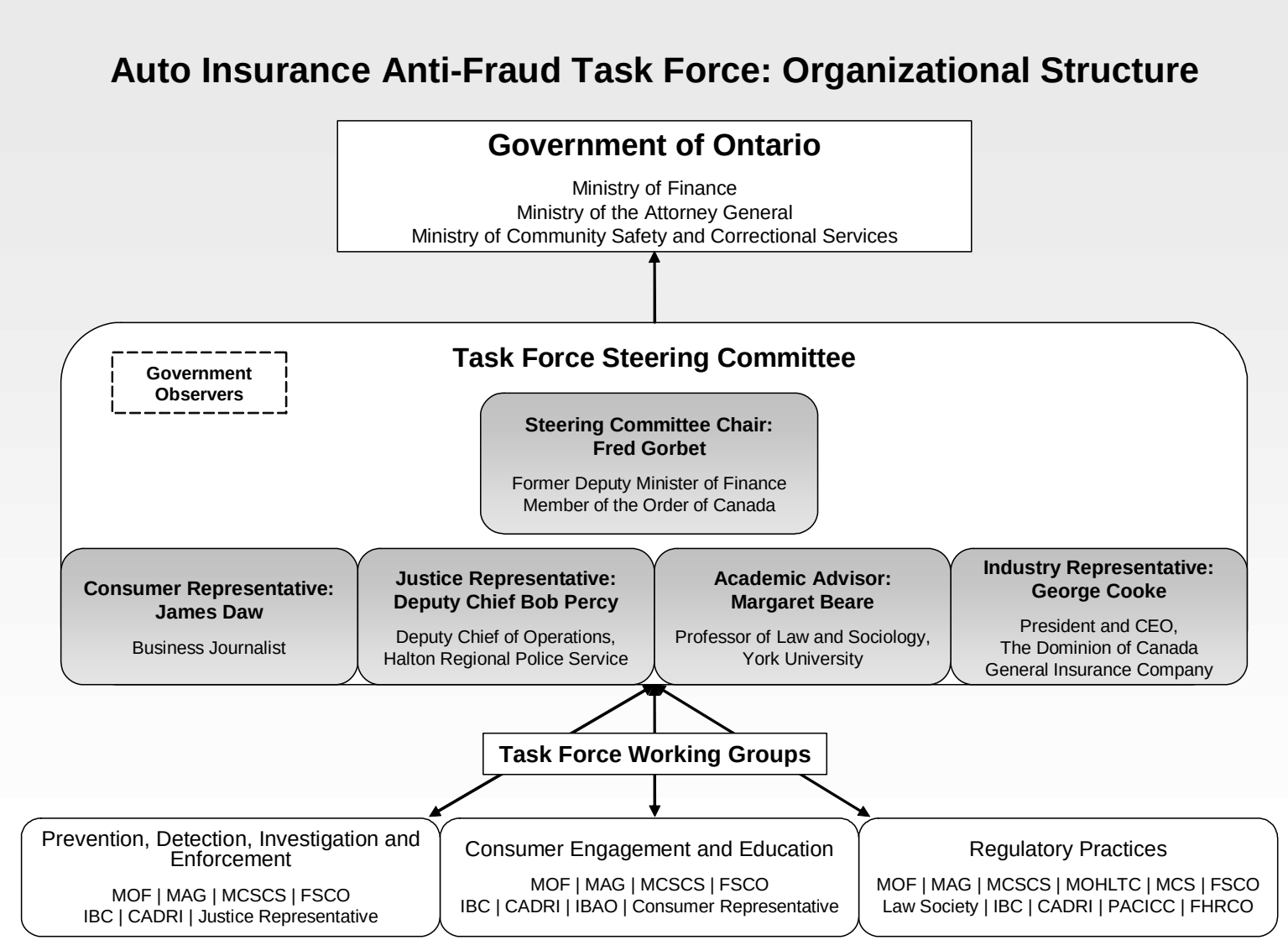
Over the coming months we will continue to refine and develop the issues identified above. Our target is to make recommendations to the government and others, where appropriate, in the fall of 2012.

