August 21, 2012

Ontario Anti-Fraud Task Force
Steering Committee

Re: Ontario Automobile Anti-Fraud Task Force – Steering Committee Status Update – July 2012

TD Insurance ("TDI") commends the important work of the Anti-Fraud Task Force and is pleased to respond to the July 2012 Steering Committee Status Update.

With roots dating back to 1949, TD Insurance (TDI) is a member of TD Bank Group, the second largest financial service organization in Canada. The wide range of TD Insurance products, including auto and home insurance, credit protection, life, health and travel insurance, help protect clients from the "accidents of life".

TDI is the largest direct insurer as well as the second largest auto and home insurer in Canada, with more than 2 million policies and more than $2.5 billion in written premiums as of December 2011. In Ontario, TDI has more than 1 million policies and more than 1.4 million in written premiums. TDI employs more than 4,000 people across Canada, with offices in Alberta, Ontario, Québec, Nova Scotia and New Brunswick.

TDI conducts its business across a variety of jurisdictions, and is able to draw upon our expertise and share our experience in operating with a variety of models. We are committed to working with the government to provide a healthy auto insurance environment that is efficient, affordable, cost-effective, sustainable, and meets the needs of all Ontario consumers.

TDI strongly supports the direction laid out in the Steering Committee Status Update, which would widen the regulatory net to include more stakeholders in the system, help regulators and insurers deal with highly suspicious claims, while educating consumers and helping them avoid and detect deceptive practices. As we understand them, the Task Force's recommendations, if implemented will help reduce the extent of organized and premeditated fraud by making it more difficult to commit and hide.

Some believe that insurance fraud is a 'victimless crime' that does not affect them. This is simply not true. Insurance fraud affects everyone. The cost of insurance fraud is passed on to each law-abiding citizen and legitimate business, and results in increased costs of doing business and in higher consumer premiums. For more details on how auto insurance fraud impacts premiums, please refer to Appendix A.
TDI is in agreement with the overall approach to combat fraud outlined in the proposal, and would like to provide comments on a number of specific areas where we think that the Task Force's recommendations could be enhanced or where there are special considerations to be addressed:

A. Fraud Detection – 1. Data Analytics, 2. Privacy & Disclosure 3. Civil Immunity
B. Regulation of Health Clinics
C. Enhanced Authorities for FSCO
D. Tightening Controls on Delivery of Accident Benefits
E. Regulating the Towing Industry

A. Fraud Detection

1. Data Analytics

Joseph Wehrle, the president and CEO of the U.S. National Insurance Crime Bureau (NICB), informed the National Insurance Conference of Canada in October 2011 that fraud rings do not respect borders – citing an auto fraud ring operating in Minnesota that moved into Canada following U.S investigations. The NICB urged Canadian legislators to pass appropriate laws to address staged auto collisions and associated medical service provider fraud.

The NICB recommended that there be a "single integrated all claims database to improve fraud detection" and "use of claims scoring or predictive modeling." As the "U.K. and U.S. do a better job of cracking down on fraud, that leaves Canada more attractive to organized crime."[1] TD Insurance agrees with this recommendation.

A group of Canadian insurance companies has developed, on a pilot basis, an anti-fraud initiative that uses data analytics to identify suspicious claims requiring further investigation[2]. The *Data Analytics Solution* combines rules based analytics, 'social network analysis' and anomaly detection on cross insurance institution data, to detect claims patterns that can reveal potential fraud; addressing the issue of organized criminal fraud on an industry-wide basis. Data analytics have been used in the insurance industry to detect fraud in the United Kingdom since 2004.

It is anticipated that the *Data Analytics Solution* will assist participating insurers in detecting organized or premeditated fraud which might, after appropriate investigation, be reported to FSCO and/or law enforcement. It should be kept in mind that identification of a claim, network or supplier through the Data *Analytics Solution* does not necessarily mean that fraud has occurred or may occur in the future. Claims identified through the Data *Analytics Solution* must still be investigated in a balanced, objective manner in order to determine if they are meritorious or non-meritorious. Direct access by FSCO and/or law enforcement to information from the *Data Analytics Solution* may not be permitted under privacy legislation.

