

## IBC Comments on the Ontario Automobile Insurance Anti-Fraud Task Force Steering Committee Status Update Report

Established in 1964, **Insurance Bureau of Canada** is the national industry association representing Canada's private home, car and business insurers. Its member companies represent **90% of the property and casualty (P&C) insurance market** in Canada. IBC's Comments to the Ontario Automobile Insurance Anti-Fraud Task Force in respect of its report on automobile insurance fraud represents the views of IBC's member companies.

### INTRODUCTION AND OVERVIEW

IBC welcomes the opportunity to provide comments on the Ontario Automobile Anti-Fraud Task Force Steering Committee Status Update Report. Since the Task Force commenced its work in 2011, there has been a noticeable increase in stakeholder focus on combating insurance fraud. We appreciate the Task Force's determination to understand auto insurance fraud, to develop strategies for dealing with it and to call for government action to address the problem.

IBC is pleased to acknowledge the numerous anti-fraud initiatives that have been proposed or which have already been put in place. These include new guidelines and bulletins introduced by FSCO to address various concerns such as billing practices, rights and responsibilities of insurers, insurer attestations, and proposed legislative amendments to provide powers to FSCO to impose administrative monetary penalties for contraventions of legislation and regulation. IBC supports the view that more aggressive action needs to be taken to combat fraud so that premiums for Ontario's drivers can be reduced.

To date, IBC and its member companies have contributed to the work of the Task Force by providing data and policy submissions on various aspects of fraud and by participating in its various working groups. To gain more perspectives on fraud, IBC also conducted two key studies: the first, by KPMG, explored the extent and scope of fraud, and the second, a survey conducted by Pollara, gathered feedback on Ontarians' views on auto insurance fraud.

## **KPMG Report**

IBC engaged KPMG Forensic to conduct a study aimed at estimating the extent of auto insurance fraud in Ontario. This study was shared with the Task Force and is available online. The Task Force welcomed the KPMG study as an opportunity to provide a fresh view of the extent of the problem. It also engaged Ernst & Young to provide it with an independent assessment of the KPMG methodology and results.

Although the KPMG study could not provide the precise cost of auto insurance fraud, it did suggest that 9% to 18% of annual claims costs are fraud-related. In 2010, this range, in dollars, would have amounted to between \$769 million and \$1.56 billion. Using this estimate, KPMG calculated the impact of fraud on the average auto insurance premium in Ontario to be between \$116 and \$236 in 2010.<sup>1</sup>

In the past, a figure of \$1.3 billion has been used to describe the annual cost of insurance fraud. The Task Force's Interim Report questioned the origin of this calculation. The KPMG report identified the source of this estimate. It was part of a 1992 Canada-wide study conducted by IBC on all lines of P&C insurance, including home, business and automobile insurance. The study, which was based on an analysis of closed claims, found the percentage of annual Canada-wide P&C claims that were considered fraudulent to be approximately 15%.<sup>2</sup>

As part of their research, the KPMG study assessed a broad range of sources and studies both in Canada and abroad, as well as three proofs of concept projects to which KPMG applied sophisticated data analysis techniques. The KPMG study was able to provide a current and credible estimate of the extent of fraud specifically for Ontario automobile insurance.

## **Polling Report**

One-thousand Ontarians were asked to share their opinions and experiences related to auto insurance fraud in the Pollara study. The results showed that Ontarians have a strong awareness about fraud and that the majority, particularly Greater Toronto Area (GTA) residents, believe that fraud is influential or very influential in increasing the price of auto insurance. For example, 83% believe insurance fraud occurs frequently or occasionally. The study also shows strong support for anti-fraud initiatives, ranging in support from 64% to

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<sup>1</sup> KPMG Forensic, Auto Insurance Fraud in Ontario, June 13, 2012, p. 58.

<sup>2</sup> Insurance Bureau of Canada, "Initial Estimates of Property and Casualty Insurance Fraud in Canada: Evidence from a Review of Closed Claim Files." September 1993.



77%. This study will serve as a useful baseline for measuring the success of future anti-fraud initiatives.

## LICENSING AND REGULATION OF REHABILITATION CLINICS

The Task Force has recognized that there are surprisingly few rules concerning the ownership of health clinics servicing automobile accident victims in Ontario. In addition, minimal investment is needed to start up and operate an independent health care clinic in this province.