We look forward to engaging in a dialogue with interested parties regarding these important issues. Input can be submitted to the Task Force by emailing autoinsurance@ontario.ca.

As well, we are planning to meet with interested parties to discuss the issues we have identified in this report. Individuals or groups interested in meeting with us should make written submissions to the e-mail address above by August 17, 2012.

Appendix 1

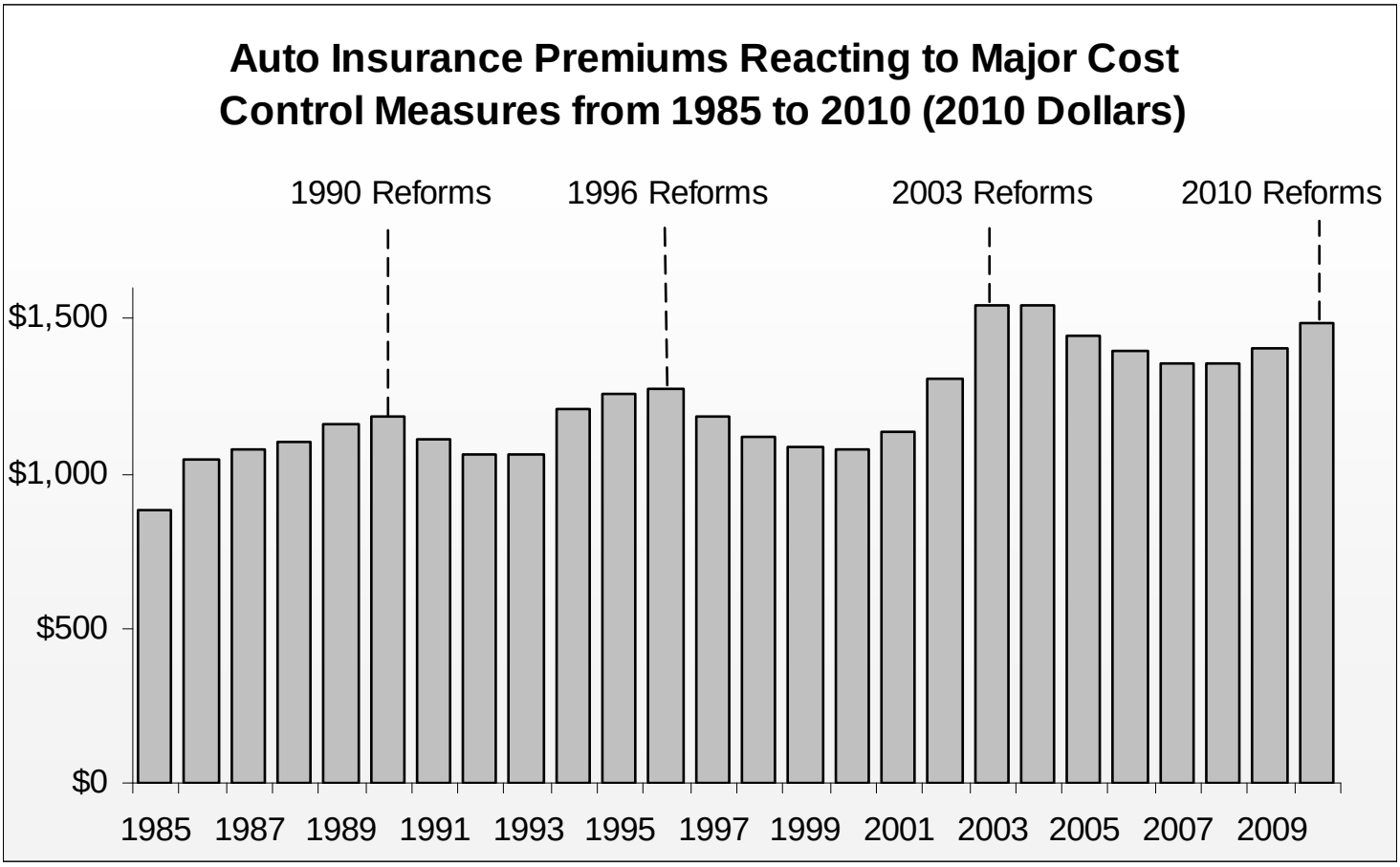
Structure of the Auto Insurance Anti-Fraud Task Force



