Aviva Canada's Response to the Ontario Automobile Insurance Anti-Fraud Task Force Steering Committee Status Update Report

October 1, 2012

Introduction

Thank you for the opportunity to provide comments on the Ontario Automobile Anti-Fraud Task Force Steering Committee Status Update Report. By way of background, Aviva Canada ("Aviva") is part of the Aviva Group of companies, the 6th largest insurance group globally. Aviva has Gross Written Premiums of $3.4bn which equates to a 8.5% market share. Aviva has over 3 million customers. Ontario Auto is a significant part of Aviva's business; $900M of Aviva's Gross Written Premium is derived from Ontario Personal Auto. Ontario auto fraud has an impact on Aviva's profitability and the premiums charged to Aviva's customers. Aviva is very pleased to see that the government is taking the issue of fraud seriously.

Aviva has long been committed to fighting fraud. Aviva established its claims investigation unit in 1994. The department has grown to 44 full time resources. In addition, to the claims investigation resources, Aviva has invested in data analytics and automated fraud detection technology, both internally and in conjunction with other members of the industry. Aviva believes that taking a tough stand on fraud is critical to controlling costs in Ontario auto insurance.

Overall, Aviva supports the recommendations outlined in the Task Force's report. Specifically, Aviva supports the need to regulate health clinics but does not agree entirely with the method proposed by the Task Force. Aviva also supports the need to tighten controls on the delivery of Accident Benefits and favours the specific actions identified by the Task Force. However, Aviva does not believe that the Task Force has gone far enough in establishing deterrents for premeditated and organized crime. Aviva has also had the opportunity to review the IBC's submissions and Aviva is supportive of the IBC's position. Accordingly, Aviva will limit its comments to regulation of health clinics and the establishment of a dedicated fraud investigation unit.

Organized Crime and Premeditated Fraud

Aviva was interested to read the reports from KPMG and E&Y. According to KPMG, organized fraud cost Ontario insurers and consumers between $175-274 million in 2010 and KPMG acknowledges that this range is likely an understated estimate. Ernst & Young supports KPMG's conclusion that organized fraud is likely greater than the range estimated by KPMG. Ernst & Young also attempted to quantify the scope of premeditated fraud and landed on a range of $130 to $260 million per year, bringing the total of organized and premeditated auto insurance fraud in Ontario to $305 to $535 million per year. These reports confirm what Aviva has concluded through its investigations, namely organized and premeditated fraud have become a significant problem in auto insurance. The problem is widespread involving a multitude of players in the system. The significance of the problem is magnified by the fact

that this type of fraud is difficult to detect. Also, the current regulatory framework does not specifically recognize this type of fraud and this hinders investigation and prosecution.

Aviva supports the Task Force's decision to "focus primarily on reducing the extent of organized and premeditated fraud." Aviva also agrees with the Task Force's conclusion that

> "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 of that coordination and the tools to do the job".
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> "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."

Focus on Deterrence, Prevention and Early Identification

Aviva believes that deterrence and prevention are the keys to fighting organized and premeditated fraud. Ideally, the Task Force would be considering product reform as a means to deter and prevent fraud. Failing that, regulating participation in the system becomes an important step in prevention. Deterrents, including prosecution and punishment are also important.

Aviva believes that fraud deterrence and prevention can best be achieved through:

1. Licensing and Regulation of Providers in the System; and Healthcare Clinics;
2. Establishment of a Dedicated Fraud Investigation Unit; and
3. Product Reform.

Licensing and Regulation of Healthcare Clinics:

The Task Force has asked for 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?

- Methods to increase accountability and whether a requirement that clinics designate a regulated health practitioner to be held responsible for the integrity of the clinic's business practices.

- Should the designated regulated health care practitioners be required to regularly confirm that appropriate business practices are being followed?

- Input on a range of appropriate sanctions for improper behaviour.