Manipulation and fraud in health care clinics increase auto insurance premiums for all Ontario drivers. FSCO is committed to investigating, prosecuting and rooting out these abuses.

– Philip Howell, CEO and Superintendent of FSCO<sup>3</sup>

The lack of rules for ownership of clinics is evidenced by the alarming growth in the number of clinics operating in the GTA. Based on June 2012 information from Health Claims for Auto Insurance (HCAI), more than 8,700 health care facilities enrolled in its online billing system provide medical/rehabilitation services. Since there are 62,000 road injuries annually, and the great majority of these injuries are minor (sprains, strains and whiplash), there are approximately 7.1 accident victims per year per clinic – a singularly astounding statistic, in IBC’s view. Moreover, the number of clinics has continued to rise despite a significant and steady decline in the number of accidents in Ontario during the past few years. One wonders how so many of these clinics continue to operate in this environment.

To address issues with respect to the clinic ownership, the Task Force has concluded that licensing and regulating the auto insurance business practices of health clinics is appropriate and necessary. The Task Force is also considering extending this regulatory scheme to commercial providers of independent medical evaluations (IMEs).

IBC supports the need for:

- a more rigorous process for clinic ownership
- the provincial government to have more of a role in accrediting clinics and assessment centres
- provisions that extend and apply these new provincial regulations to commercial enterprises that supply IMEs

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<sup>3</sup> FSCO, “Rehabilitation Clinics and Clinic Owners and Directors Face 15 Charges Related to Submitting False Invoices to Insurers for Payment.” News Release, May 25, 2012.



In previous submissions to the Task Force, IBC has provided examples of the types of stringent provisions other jurisdictions have enacted to regulate medical/rehabilitation clinics. In particular, IBC recommends that the Task Force review again the ordinance enacted by Hillsborough County, Florida, a particularly rigorous provision that requires clinic owners to be licensed and that clinics be operated by designated physicians (Florida ordinance is attached). While IBC supports the Hillsborough County ordinance, we would extend the class of professionals who can own med-rehab clinics to all regulated health professionals.

We note that the Task Force is *not* proposing to regulate the professional credentials of health care professionals or their methods of treatment. However, the Task Force does want to increase the accountability of these professionals. IBC supports this position.

Given FSCO's current responsibilities, IBC is concerned about FSCO having the resources to take on the authority to license and regulate the business practices of clinics. These responsibilities would include who can own and manage clinics, prescribing the classes of persons who shall not be owners, and the denial of licences to operate these clinics. Since the insurance industry currently finances FSCO's operations in relation to automobile insurance, a system would need to be developed to ensure that the full costs associated with administration and regulation of health care clinics be recovered from health care providers and captured through licensing fees.

We appreciate that in a free market it may be difficult to place ownership restrictions on a business. However, we believe that ownership restrictions are necessary and that clinic owners should be subject to licensing provisions that include sanctions that could ultimately lead to the withdrawal of licences to operate (similar to restaurant or taxi licences) if clinics or clinic owners are found to have committed fraud.

The Independent Health Facilities Act, 1990 (the Health Facilities Act) allows for licences to be granted to individuals or corporations for the establishment of independent health clinics. When compared with legislation in other jurisdictions, the Health Facilities Act does not require heavy scrutiny of independent facilities. In particular, criminal background checks, company officers and day-to-day managers are not required, and no aspect of the legislation specifically deals with insurance fraud, such as giving investigators appointed under the act powers or a mandate to investigate or audit insurance claims. IBC believes that the Act must be strengthened so as to integrate these powers into what is currently in place. We understand that the Task Force is contemplating that FSCO be the appropriate administrative agency for the purposes of approving or denying a licence to or operate a clinic and for the regulation and enforcement of this function.

The Task Force is also considering a conjunctive requirement that clinics designate a regulated health practitioner to be held responsible for the integrity of the clinic's business



practices. While we understand the basis for this recommendation, IBC does not believe that this will be effective in rooting out fraud within the med-rehab clinic sector. We recommend that a designated regulated health professional must own the clinic and be responsible for the clinic's business practices. Moreover, that professional must physically be in attendance at the clinic for a minimum of three days per week. How else to reinforce the notion that these clinics should be focused on providing quality treatment undertaken under the ownership and management of a regulated health professional who is both present at the clinic and is intimately involved with its operations. These health care professionals should be held accountable for their clinics' business practices and know that their professional licences are at stake if their clinics are found to have participated in fraudulent activity. Imposing such accountability will increase the likelihood that owners/regulated health professionals will comply with professional standards, licensing requirements, and regulatory and legislative provisions.