Acronym	Full Name
CADRI	Canadian Association of Direct Response Insurers
FHRCO	Federation of Health Regulatory Colleges of Ontario
FSCO	Financial Services Commission of Ontario
IBAO	Insurance Brokers Association of Ontario
IBC	Insurance Bureau of Canada
Law Society	Law Society of Upper Canada
MAG	Ministry of the Attorney General
MCS	Ministry of Consumer Services
MCSCS	Ministry of Community Safety and Correctional Services
MOF	Ministry of Finance
MOHLTC	Ministry of Health and Long-Term Care
PACICC	Property and Casualty Insurance Compensation Corporation

Appendix 2

Auto Insurance Premiums Reacting to Major Cost Control Measures, 1985 to 2010 (2010 Dollars)



Appendix 3

Consultation Options with respect to the Towing Industry

The Regulatory Practices Working Group, on behalf of the Task Force, is continuing research and analysis around the value of greater regulation and a range of regulatory and non-regulatory options for the towing industry, including:

- options to address practices that may fraudulently inflate insurance costs;
- broader regulatory options that address not only auto insurance concerns but road safety and consumer protection issues; and
- market-based options.

Broader regulatory options are being examined as some stakeholders raised additional concerns around consumer protection and road safety.

This Appendix sets out details of some of the options being considered, as a basis for further consultation. The Working Group has been asked to report its recommendations to the Task Force by the end of July.

A. Options to address auto insurance concerns

1. Give consumers better information, including information about personal rights and responsibilities, as well as existing protection from potentially unfair or deceptive acts or practices.

Consumers may be unaware that they have the right to refuse towing services and referrals to auto body shops, legal and health care services. Such information could be incorporated in the larger anti-fraud consumer education strategy being considered by the Task Force, to help inform the public around their basic consumer rights in towing situations.

Consumers could also be made aware of regulations under the *Insurance Act* that prohibit towing service providers from unfair or deceptive acts or practices (UDAP) for services that are partially or fully funded through insurance claims, including charging for services not provided; excessive fees; and soliciting, accepting, or paying referral fees. The objective would be to alert consumers — and provide a signal to members of the towing industry potentially involved in fraudulent or abusive activities — that these activities are prohibited.

2. Strengthen existing bans on paid referrals to other services

Bans on accepting referral fees already exist in some municipal bylaws and UDAP regulations — however, these are not consistent. For example, they do not apply to every tow and are limited to municipalities where bans exist and/or where auto insurers pay. Creating a province-wide ban on referral fees for other services could provide greater clarity and consistency.

B. Broader regulatory options

1. Harmonized municipal business licensing

This option would require municipal business licensing based on provincially-set standards/requirements — potentially including fees, codes of conduct, and bans on paid referrals. This would have the objective of creating greater consistency in municipal licensing. There is currently no precedent for mandatory or standardized business licensing at the municipal level.

Under this scenario, the province would mandate municipalities to develop licensing standards and requirements that reduce the potential for practices that may inflate insurance costs. This would apply to municipalities that issue business licences to the towing industry. To ensure consistency across jurisdictions, the province would need to set minimum elements to promote consumer protection and reduce unnecessary auto insurance costs. As an example, these programs could be required to include:

- a schedule for local towing rates;
- prohibitions on paid referrals for services not offered by the licensee, such as storage, auto body shops, health care and legal services;
- rules around transparent billing practices, such as itemized billing; and
- a requirement that vehicles towed from a collision scene are taken directly to a collision reporting center, if one is available (would not apply to heavy tows or where police have attended the scene).