A cross-insurance company anti-fraud solution across Ontario would provide improved detection that individual insurance companies cannot do on their own, from model building to the identification of suspicious activities and trends. The *Data Analytics Solution* applies advanced data analysis to detect patterns of potential fraudulent behaviour in large volumes of claims data supplied by insurers. The focus is on potential claims fraud through which organized criminals make multiple, fraudulent insurance claims across many insurers. The Proof of Concept phase has demonstrated that a data analytics system efficiently identifies suspicious 'investigation worthy' claims, networks, and suppliers.

2. Privacy and disclosure of personal information

The success of several parts of the anti-fraud initiative rest on the proposals for changes to disclosure of personal information. Thorough discussion and consultation on this area will be very important. We agree with the Steering Committee observation that a critical requirement for effective investigation and enforcement of organized and premeditated fraud is early identification of suspicious cases[3]. Identification of suspicious cases can be enhanced through pooling of data such as that proposed in the *Data Analytics Solution.* A challenge is to find appropriate ways in which to pool data in accordance with the requirements of privacy legislation.

---

[1] *U.S. fraud-buster warns insurers: Sophisticated fraud rings invade Canada*", Thompson's World Insurance News, October 3, 2011, p. 1 and 4

[2] As noted on page 21 of the Steering Committee Status Update, July 2012

[3] As noted on page 39 of the Steering Committee Status Update, July 2012

The obligation to obtain consent is subject to certain exceptions found in PIPEDA. Of most relevance to *Data Analytics Solution* is the exception for investigating a breach of an agreement or a contravention of the laws of Canada or a province.

The "investigation" exception for collection of personal information applies if it is reasonable to expect that the collection with the knowledge or consent of the individual would compromise the availability or the accuracy of the information and the collection is reasonable for purposes related to investigating a breach of an agreement or a contravention of the laws of Canada or a province.

The "investigation" exception for use of personal information applies if it is reasonable to believe the information could be useful in the investigation of a contravention of the laws of Canada, or a province or a foreign jurisdiction that has been, is being or is about to be committed, and the information is used for the purpose of investigating that contravention.

The "investigation" exception for disclosure of personal information without consent to non-governmental entities are currently restricted to disclosures to an "investigative body" specified in regulations if the disclosing organization has reasonable grounds to believe that the information relates to a breach of an agreement or a contravention of the laws of Canada, a province or a foreign jurisdiction that has been, is being or is about to be committed. Disclosures "by" an investigative body are permitted only if the disclosure is reasonable for purposes related to investigating a breach of an agreement or a contravention of the laws of Canada or a province.

An amendment to the Ontario Insurance application process for automobile insurance should be implemented to include client consent specifically addressing the collection, use and disclosure of personal information for fraud detection and prevention purposes related to fraud detection analytics.

The existing consent provided in the *Application for Automobile Insurance Owner's Form* (OAF1) already refers to the detection and prevention of fraud, but we recommend that the wording be improved to be more transparent and less restrictive. A requirement of PIPEDA is that the consent for the collection, use and disclosure of personal information be knowledgeable in the sense that the individual be aware of the purpose for which the personal information will be used. The consent should refer to disclosure to fraud detection analytics and possibly fraud detection agencies. This would require an appropriate amendment to the existing consent and brochure provided to Ontario consumers in the initial insurance application, as well as the consent obtained at the time a claim is filed. To take into consideration the *Data Analytics Solution* initiative, the consent should include more specific consent language related to fraud detection analytics.

The consent obtained at the time the claim is filed could, in part, be facilitated through an amendment to Part 11 of the *Application for Accident Benefits* (OCF – 1) which would be effective for accident benefit claims. A legislative requirement to provide consent would be useful for other claims such as third party tort claims and property damage claims. The requirement for third party claimants to provide consent could be added to the Claimant's obligation to inform in section 273 of the *Insurance Act.*

3. Civil Immunity

In order to better protect the consumers, insurance companies, investigators, etc., who report or provide information of suspicious or fraudulent activity / suspected fraud, civil immunity laws (particularly privacy, libel and slander laws) should be implemented.

This measure involves the introduction of appropriate legislation to protect insurers and citizens providing information in the investigation of fraud and abuse. Immunity statutes must include protection of insurance companies who share claim information about suspected fraudulent claims with law enforcement and other agencies. Without such protection in today's litigious environment, reasonable insurers may be forced into difficult circumstances – due to potential

lawsuits and the spectre of large punitive damage awards and special awards – to avoid or limit investigating and challenging suspicious claims and simply pay them, which of course, unfairly penalizes all other consumers with an increase in premiums.