IBC believes the following provisions from Bill 41, Reducing Automobile Insurance Premiums by Eliminating Fraud Act, 2012, introduced by Amrit Mangat, MPP should be considered:

#### **Amendments to the Independent Health Facilities Act**

7. (1) Subsection 1 (1) of the Independent Health Facilities Act is amended by adding the following definition:

"health practitioner" means a member of a College as defined in the Regulated Health Professions Act, 1991; ("praticien de la santé")

(2) The Act is amended by adding the following section:

#### **Licensee must be a health practitioner**

6.1 (1) The Director shall not issue, renew or consent to the transfer of a licence unless,

- (a) the person who would be the licensee is a health practitioner; or
- (b) in the case that a corporation would be the licensee, all of the shares of the corporation are legally and beneficially owned, directly or indirectly, by one or more health practitioners.

#### **Same**

(2) It is a condition of every licence that the licensee meets the requirement described in clause (1) (a) or (b).

IBC agrees that the regulation of professional credentials and methods of treatment should remain under the jurisdiction of the various respective regulatory health colleges.

With respect to enforcement, explicit audit provisions need to be enacted so that the activities of the clinics and the designated health care professionals can be reviewed at any time.



The Task Force has also considered requiring that the designated regulated health care practitioners regularly confirm that appropriate business practices are being followed. While IBC supports this concept, there may be hundreds of different business models in play in Ontario health facilities. Defining *appropriate business practices* may be difficult. In some cases, it may be easier to define and seek confirmation that *inappropriate* business practices are *not* being carried out. To implement this control, the definitions of appropriate and inappropriate business practices must be clear and succinct. A starting point for determining business practices could come from the various health regulatory colleges, which have existing standards of business in place. For example, the College of Physiotherapists of Ontario has a Standard for Professional Practice – Fees and Billing. The fact that many regulated health practitioners are already subject to standards of business practices through their regulatory colleges also supports our earlier recommendation to require that a designated regulated health professional own the clinic and be responsible for the clinic’s business practices.

IBC would also suggest that a process similar to the Red, Amber, Green (RAG) system used in restaurant inspections and licensing in Toronto be considered. Clinics would be required to publicly display their rating on their premises and, if applicable, on their websites. The posted rating would assure the public that the clinic operates in an appropriate manner. Moreover, this system would ensure that insurers are not liable for paying for treatment provided at clinics that do not meet provincial licensing standards.

To complement the RAG system, IBC suggests the establishment of an administrative tribunal to adjudicate disputes and allegations of improper behaviour by clinics. The outcome of the disputes would result in the RAG system being applied. Any medical provider or facility should be subject to the same standards and degrees of governance, including commercial enterprises providing IMEs.

The Task Force identified four objectives for a clinic licensing regime:

## **1. Transparency**

The Task Force is not recommending that ownership of a clinic be restricted to a regulated health professional but that the ownership is transparent. As we have noted above, IBC disagrees with this proposal. We do agree with a “fit and proper” test for clinic ownership and that possible clinic owners should be required to disclose any conflicts of interest (real or potential).

The Task Force has specifically asked if lawyers or paralegals representing auto insurance claimants be allowed to own med-rehab clinics. As noted earlier, in a free market economy, it may be difficult to impose this type of ownership restriction. However, lawyers and paralegals representing injured motorists would have an insurmountable conflict of interest should they be permitted to own med-rehab clinics. Even with the proper degree of disclosure of the lawyer’s or paralegal’s interest in the clinic, how could the client ever be certain that the treatment being recommended was unrelated to the financial interests of her or his lawyer or



paralegal? The opportunities for abuse are too readily available for a ban not to be instituted. Why would such an approach be contemplated when there are alternatives that do not present these opportunities for fraud? As stated above, IBC's preferred recommendation would be for restrictions on clinic ownership; however, in the absence of restrictions, full disclosure of ownership would need to be a condition of applying for and holding of a licence. Information with respect to ownership should be made readily available to customers upon request. If the RAG system were to be implemented, then a non-disclosure should be reflected by a downgrade in their rating.