2. Provincial business licensing through a Designated Administrative Authority (DAA)

Under this option, the province could create a new regulatory regime that would require tow truck drivers and operators to obtain a licence and meet regulatory standards around road safety, consumer protection, and auto insurance concerns.

This could be implemented through a third-party Designated Administrative Authority (DAA, a non-Crown and non-profit entity) that would oversee province-wide requirements. A DAA model establishes an accountability and governance framework between a Ministry and a not-for-profit corporation that administers legislation on behalf of the government.[22]

A DAA would be responsible for administering provincial requirements for towing drivers and operators. The DAA would be responsible for registration of participants, issuing licences (including how applicants meet standards/requirements) as well as for monitoring and enforcement activities.

The province (or the DAA, if the province delegated such authority to it) would need to develop a broad range of standards that would apply to towing businesses, which could potentially include:

- minimum training and safety standards for drivers/operators
- registration and licensing requirements
- collision management practices/procedures
- local rates/fee schedules
- prohibitions on paid referrals
- transparent billing practices
- consumer consent for tows

C. Market-based options

The RPWG is also investigating current contracting approaches and methods by road authorities (Ontario Provincial Police, Ministry of Transportation, and local police services) and whether these have potential to be more broadly applied. The entities may have contractual relationship with tow truck operators in cases where they assume responsibility for directing towing services, such as impound tows, or pre-selected towing operations for recommendation to consumers.

[22] Examples of DAAs operating in Ontario include: Electrical Safety Authority, Travel Industry Council, Real Estate Council of Ontario and the Ontario Motor Vehicle Industry Council.

Market-based Options for the Towing Industry

Halton Regional Police Service Example

Halton Regional Police Service maintains a list of pre-selected towing operators to recommend to consumers requiring towing services. Consumers are directed to the first available towing operator based on a rotating list of eligible businesses. This type of program can help avoid competition between towing operators who arrive first on-scene and help make consumers feel more confident in selecting a towing operator.

To be eligible to participate in the program, tow operators must apply and meet various requirements around:

- road safety
- office and storage facilities
- insurance coverage
- adherence to municipal by-laws
- using a set fee schedule

Appendix 4

Proposals to Increase Ability of FSCO to Obtain Information

These potential amendments could be considered to enhance the Superintendent's powers to obtain information:

(i) Expand the scope/type of person from whom information can be requested. Add the power to demand information and examine unlicensed persons. This would solve an ambiguity in the Act as to whether demand and examination powers can be used against previously licensed or unlicensed persons, such as when looking into allegations of unlicensed activity that is ongoing or that occurred in the past. Similar provisions are contained in Alberta insurance legislation.

(ii) Expand the scope of persons required to furnish information to the Superintendent upon request. This could include, for example: a subsidiary, related party or holding body corporate of a licensee or of another person engaged in the business of insurance, a present or former director, auditor, officer, employee or creditor of a licensee or a licensee's holding body corporate and/or a prescribed person. Similar provisions are contained in Alberta insurance legislation.

(iii) Expand the type of information that can be sought by the Superintendent in s. 31(1), and from insured persons under s. 31(2). This could include any other information the Superintendent considers appropriate in the circumstances and prescribed information, such as "*respecting any other matter, activities or information as may be prescribed."* The current list of information that can be requested under section 31(1) (a) through (c) is fairly limited, i.e.: information about contracts, settlements or adjustments, and activities related to the business of insurance. Similar provisions are contained in the *Mortgage Brokerages, Lenders and Administrators Act*.

(iv) Allow the Superintendent to specify timing/format of disclosure. For example specify that the information requested must be provided within the time and in the manner specified by the Superintendent/delegate. The current provision in the Act contains no specific authority about timing or format, though may be implied. Similar provisions are contained in the *Mortgage Brokerages, Lenders and Administrators Act*.