Enactment of civil immunity laws to protect individuals, organizations and insurers will allow for the exchange of relevant information for the purpose of detecting and deterring insurance fraud and would put Ontario on par with many other Canadian jurisdictions.

Civil Immunity is provided for in Ontario in some cases for persons providing information to regulatory bodies and has been proposed for persons who report suspected insurance fraud in a Private Members Bill recently introduced in the Ontario legislature.

As noted in the Steering Committee Status Update, some degree of civil immunity is provided under section 446 of the *Insurance Act,* R.S.O. 1990, c I.8 which reads as follows:

> ***No liability***
>
> ***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. R.S.O. 1990, c. I.8, s. 446; 1997, c. 28, s. 146.*

The immunity under section 446 is limited to oral and written statements given to the Financial Services Tribunal, the Superintendent of Financial Services, an employee of the Financial Services Commission of Ontario or any other person acting under the authority of the *Insurance Act* and therefore would not provide protection for information shared with law enforcement, insurance companies or regulatory colleges.

Similar protection is provided under subsection 43.1 (7) of the *Health Insurance Act,* R.S.O. 1990, c. H.6 for persons who report information about ineligible claimants attempting to receive reimbursement for medical services through OHIP. Subsection 43.1(7) reads as follows:

> ***Protection from liability***
>
> *(7) No proceeding for making a report under subsection (1) or (5) or for providing information in connection with the report shall be commenced against a person unless he or she acts maliciously and the information on which the report is based is not true.*

Protection of private individuals who provide information about suspected insurance fraud, including protection from retaliation, such as employees of Health Clinics is also required. In addition to potential civil action, these individuals may face the loss of their employment and harassment.

We note that civil immunity has been proposed as part of Bill 41 *Reducing Automobile Insurance Premiums by Eliminating Fraud Act, 2012* which has passed through Second Reading in the Ontario legislature. The relevant sections are noted in Appendix B.

The proposed legislation would provide the recommended protection, and encourage the reporting of information leading to the protection of insurance fraud. A concern, however, is that the protection from legal action does not provide protection in the event that the person acted in "bad faith." Since the term "bad faith" is not defined there is a risk that actions brought against insurers related to the release of information could allege "bad faith" as part of the cause of action, and therefore actions, even if without merit, would likely be allowed to go forward thus lessening the protection intended by the Bill. TDI recommends that section 1(3) be amended to

provide the same protection as subsection 43.1 (7) of the *Health Insurance Act* which is reproduced above.

The amended section would therefore read as follows:

> *(3) No action or other proceeding shall be instituted against any person for making a disclosure or giving evidence described in subsection (1), unless the person acted maliciously and the information on which the report is based is not true.*

Adoption of the provisions of section 1(3) of Bill 41 with the recommended amendment would, in our opinion, provide the appropriate protection of individuals, insurers, investigators, etc. who report or provide information of suspicions of fraudulent activity/ suspected fraud without protecting those who report untrue information for malicious purposes.

B. Regulation of Health Clinics

TDI agrees with the Steering Committee's conclusion that licensing and regulation of auto insurance business practices of health clinics is appropriate and necessary.

One factor contributing to the increase in claim costs may be the dramatic increase in the number of health professionals in Ontario who work in the auto insurance sector. According to a report from the Canadian Institute of Health Information entitled *Canada's Health Care Providers 2000 – 2009,* there was an average increase of 46% in the number of rehabilitation professionals between 2000 and 2009, whereas there was only a 16% increase in the number of physicians during the same period.

According to the Health Claims for Auto Insurance ("HCAI") System, as of the end of April 2012, there were 8515 Health Care Facilities enrolled in HCAI. Considering that there are 62,000 new claimants per year, it appears from this data that there would be, on average, only 7.3 new patients per clinic per year. These figures suggest that there may be an incentive, in order to be financially viable, for multiple treatment providers to treat and assess claimants and for treatment to be prolonged.

There is evidence indicating that some health care professionals and clinics are involved in presenting non-meritorious claims to insurers. An example is Project Whiplash, in which criminal charges have been laid by the Toronto Police Service, against a number of medical clinics and individuals, related to alleged staged accidents and false Employment Insurance claims.

On May 25, 2012, FSCO announced that five Rehabilitation Clinics had been charged with knowingly making false or misleading statements to an auto insurer to obtain payment for goods or services provided to an insured and engaging in unfair or deceptive acts or practices.