The Task Force has also commented on whether doctors who refer patients for rehab should be allowed to refer patients to clinics they own and, if so, what disclosure policies should be instituted to ensure that claimants are well informed about potential conflicts of interest. If doctors make referrals to clinics that they own or have a financial interest in and do not disclose their interest, their actions should result in disciplinary action by their own regulated professional association. Sanctions could also be placed on the clinic's licence. The Task Force needs to recognize that the potential for conflicts of interest exists not only with doctors that own clinics but with all health care professionals. Physiotherapists, chiropractors, psychologists and other health professionals routinely assess injured persons; prescribe the frequency, duration and type of treatment; and then deliver the prescription at their own clinic, sending the bill to the insurer.

The proposed regime should apply to all assessment providers, including IMEs. As stated previously, any medical provider or facility should be subject to the same standards and degrees of governance, including commercial enterprises providing IMEs. This should include mandated disclosure of the schedule of fees paid.

With respect to transparency, IBC also recommends that criminal background checks and the fingerprints of any director, officer or proprietor of an independent health clinic be provided to the appropriate administering agency for the purpose of approving or denying a licence to operate a clinic. Clinic licences should be restricted to those individuals who reside in Ontario and who have not been convicted of any type of criminal offence (not specific to insurance fraud).

## **2. Accountability**

The Task Force is proposing to focus on the regulation of the business practices of licensed clinics to defer fraud and identify where it occurs. It is not proposing to regulate the professional credentials or methods of regulated health practitioners, as this is already within the mandate of the regulatory health colleges.

IBC agrees that the regulation of professional credentials and methods of treatment should remain under the jurisdiction of the respective regulatory colleges. However, more must be done to ensure that the regulatory colleges themselves take an active role in acting on and reporting insurance fraud. For example, IBC recommends that investigators employed, or



retained by, professional colleges must be provided with the authority to investigate allegations of fraud when they are reported to them. As we note below, if they do not have the power to investigate fraud, and unless that information can subsequently be shared with criminal prosecutors, the power means little in the context of auto insurance fraud prevention. Furthermore, IBC recommends that the Regulated Health Professions Act should be amended to mandate that medical practitioners can lose their licences or be suspended for not referring reasonable suspicions of fraud or attempted fraud within their clinics to the police. This amendment would be consistent with current OHIP provisions that include a mandatory reporting requirement for doctors who are aware of fraudulent OHIP billings occurring within their hospitals.<sup>4</sup>

The Regulated Health Professions Act, 1991 (RHPA) regulates many of the professionals that provide health care benefits. Each health profession has its own governing or enabling act for the creation of a self-regulating body or college. There is also a Health Professions Procedural Code in Schedule 2 of the RHPA that governs each professional college. Under the RHPA, it is the duty of the relevant minister (depending on the college) to ensure that the health profession is regulated and coordinated in the public interest.

The Code allows the registrar of each college to appoint one or more investigators to determine whether a member has committed an act of professional misconduct, or is incompetent. However, the Code does not specifically provide the authority to investigate allegations of insurance fraud. Even though colleges can investigate their members' conduct, unless that power is expressly extended (by way of legislation) to include insurance fraud, and unless that information can be shared with criminal prosecutors, that authority means little in the context of combating insurance fraud. In addition, unlike in other jurisdictions, public prosecutors or courts in Ontario have no obligation to notify professional colleges of convictions of their members.

IBC recommends to the Task Force the provisions of Bill 41 and more particularly the following:

### **Investigators**

2. (1) The Registrar of a College within the meaning of the Regulated Health Professions Act, 1991 may appoint one or more investigators to determine whether a member of the College has been involved in fraudulent activity in connection with automobile insurance claims if the Registrar believes on reasonable grounds that the member may have been involved in such activity.

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<sup>4</sup> Health Insurance Act, R.S.O. 1990, c. H.6, s. 43.1(1).

### **Powers, duties and functions**

- (2) An investigator appointed under subsection (1) has all of the powers, duties and functions of an investigator appointed by a College under the Regulated Health Professions Act, 1991.