(v) Expand s. 29 so that the power to make "inquiries" is not limited to insurers and is coextensive with the same group of persons to whom the duty to furnish information applies under s. 31(1). As a practical matter, FSCO needs to make the same inquiries of health care providers as they do insurers in conducting investigations. Presently the power is limited to insurers. Similar provisions are contained in Alberta insurance legislation.

(vi) Provide an expeditious process to resolve disputes about information requests. Allow the Superintendent/delegate to apply to the court or to the FST, on short notice, for an order requiring the person to provide the information sought. Similar provisions are contained in Alberta insurance legislation.

Appendix 5

Proposals to Increase the Power of FSCO to Investigate and Sanction Unfair or Deceptive Acts or Practices

These potential amendments could be considered to enhance the Superintendent's powers to investigate and sanction unfair or deceptive acts or practices, and apply the unfair or deceptive acts or practices provisions under the *Insurance Act*.

Power to investigate unfair or deceptive acts or practices (s. 440)

(i) Clarify that the authority to "perform such acts that are necessary to remedy the situation" in section 441(2)(c) includes the authority to order "restitution". From time to time, an appropriate remedy in a situation may be for the Superintendent to order the wrongdoer to pay back the victim, such as when an unlicensed person sells auto insurance to a member of the public. Currently, only a court can order restitution under s. 447(5) of the Act.

(ii) Expand the power to investigate UDAPs committed by persons engaged in the business of insurance, so that it specifically applies to unlicensed persons.

The same problem in investigating unlicensed persons arises in s. 440 as it does in s. 31, discussed in Appendix 4. In both cases, the power to investigate, or demand information, is linked to being "engaged in the business of insurance", which is ambiguous and arguably excludes unlicensed/formerly licensed persons, as discussed under s. 31. The licence status of a person should be irrelevant to the ability to investigate and enforce the Act. Similar provisions are contained in the *Mortgage Brokerages, Lenders and Administrators Act*.

(iii) Expand the type of "person" whose affairs the Superintendent can examine and investigate as to whether the person has engaged in a UDAP, to include *prescribed persons in prescribed circumstances that* is not just "persons engaged in the business of insurance". This proposal would provide additional flexibility to investigate persons who currently are outside of the Superintendent's reach because they may not be considered engaged in the insurance business, but still have a close connection to the insurance business, for example health care providers treating SABS claimants.

Note, for example, that the existing UDAPs prescribed in O.Reg. 7/00 cover: "activities of persons who provide goods or services to or for the benefit of a person who claims statutory accident benefits or who otherwise claims payment under a contract of insurance". However, since these persons are often not "engaged in the business of insurance in Ontario" (e.g., health care providers, tow truck operators, etc.), there is currently no authority to examine/investigate these parties to determine if they are breaching these UDAP provisions, (and similarly no ability to demand information under s. 31), even though they are responsible for significant costs to the insurance system. Similar provisions are contained in the *Mortgage Brokerages, Lenders and Administrators Act.*

(iv) Provide specific authority for the Superintendent to enter into a binding compliance "undertaking". Though not strictly an "investigation" tool, one of the most frequent regulatory/enforcement tools used by the Superintendent — often resulting from an examination/investigation, is an "undertaking". Similar provisions are contained in Alberta insurance legislation.

Power to conduct examination of an insurer, agent or adjuster under Part XIX, "Examination and Enforcement" [ss. 442 to 444]

This part governs "examination and enforcement" under the Act, and is the primary source of authority for investigations/examinations. This part makes it a condition of the licensing for a person to facilitate "examinations". It provides the authority for FSCO staff to attend at the place of business to obtain information, interview officers and employees, obtain books and records, enter non-residential dwellings, obtain search warrants, etc.