A 2010 report by CTV News noted that the "*rules concerning the ownership of clinics are surprisingly lax in the province. For an initial fee of $500, any person – not necessarily a doctor [or even a medical practitioner] – can register as the owner of a clinic; hire practitioners and bill insurers for claims. In order to file those claims, a doctor or registered practitioner's name, signature, and other billing information is needed, but this is sometimes forged. Certainly an area where we all should be taking a close look is just what is the process to allow a person to own a health-care clinic? … It should be at least as stringent as the process to obtain a licence to become a health-care professional."*[4]

[4] Grant Robertson, Tara Perkins, "How Small-Time Auto Insurance Scams Have Evolved into Big Business" (2010) CTV News. www.ctv.ca/generic/generated/static/business/article 1850088.htm

Below are TDI's responses to the specific questions asked by the Anti-Fraud Task Force in the Steering Committee Status Update.

- **Should there be restrictions placed on the ownership of clinics and what kind of transparency by the owners should be required?**

TDI recommends that the Ontario Government create regulations under the *Independent Health Facilities Act:*

- Regulating classes of persons who shall not be owners of independent health clinics, or specify what qualifications they must possess (i.e., reputable and responsible in character etc).

- Requiring that criminal background checks and fingerprints of any director, officer or proprietor of an independent health clinic (clinic administrator, program director and fiscal officer) be provided to the appropriate administering agency for the purpose of approving or denying a licence to operate.

- Providing that licenses are not transferable and must be renewed every 12 months.

Regulation and licensing of health clinics is governed by the *Independent Health Facilities Act, 1990* (the "*Health Facilities Act*"). The *Health Facilities Act* allows for licences to be granted to individuals or corporations for the establishment of independent health clinics. The directors (but not all officers, managers, operators, major shareholders, etc.) of a corporate licensee must be disclosed to the Minister of Health.

Compared to other jurisdictions, and other legislation within Ontario, the *Health Facilities Act* does not appear to require heavy scrutiny of independent health facilities. The current *Act* does not require criminal background checks of company officers and day-to-day managers, and the legislation does not specifically deal with insurance fraud. Other than the directors, the officers, managers, operators, and major shareholders of a corporate licensee are not required to be disclosed to the Minister of Health.

In the United States, jurisdictions such as California require licenses to be obtained to operate a clinic, and the following issues are addressed:

- Evidence indicating that the applicant (and for corporations, the directors and officers) are reputable and responsible in character.
- Criminal history check on the clinic administrator, program director, and fiscal officer. The criminal record clearance requires people in these roles at the proposed clinic to submit electronic fingerprint images to the Department of Justice.
- Any crime involving the misuse of funds requires the licence application to be denied.
- Licences are not transferrable and must be renewed every 12 months. [*California Health and Safety Code, s. 1575.7 and s.1576.2]*

The other Ontario legislation that should be considered is the *Laboratory and Specimen Collection Centre Licensing Act, 1990,* R.S.O. 1990, c.L.1 *(*the *"Specimen Act")*. This *Act* has more regulatory discretion than the current *Health Facilities Act* does – such as with respect to regulating who can own and manage a specimen collection centre.

TDI recommends that the Minister of Health develop regulations under the *Health Facilities Act* to regulate who is able to own and operate an independent health facility, or specify what qualifications they must possess. In addition, licenses should not be transferable and should be required to be renewed every 12 months in order to maintain the standards of ownership required by the new regulations.

To encourage transparency with regard to the ownership of the clinics, TDI supports reinstatement of the conflict of interest provisions which were contained in sections 37.1, 38, 38.1, 38.2 and 38.3 of the *Statutory Accident Benefits Schedule ("SABS")- Accidents on or After November 1, 1996,* O.Reg 403/96. Those provisions required lawyers, paralegals, members of a health profession and social workers to indentify a conflict of interest with respect to claims for medical and rehabilitation benefits. These provisions were deleted from the present *Statutory Accident Benefits Schedule – Accidents on or After September 1, 2010,* O.Reg 34/10 while maintaining conflict of interest provisions for insurers.