### **Registrar's duty to report to Committee**

- (3) The Registrar shall report the results of an investigation made under this section to the College's Inquiries, Complaints and Reports Committee established in accordance with the Regulated Health Professions Act, 1991.

### **Duty, investigators appointed under the Regulated Health Professions Act, 1991**

3. An investigator appointed by a College under the Regulated Health Professions Act, 1991 to determine whether a member of the College has committed an act of professional misconduct or is incompetent shall also determine whether the member has been involved in fraudulent activity in connection with automobile insurance claims.

### **Registrar's duty to notify police office**

4. The Registrar of a College within the meaning of the Regulated Health Professions Act, 1991 shall notify a police officer if the results of an investigation made under that Act or made under this Act suggest that a member of the College has been involved in fraudulent activity in connection with automobile insurance claims.

### **Protection from legal action, investigators**

5. No action or other proceeding shall be instituted against an investigator for an act done in good faith in the performance or intended performance of a duty or function or in the exercise or the intended exercise of a power under this Act or for any neglect or default in the performance or exercise in good faith of the duty, function or power.

### **Offence**

6. Every person who contravenes section 1 is guilty of an offence and on conviction is liable to a fine of not more than \$25,000 or to imprisonment for a term of not more than 12 months, or to both.

## **3. Verification**

IBC supports the Task Force recommendation that owners and designated health professionals would be expected to attest regularly to the integrity of the business practices of licensed clinics. We also support that the professionals' records would be maintained and available for inspection so they could be auditable and verifiable.



## 4. Sanctions

IBC supports the Task Force recommendation that a range of sanctions should be available where business processes are found to be inadequate, such as cease-and-desist orders, suspension of billing rights through HCAI, restriction of rights to own a clinic and criminal or civil charges.

While there are examples of these types of sanctions – for example, FSCO’s July 2012 HCAI Guideline allows suspension of billing rights if health care professionals persist in contravening the requirements of the Guideline – it is clear that they must be more stringent. In the case of the above-noted HCAI Guideline, for example, a process has not been established that sets out how contraventions are to be reported and to whom, rendering this provision ineffective. A process needs to be established so that the provisions in the HCAI Guideline can be enforced effectively.

As stated above, the regulatory colleges and professional organizations need to take a larger role in fighting fraud. These organizations should be mandated and legislated to be involved in the process of working with tribunals and licensing bodies to ensure the professional standards of their members are maintained. Presently regulated health professional colleges have often shied away from taking complaints from insurance companies or organizations on the basis of their expressed concerns over privacy issues and lack of resources. A more comprehensive dialogue with the colleges is required to ensure that these concerns are dealt with and the fight against fraud is not hampered because of a lack of involvement by these associations.

When sanctions are placed on clinic owners or providers, a notification system should be established to alert insurers and other stakeholders. This notification is especially important if the sanction involves a licence suspension. This alert system should also apply to regulatory colleges.

### OTHER GAPS IN REGULATION

The Task Force has noted gaps in regulation in three key areas:

1. Regulation of the Towing Industry
2. Scope of Enhanced Authorities for FSCO
3. Regulations Governing Relations between Insurers and Claimants

#### 1. Regulation of the Towing Industry

The Task Force provided options for addressing improper billing practices and paid referrals, including better consumer education, harmonized municipal licensing requirements, and provincial business licensing and regulatory standards. Overall, we support these recommendations.



IBC has a working group dedicated to discussions about the towing industry. This group has identified key issues and solutions related to towing operations. These identified issues and possible solutions have been included in the table below for the Task Force’s consideration.

Issue	Possible Solution(s)
Commissions or kickbacks paid to towing operators by auto body shops and med-rehab clinics	<p>Requirement that towing authorization forms completed and signed by tow truck operators include a statutory declaration stating that the operator had no role in or knowledge of collision and direction provided (leaving the operator open to perjury charges)</p> <p>Mandatory drop-off of vehicle from collision scene to a designated, secure location (e.g., a collision reporting centre or an authorized pound); allows for a cooling-off period from collision and separation of final tow.</p>
Multiple tows and excessive tow bills	<p>Uniform provincial regulation and oversight of towing practices</p> <p>Provincial licensing and bonding of tow truck operators</p> <p>Independent complaints and oversight body (Highway Traffic Act or Ministry of Consumer Services)</p>
Additional damage to vehicle post-accident (i.e., damage incurred when vehicle is towed from the collision location to the body shop)	<p>Education for police</p> <p>Consumer education campaign (e.g., plan ahead in case of collision, take photos of accident)</p>

**2. Scope of Enhanced Authorities for FSCO**

The Task Force report proposes a number of anti-fraud policies that would expand FSCO’s role in Ontario’s auto insurance system. Specific proposals include its authority to license and regulate the business practices of clinics and its authority to enforce administrative sanctions related to HCAI in appropriate circumstances.