The following list of potential amendments that could be considered to enhance examination and enforcement powers:

(v) Expand/clarify the list of items the Superintendent can require/inspect in an examination. For example by replacing "documents or things" in s. 444(1)(b) with: *all money, valuables, documents and records of the licensee, person or entity being examined that is relevant to the examination.* Similar provisions are contained in the *Mortgage Brokerages, Lenders and Administrators Act*, the *Real Estate and Business Brokers Act* and other regulatory Acts.

(vi) Give the Superintendent authority to make use of any data/retrieval storage system in place. For example, provide authority in s. 444(1) to: *use any data storage, processing or retrieval device or system that is used in connection with the business or activities of the person or entity in order to produce information.* Similar provisions are contained in the *Mortgage Brokerages, Lenders and Administrators Act.*

(vii) Expand the list of items that can be removed during an examination. For example, to include: *any data storage, processing or retrieval device in order to produce information.* Currently the Act provides authority to remove *documents or things for the purpose of making copies or extracts* — see s. 444(1)(c). Therefore, current authority contemplates paper-based records only, or is at least ambiguous, whereas in some cases it may be necessary to remove computer disks, hard-drives or other equipment in order to obtain information. This authority is contained in many other statutes, including the *Mortgage Brokerages, Lenders and Administrators Act*.

(viii) Expand the duty to assist to include not just opening the books and facilitating an examination in s. 443(3). For example, expand to include *to answer questions or to provide assistance in the manner and within the period specified by the Superintendent or designate.* This authority is contained in the *Mortgage Brokerages, Lenders and Administrators Act.*

(ix) Require investigators to provide evidence of his or her authority to conduct the examination, on request. The requirement for the investigator to provide identification is standard in many Acts, including the *Mortgage Brokerages, Lenders and Administrators Act*.

(x) Clarify that a person conducting an examination may not use force to enter and inspect any premises without a warrant, but clarify that the person executing the warrant can use whatever force is reasonably necessary. This is standard in statutes containing investigation powers, such as the *Mortgage Brokerages, Lenders and Administrators Act*.

(xi) Clarify that a search warrant issued under s. 444(3) can authorize a person not just to search for documents and things "for the purpose of making copies/extracts", but may also authorize the exercise of *any* of the powers of examination under s. 444(1), including the power to use data storage equipment, question a person on matters that may be relevant. The potential amendments described in items (v), (vi) and (vii) would expand powers of examination under s. 444(1). For example, those changes would authorize the person conducting an examination to make use of any data storage, processing or retrieval device in order to produce information. The scope of warrant orders from s. 444(3) should be made consistent with the scope of examinations so that the person conducting a search is able to produce the same information as a person conducting an examination.

(xii) Expand/modify the authority to obtain a warrant for entry, so that it is available not just when entry has been denied, but also where there are reasonable grounds to believe that entry will be denied. Remove the requirement to show reasonable and probable grounds where entry has already been denied. The search warrant and warrant for entry provisions in the Act [ss. 444(3) and (4)] are rarely used in practice, and are dated. One option would be to completely re-write the sections using the new terminology, although this is not necessarily needed or recommended. However, even if they are not re-drafted it would make sense to ensure that a warrant for entry is available where denial is anticipated. Also, in keeping with similar legislation, it should not be necessary to demonstrate "reasonable and probable grounds" if entry has already been denied. Similar provisions exist in many other statutes, including the *Mortgage Brokerages, Lenders and Administrators Act*.

(xiii) Provide authority to authorize persons with special, expert or professional knowledge to accompany and assist the person executing the warrant. This is standard in many similar statutes containing investigation powers, such as the *Mortgage Brokerages, Lenders and Administrators Act*.

(xiv) Provide authority to seize things not specified. This authority, also common, would provide a person who is lawfully present in a place pursuant to a search warrant, or otherwise in the execution of his or her duties without a warrant, to seize anything in plain view that the person believes on reasonable grounds will afford evidence relating to a contravention of the Act or regulations. Similar provisions are contained in the *Mortgage Brokerages, Lenders and Administrators Act* and the *Real Estate and Business Brokers Act*.