- **Requirement that clinics designate a regulated health practitioner to be held responsible for the integrity of the clinic's business practices and confirm that appropriate business practices are being followed.**

TDI supports the proposal to have a regulated health practitioner held responsible for the integrity of a clinic's business practices in order to protect the consumer and to enhance accountability of the clinic. This requirement should, however, be accompanied by a requirement that appropriate records be kept and that rights be given to the regulatory body responsible (i.e. FSCO) to audit the clinics to verify the attestations given by the regulated health professional.

- **Sanctions for improper behaviour of medical clinics**

TDI supports the sanctions proposed on page 30 of the Steering Committee Status Update. TDI also submits that, in appropriate cases, the clinic's licence to operate should be suspended or terminated.

The Steering Committee has indicated that it is considering whether the regulatory regime recommended for health clinics should also apply to other commercial enterprises that provide independent medical assessments to insurers or to claimants[5] and is considering requiring an attestation from an organization performing Independent Medical Assessments that all medical examiners are qualified and operating within the scope of their competency.[6]

FSCO has noted that the number and costs of medical assessments have steadily grown in the last 12 years[7] and cited an IBC submission which indicated that in 2007, 60 to 80 cents was spent on medical assessments for every dollar spent on treatment. As a result, the Ontario Government implemented changes on September 1, 2010 requiring that expenses for assessments requested by claimants be included in the limit for medical and rehabilitation expenses provided under the Statutory Accident Benefits Schedule (SABS), and that the cost of all assessments be capped at $2000.

TDI supports the recommendations of the Steering Committee noted above which will provide a greater degree of transparency and accountability on the part of the commercial enterprises performing medical assessments. TDI submits that the recommendations should apply equally to commercial enterprises performing medical assessments at the request of claimants and at the request of insurance companies.

C. Enhanced Authorities for FSCO

TDI supports the recommendations in Appendix 4 of the Steering Committee Status Update to increase the ability of FSCO to obtain information and in Appendix 5 to authorize FSCO to investigate and sanction unfair and deceptive acts or practices. These recommendations will

[5] As noted on page 29 of the Steering Committee Status update, July 2012
[6] As noted on page 48 of the Steering Committee Status update, July 2012
[7] *Report on Five Year Review of Automobile Insurance* dated March 31, 2009

enhance FSCO's ability to conduct a comprehensive investigation and sanction incidents involving organized or premeditated insurance fraud.

As noted on page 64 of the Steering Committee Status Update, while failing to disclose a conflict of interest to a claimant of an insurer where required by the *SABS* is an unfair or deceptive act or practice, after September 1, 2010, the *SABS* no longer required healthcare goods and services provider and legal services providers to disclose a conflict of interest. TDI supports reinstatement of the conflict of interest provisions which were contained in sections 37.1, 38, 38.1, 38.2 and 38.3 of the *SABS - Accidents on or After November 1, 1996,* O.Reg 403/96. Those provisions required lawyers, paralegals, members of a health profession and social workers to indentify a conflict of interest with respect to claims for medical and rehabilitation benefits. It is not clear why those provisions were not included in the *SABS - Accidents on or After September 1, 2010,* O.Reg 34/10.

Increasing the authority of FSCO will not have its desired impact on insurance fraud without the correct structure being developed and adequate resources being provided to FSCO to hire sufficient staff with requisite expertise. TDI supports providing FSCO with additional resources in order to effectively implement its additional regulatory responsibilities.

D. Tightening Controls on Delivery of Accident Benefits

TDI supports the regulations recommended by the Steering Committee on governing relations between insurers and claimants with respect to accident benefit claims.[8]

TDI also recommends that the rules regarding mediations at FSCO be strengthened to require an insured claimant to actively participate in the mediation process. This will ensure that claimants are aware of all and any claims being advanced and all actions taken on their behalf. It also allows them to actively participate throughout the entire resolution process to ensure that their best interest is being represented without any potential abuse.

The procedure for the mediation process at FSCO is governed by the *Dispute Resolution Practice Code (*the *"Code").* Rule 17 of the *Code* which provides the requirement for participation in the mediation process reads as follows:

> *PARTICIPATION IN MEDIATION 17.1 Parties to the mediation and their representatives (if any) must participate in good faith in the mediation process and provide all relevant documents within the time frames set out in these Rules. 17.2 The appointment of a representative does not relieve any party of the obligation to participate in the mediation, in person, by telephone or other electronic technologies, and to provide instructions to any representative in respect of any issue in dispute or settlement offers made. 17.3 Where a party does not comply with Rules 17.1 and 17.2 the mediator may:*
>
> > *a) Adjourn the mediation on such terms as he or she considers appropriate; or b) Report to the parties that mediation did not take place.*