IBC supports the proposals to increase FSCO’s power to investigate and sanction unfair and deceptive acts or practices and its authority to levy administrative monetary penalties. With respect to the clinic licensing, if FSCO were to take on this function, the licensing fees charged should be sufficient to cover FSCO’s operating and administrative costs. The insurance



industry currently finances FSCO's regulatory oversight of the industry and should not be responsible for the costs of licensing clinics.

The Task Force has also planned a review of acts and practices currently defined as "unfair or deceptive" as well as the powers and authorities of the FSCO Superintendent to investigate those practices.

IBC supports proposed amendments to enhance the FSCO 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. Any service provider who provides a service to an insured and submits an invoice to an insurer for payment as a result of a motor vehicle accident claim should be subject to the unfair or deceptive acts or practices provisions.

The Task Force also believes FSCO should be taking a more active role in investigating and prosecuting offences under its legislation. IBC shares the view that FSCO should be exercising its current investigatory and prosecutorial authority in a more rigorous manner.

### **3. Regulations Governing Relations between Insurers and Claimants**

The Task Force is prepared to recommend changes in seven areas:

- i. Require claimants to confirm attendance at treatment facilities
- ii. Require claimants to confirm receipt of goods and services billed to insurers
- iii. Require claimants to attend up to two examinations under oath upon request of insurer
- iv. Require claimants to pay their insurer a \$500 fee for missing an insurer-requested medical examination
- v. Strengthen enforceability of FSCO's Cost of Goods Guideline by making direct reference to its application in the Statutory Accident Benefits Schedule
- vi. Make it an unfair or deceptive act or practice to request that a claimant or injured person sign a claim form that has been left blank or incomplete
- vii. Require insurers to include an itemized list of expenses in the benefit statement sent to claimants every two months

IBC supports each of these recommendations.

In addition to item (ii), IBC recommends that health care facilities be required to obtain the claimant's signature on all completed invoices. This obligation will allow the claimant to verify all the dates of treatment visits and goods and services delivered. Final invoices (upon discharge from a clinic) would not have to be signed as they are completed after the final treatment. In addition, the health care facilities should be required to supply copies of all signed invoices to the insurer and to keep these signed invoices on file for audit purposes.



With respect to the signing of blank claim forms, IBC recommends that the Ontario claims form be modified so that bolded text above the form's signature line warns insureds that they must not sign the form if it is blank and that signing a blank form is considered an unfair and deceptive act.

## **ESTABLISHMENT OF A DEDICATED FRAUD INVESTIGATION UNIT**

The Task Force has indicated that it is focused on combating fraud through actions that curtail the flow of revenue to organized fraudsters, in part, through the use of sophisticated analytical technology. While IBC supports this focus, we believe that it is nevertheless necessary to establish a dedicated prosecutorial unit within the Ministry of the Attorney General that would focus on insurance fraud. These prosecutors could collaborate in the prosecution of auto insurance fraud with insurance industry investigators, health facility investigators, medical professional college investigators and local police.

## **PRIVACY AND CIVIL IMMUNITY**

The Task Force identified a number of challenges that need to be overcome in order for insurers to use pooled data and fraud identification tools as effectively as possible. These include privacy legislation and the possibility of finding appropriate ways to allow for the pooling of data and civil liability.

In its previous submission, IBC recommended legislative changes to provide civil immunity (from privacy, libel and slander laws) to insurance companies, insurance professionals, investigators and members of the public who report suspicions of fraudulent activity. IBC also identified the need to provide civil immunity to medical service providers and support staff who report such suspicions as a result of being victimized in an identity theft scheme, being approached to take part in a fraudulent scheme, or being a witness to a fraudulent scheme during their employment.