(xv) Provide time of execution of warrant provision requiring entry or access be made between 6 a.m. and 9 p.m. unless the order specifies otherwise. This sort of provision is commonly contained in other comparable legislation, such as the *Mortgage Brokerages, Lenders and Administrators Act*.

Power to apply existing unfair or deceptive acts or practices provisions (s. 3, 0 reg. 7/00)

(i) Expand the type of persons/service providers to which existing unfair or deceptive acts or practices provisions apply. For example, this would make the unfair or deceptive acts or practices provisions apply consistently to all legal service providers, including those who are authorized under the *Law Society Act* as lawyers or paralegals.

Currently the unfair or deceptive acts or practices provisions include:

- using a document in place of a form approved by the Superintendent (applies to all health care and legal service providers, insurers)
- charging for goods or services that are not provided (applies to health care goods or service providers, legal service providers not authorized under the *Law Society Act,* auto towing, storage and repair service providers, and insurers)
- requesting, accepting or paying referral fees (applies to health care goods or service providers, legal service providers not authorized under the *Law Society Act,* auto towing, storage and repair service providers, and insurers)
- charging unreasonable fees compared to amounts charged for similar goods or services (applies to health care goods or service providers, legal service providers not authorized under the *Law Society Act*, auto towing, storage and repair service providers, and insurers)
- failing to disclose a conflict of interest[23] to a claimant or insurer where required by the Statutory Accident Benefits Schedule (applies to health care goods or service providers, all legal service providers).
    - For collisions on or after September 1, 2010, the SABS conflict of interest disclosure requirements apply only to insurers.

[23] A conflict of interest may exist if the person or a related person may directly or indirectly receive a financial benefit from the provision of the goods and/or services.

- For collisions on or after November 1, 1996 and before September 1, 2010, SABS requires conflicts of interest to be disclosed in the following circumstances:
  - Confirming delivery of pre-approved goods or services payable under the SABS (i.e., submitting a treatment confirmation form) (applies to health care service providers and legal service providers)
  - Submitting a treatment plan (applies to health care goods and service providers, legal service providers, and insurers)
  - Making a referral to obtain medical or rehabilitation goods or services (applies to health care goods and service providers)
  - Submitting a request for approval of an assessment or examination (applies to health care goods and service providers, legal services providers, and insurers)

Appendix 6

Illustrative Matrix of 'Learning Moments'

Learning Moment	Objective	Potential Delivery Mechanism
Visiting a Collision Reporting Centre (CRC)	▪ Help ensure collision victims are aware of fraud possibilities that exist around time of collision ▪ Spread messages on specific types of organized fraud schemes that collision victims should avoid ▪ Engage collision victims as a valuable source of accurate information about a collision that can help prevent fraud	▪ Printed materials for collision victims ▪ Anti-fraud posters and videos ▪ Further training for CRC staff that work directly with collision victims
Receiving Medical Treatment	▪ Help people become more aware of the types of scams that could occur when they are receiving medical or rehabilitation treatment ▪ Promote better education of providers on fraud to help make them more aware and able to answer questions from patients	▪ More substantive anti-fraud warnings on claims forms collision victims sign before starting treatment ▪ Printed materials made available to claimants through health care practitioners and clinics
Making an Auto Insurance Claim	▪ Provide claimants with information that can help them detect fraud and protect their benefits ▪ Inform claimants about what they should do when they become aware of suspicious activity involving their claim ▪ Ensure that brokers and insurance company staff are equipped to discuss fraud issues with policyholders	▪ Benefit statement (itemized information, advice on what to do if suspicious activity is detected). ▪ Additional anti-fraud messaging in claims welcome packages ▪ More substantive anti-fraud warnings on claims forms collision victims sign before starting treatment ▪ Better training for auto insurance adjusters regarding specific fraud issues ▪ Anti-fraud information, professional development courses or seminars for insurance brokers
Having a Vehicle Towed	▪ Inform claimants regarding potential fraud schemes directly after a collision has occurred	▪ Printed materials distributed to collision victims by tow truck drivers ▪ Awareness posters around entrance to CRCs and other areas tow trucks may take damaged vehicles