Currently, there are few rules regarding the ownership and operation of health care clinics in the auto insurance system. Aviva applauds the Task Force for focusing on this deficiency. In order to meet its short term goal of "implementing measures that can reduce the economic incentive to act fraudulently", Aviva recommends that the Task Force focus on entry into and removal from the system. Aviva believes that there should be restrictions on clinics that can operate within the system and also, there should be means to quickly and efficiently remove any suppliers from the system who have committed fraud. Aviva does not believe that verification of business processes would be an effective short term measure.

There are too many health care clinics and providers in the auto insurance system. HCAI reports 8,700 healthcare facilities are enrolled in its online billing system. Since the implementation of HCAI in February 2010, Aviva has received billings from 3,942 unique clinics and/or providers. (During the same time period, Aviva received approximately 23,000 new AB claims). The number of clinics and/or providers is out of proportion to the number of claimants. It is impossible for an insurer to exercise oversight over this number of suppliers. The same challenge would exist for FSCO or any other entity tasked with oversight of this many diverse providers or clinics. In order to effectively regulate healthcare clinics, the number of clinics must be reduced. Otherwise, any attempt to create a verification or attestation process would be unwieldy, would require a significant bureaucracy to administer and be costly to establish.

Aviva therefore strongly recommends that the Task Force restrict entry into the system by requiring:

(i) A clinic to be licensed under the Independent Health Facilities Act; and
(ii) Granting a licence under the Independent Facilities Act only to clinics that are owned by a registered health care provider.

This proposal would have the advantage of leveraging other licensing systems that are already in place in Ontario, which in turn would minimize costs. Aviva believes that linking ownership to a professional health care licence is a key control. A professional licence would in effect become collateral for the clinic's business practices. The potential to lose a professional licence as a consequence of fraud is a very powerful deterrent.

While it is critical to control entry of health care providers into the auto insurance system, it is equally critical that those who perpetrate fraud be removed quickly and efficiently from the system. The current system is an open one and clinics and providers can come and go as they please. The individuals that are committing fraud make good use of corporations and the protection of the corporate veil.

Currently, there is no easy way to stop transacting with a clinic or provider who commits fraud. An insurer can continue to challenge the clinic on a transaction by transaction basis. Alternatively, the

insurer can attempt to obtain an injunction from a civil court or have FSCO issue a "cease and desist" order so that it can cease doing business with a clinic or provider who has been found guilty of fraud. These solutions are all costly. Aviva recommends that a clinic that has been found guilty of fraud in an auto insurance related claim matter, lose their licence to transact business in the auto insurance system. This should apply whether the finding is made by a criminal court, a civil court or the FSCO Arbitration process. Aviva would be pleased to help the Task Force work out the particulars.

Establishment of a Dedicated Fraud Investigation Unit

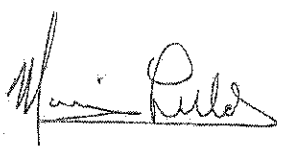
The Task Force does not favour the establishment of a dedicated Fraud Investigation Unit. Aviva respectfully requests that the Task Force reconsider its position. The Task Force is focused on actions that would curtail the flow of revenue to organized and premeditated fraudsters. Through its investigations, Aviva has seen evidence of criminal activity- organized fraud and money laundering. These are serious criminal offences which warrant police and Crown involvement. FSCO is well suited to investigate and prosecute administrative offences, but criminal activity should fall within the bailiwick of the police and Crown Attorney. Insurers need assistance in fighting this type of crime. Criminal prosecutions and penalties also serve as an important deterrent.

Product Reform

Aviva acknowledges that product reform is outside the mandate of the Task Force. However, Aviva would be remiss not to comment on the role that the product has played in fostering fraud. The Ontario Accident Benefits product remains one of the richest of its kind and this, in and of itself, provides incentive for fraud. In addition to the amount of benefits available, the SABs processes have traditionally been very consumer focused, often to the detriment of the insurers' ability to properly detect, investigate and deal with fraud. While recent reforms have attempted to correct the imbalance, further product reform is still needed. Aviva encourages the Minister of Finance to continue its review of the product.

Aviva thanks the Task Force for the opportunity to provide comments. Aviva would be pleased to discuss any of its recommendations in further detail. Aviva looks forward to the Task Force's report and thanks the members of the Task Force for their work.

Yours very truly,



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