Industry members continue to express concerns that disclosure of suspicious activity to other insurers, to regulatory agencies such as FSCO and to law enforcement may expose them to civil liability. They have requested enhanced civil immunity provisions for those company staff dealing with suspicious claims.

IBC recommends the provisions of Bill 41, whose objective is to encourage the disclosure and investigation of fraudulent activity in connection with automobile insurance claims. The bill provides comprehensive whistle-blower provisions that can serve as an example of the civil immunity protections that are needed:

### **Whistle-blowing protection**

1. (1) No person shall retaliate, whether by act or omission, or threaten to do so because,



- (a) anything relating to another person's activity in connection with automobile insurance claims has been disclosed to,
  - (i) an inspector appointed under the Independent Health Facilities Act,
  - (ii) an investigator appointed under the Regulated Health Professions Act, 1991,
  - (iii) the Director within the meaning of the Independent Health Facilities Act,
  - (iv) the Registrar of a College within the meaning of the Regulated Health Professions Act, 1991,
  - (v) an insurance company,
  - (vi) the Insurance Bureau of Canada, or
  - (vii) a peace officer within the meaning of the Criminal Code (Canada); or
- (b) evidence relating to another person's activity in connection with automobile insurance claims has been or may be given in a proceeding, including a proceeding in respect of the enforcement of the Independent Health Facilities Act, the Regulated Health Professions Act, 1991 or the regulations made under those Acts.

## **DEVELOPMENT OF A CONSUMER ENGAGEMENT AND EDUCATION STRATEGY**

The Task Force has proposed the development of a dedicated website for consumer engagement as an education strategy to help consumers better understand insurance fraud. IBC supports the Task Force's recommendation for a multi-stakeholder strategy to educate and empower consumers to help combat insurance fraud. A website, assuming it is adequately promoted, could play a helpful role in giving consumers the information they need to identify fraud, to avoid being involved in it and to become more educated about the claims process.

As part of the approach, IBC recommends that the education program generally, and the website specifically, be delivered and branded as a coalition of stakeholders, including industry, government, the regulator, law enforcement and others. While the branding would be shared, it is appropriate for IBC, as the industry association, to play a lead role in creating, managing and housing the website. IBC has many years' experience in consumer education. In terms of the costs associated with the website, it is too early to estimate numbers because the expenses will depend on many factors. However, the various functions that would need to be considered, include:

- Creative concept
- Creative direction
- Production of creative elements (e.g., photo shoots, video creation)



- Writing
- Site architecture
- Wireframing
- User experience design
- Coding and development
- Quality assurance testing
- User acceptance testing
- Hosting of site
- Ongoing maintenance
- Promotion

It is important to emphasize the final bullet: promotion. A website provides value only if people know about it and use it. Significant and sustained effort would be required to raise and maintain awareness of the site as a critical resource.

## **REGULATORY DISCLOSURE OBLIGATIONS**

The Task Force is also considering new requirements for disclosure on company websites to help consumers better understand the claims process.

Overall, IBC supports the need for the additional disclosures; however, with respect to the disclosure about preferred provider arrangements, there may be some information about contractual arrangements with providers that is proprietary. So as not to inadvertently hinder competition, IBC suggests disclosure only of information that would assist customers in their decision making.

## **OTHER ISSUES**

### **Collision Reporting Centres (CRCs) and Reporting Forms**

IBC understands that CRCs expressed a willingness to make the Collision Reporting and Occurrence Management System (CROMS) database available to all police services free of charge. In addition, a project is underway to replace paper-based reporting with the new e-Collision system for statements from witnesses and a variety of documents, including photos and diagrams. IBC supports the need for consistent reporting by CRCs and police services. If possible, vehicle photos should be taken at the scene and at the CRC to corroborate the damages.

### **Abuse of the Repair and Storage Liens Act**

In light of excessive fees charged for storage, the Ontario Bar Association is recommending possible changes to the Repair and Storage Lien Act with respect to placing a lien on stored vehicles.



Fees associated with vehicle storage and repair can be astronomical. In addition, some repair shops provide limited or no access for insurers to inspect the vehicle for damages, thus limiting the insurers' ability to complete an accident reconstruction report. In principle, IBC supports efforts to address potential abuse that can occur at repair shops and storage facilities.

### **Independent Medical Examinations**

The Task Force raises questions relating to the credentials and qualifications of individuals providing IMEs.