Learning Moment	Objective	Potential Delivery Mechanism
Purchasing and Renewal of a Policy	▪ Engage consumers on the subject of fraud when they are reviewing their coverage levels and premiums	▪ Printed materials provided to policyholders by insurers, brokers and agents upon time of policy purchase or renewal ▪ Small "what to do if in an collision" pamphlet to be kept in the insured vehicle sent to policyholders
Learning about Driving and Insurance	▪ Ensure new drivers are aware of the consequences of fraud and how they can protect themselves from being used in an organized scheme ▪ Reach young drivers with messages about the consequences of fraud and how they can protect themselves from being used in an organized scheme	▪ Ministry of Transportation Driver's Handbook ▪ Beginner driver education courses ▪ Learning modules on auto insurance developed for classroom lessons ▪ Career education days involving insurance industry organizations ▪ Financial literacy programs including insurance-related content ▪ Printed materials distributed at public events through service delivery partners
Renewing a Driver's Licence or Vehicle Registration	▪ Ensure new drivers and vehicle owners are aware of the consequences of fraud and how they can protect themselves from being used in an organized scheme	▪ Licence and registration renewals ▪ Printed materials provided at vehicle dealerships
Whistle-Blowing	▪ Resolve the issue of individuals not knowing where to report suspicious behaviour related to an auto insurance claim ▪ Provide individuals with a trusted whistle-blowing resource that guarantees anonymity	▪ Partnership between IBC and Crime Stoppers
News and Public Interest Events	▪ Take advantage of publicized events (such as road safety crackdowns) that can be linked to auto insurance fraud	▪ News releases and social media campaigns from insurance industry and government organizations ▪ Public Safety Announcements created for television viewers.

Appendix 7
List of Presenters to Task Force

Stakeholder	Level of Presentation Working Group, Steering Committee or Both
1. Able Translations	Working Group
2. Accident Support Services International	Working Group
3. Alliance of Medical and Rehabilitation Providers	Working Group
4. Andrew Shaul, Psychologist	Steering Committee
5. Association of Canadian Car Rental Operators	Steering Committee
6. Canadian Association of Special Investigation Units	Steering Committee
7. Canadian Life and Health Insurance Association	Steering Committee
8. Canadian Society of Medical Evaluators	Steering Committee
9. City of Toronto (Licensing and Enforcement)	Working Group
10. Coalition Representing Regulated Health Professionals in Auto Insurance Reform	Steering Committee
11. Crime Stoppers	Working Group
12. Dr. John Clifford	Steering Committee
13. Federation of Health Regulatory Colleges of Ontario	Working Group
14. Health Claims for Auto Insurance	Steering Committee
15. Insurance Brokers Association of Ontario	Working Group
16. Insurance Bureau of Canada	Both
17. Insurance Fraud Group	Both
18. Law Society of Upper Canada	Working Group
19. Lawrence Gold, Vehicle Storage Expert	Working Group
20. Michael Seaton, Digital Marketing Expert	Working Group
21. National Insurance Crime Bureau	Both
22. Ontario Bar Association	Working Group
23. Ontario Provincial Police Anti-Rackets Branch	Both
24. Ontario Trial Lawyers Association	Working Group
25. Police Panel (Peel, Hamilton, York Region)	Working Group
26. Provincial Towing Association of Ontario	Working Group
27. RBC Insurance	Working Group
28. Robin Ingle, Ingle Insurance	Working Group
29. State Farm Insurance	Both
30. The Dominion of Canada Insurance	Both
31. Workplace Safety and Insurance Board	Steering Committee