As stated elsewhere in this report, proposals with respect to the regulation of clinics could also apply to IME providers.

### **CONCLUSION**

Auto insurance fraud is a serious problem in Ontario. Fraud costs Ontario drivers on average between \$116 and \$236 annually, based on the KPMG study.<sup>5</sup> Ontario drivers are aware fraud is an issue in the auto insurance system and believe it is influential in driving up the price of auto insurance.

Deterring fraud through licensing, stringent oversight and enhanced regulatory authority is essential for controlling fraud and lowering premiums. IBC supports legislative and regulatory amendments that will be effective in curtailing the escalating claims costs and rising premiums attributable to fraud. Moreover, we believe it is equally important that any authority given to regulate fraud should come with some assurance that those powers will be exercised diligently and effectively.

IBC is encouraged by the Task Force's dedication and commitment to examining the issues related to auto insurance fraud from its many perspectives. We appreciate this opportunity to provide comments and hope that the views we have advanced on behalf of the auto insurance industry will be given due consideration. We would be pleased to discuss IBC's recommendations in further detail and look forward to the Task Force's final report and to government's subsequent actions to combat fraud this fall.

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<sup>5</sup> KPMG Forensic, Auto Insurance Fraud in Ontario, June 13, 2012.



October 3, 2011

## Submission to the Anti-Fraud Task Force: Re Medical Rehabilitation Clinics

### Hillsborough County Ordinance 11 relating to Public Health and Safety: Providing for the Regulation and Licensing of Medical Rehabilitation Clinics

Hillsborough County has recently enacted an ordinance relating to the regulation and licensing of medical rehabilitation clinics. The provisions of that ordinance are instructive in that they detail the means by which that jurisdiction will attempt to prevent fraud by such clinics.

The County determined that:

- there has been a questionable rise in accidents with inconsistent explanations as to how the accidents have occurred
- a large number of automobile accidents were staged
- the parties involved in these accidents are part of a larger organized crime group that is involved in defrauding insurance providers through medical rehabilitation clinics
- the number of auto accident questionable claims within Hillsborough County increased 546% from 2008; and
- fraud on insurance providers cost individual policyholders in Hillsborough County as much as \$50 per vehicle in increased insurance premiums - with the expectation that this amount will increase to approximately \$85 per vehicle in 2011.

The relevant provisions of the ordinance are:

**Section 5:** A license is required for a Personal Injury Provider (PIP) to operate in Hillsborough County.

**Section 6A:** The application for a licence must include:

- the license number from the State Department of Health
- the designation of a physician who is to be responsible for operating the clinic and for ensuring that all requirements relating to registration and operation of the clinic are complied with

- the physician must actively practice at the clinic location – i.e. the physician is personally and physically involved in the day-to-day operation of the clinic and is physically present at the clinic location at least three days per calendar week and for at least four hours each of those three days
- the physician must file proof that he or she is a signor on the clinic operating bank account and all liability insurance policies
- A list of all persons associated with the management and operation of the clinic - including all full-time, part-time, contract labour, independent contractors, etc – must be submitted
- The list must include: the person’s title; his or her licence issued by the State Department of Health to engage in the medical-rehabilitation practice; current contact information for each person; criminal convictions, if any; driver’s licence or other photo ID; set of the person’s fingerprints;

**Section 6C:** The State Department of Health will perform inspection(s) of the clinic facility to determine whether the application submitted is accurate.

**Section 7:** A licence may be denied or revoked for the following reasons:

- where the application contains false information
- if there is no proper registration of the clinic
- a failure to allow for an inspection of the clinic
- a failure of any licensed person connected with the clinic to maintain an active licence in good standing with the body that regulates the person’s professional practice
- the arrest of any staff person on a charge of fraud related to the operation of the clinic
- the employment or continued employment of any person convicted of fraud or other crime or moral turpitude
- failure to abide with any provision of the Ordinance.

**Section 11:** A law enforcement officer, a code enforcement officer or any person entitled to enforce county ordinances – may enter the clinic premises to conduct an inspection to determine the clinic’s compliance with the Ordinance.

**Section 13: Enforcement and Penalties:**

- \$500 fine, or
- imprisonment for a term not exceeding 60 days, or
- a fine and imprisonment, and
- any other lawful action that the County may be able to take in law and equity