Despite the wording of Rule 17, it is not unusual for represented claimants to be "available" by telephone rather than actively participating in the mediation – in other words, the insured claimants do not actually participate at all in the mediation, but the representative states to the mediator that the insured can be contacted by telephone if required by the mediator. Generally the mediator will not require the insured claimant to actively participate. Under those circumstances, the insured claimants do not have an opportunity to actually resolve the issue, hear what is occurring, or be involved in the discussions taking place during the mediation

[8] As noted on pages 34-36 of the Steering Committee Status update, July 2012

process. We believe it is difficult for claimants to fully understand the evolution of their case unless they actively participate in discussions, whether by phone or in person.

We recommend that Rule 17.3 be amended by replacing the word “may” with the word “shall”. This will require a mediator to adjourn the mediation or to report to the parties that the mediation did not take place where the insured claimant did not actually participate in the mediation process. It is recommended that the Superintendent of Insurance issue a guideline stating that participation in mediation requires active participation and not merely being “available” by telephone.

TDI would be pleased to participate in further consultations with respect to drafting and implementation of the regulations.

E. Regulating the Towing Industry

TDI supports the implementation of province-wide standards and requirements of the Towing Industry with respect to the following:

1) Fees and transparent billing practices.
2) Bans on paid referrals for services not offered by the tow truck operator including storage, auto body shops, health care and legal services.
3) Requirement that vehicles towed from a collision scene be taken directly to a collision reporting centre, if one is available.
4) Information to be provided to consumers at the time that the towing operator is engaged.

We believe that consumers should have the same rights and experience when it comes to towing services, regardless of the location where an accident takes place. Standardized province-wide regulation would help ensure that tow truck operators tow vehicles to locations based upon specific regulatory requirements as opposed to possible incentives.

TDI appreciates the challenge FSCO will face in enforcing compliance with the regulations which are implemented. We fully support the Steering Committee Status Update recommendation, as proposed in Appendix 5, to expand the definition of “person” whose affairs the Superintendent can examine and investigate as to whether the person has engaged in an *Unfair and Deceptive Act or Practice*. We believe that this would allow FSCO to investigate and enforce the regulations put in place in order to better protect the consumers.

Conclusion

At TDI, we believe that all stakeholders have a common interest in ensuring that only meritorious claims are paid. Increased payments of inappropriate claims by insurers lead to increased premiums for consumers and undermine no-fault insurance and its ability to meet its important social policy function. Helping to bring this crime under control is an important public policy and provincial government objective. We agree with the focus of the task force on consumer education and engagement as an important component of an effective solution to combating fraud.

TDI supports the work of the Ontario Anti-Fraud Task Force, and appreciates the opportunity to provide input. We feel that the general framework and recommendations are on track and we have provided several suggestions throughout this submission where we feel the Task Force recommendations could be enhanced.

We feel that one of the most important recommendations relates to the creation of a regulatory level playing field for FSCO oversight by expanding the reach of the “unfair and deceptive practices” regulation to apply equally to other non-insurance company stakeholders in the system. We trust our comments are of assistance with respect to these important matters of public policy, and we would be pleased to continue to assist with further consultations.

Sincerely,

(Original signed by)

Carol Jardine
Vice President, Claims Services
TD Insurance

Appendix A

Impact of Fraud on Auto Insurance Premiums

Ontario automobile insurance claim costs are higher than any other province in Canada.
In the five years between 2005 and 2010, claims costs increased by 61% from $5.4 billion to $8.7 billion. This increase represents approximately $450.00 in additional premiums per registered vehicle in Ontario.

The Ontario Auditor General stated in his 2011 Annual Report that the "*responsibility of the government includes balancing the need for a financially stable auto insurance sector with the need to ensure that consumers pay affordable and reasonable premiums and receive fair and timely benefits and compensation when they are involved in accidents."*

The Auditor General reported that from 2005 to 2010, the average Statutory Accident Benefit ("SABS") claim cost rose 92% from $29,189 to $56,092. Ontario's claims cost of $56,092 is more than five times higher than the average claim in other provinces. This follows the Federal Superintendant of Financial Institution's statement in 2008 that, "*in Ontario, the flat premium environment is being overtaken by the inexorable rise in claims costs… with absolutely no sign of abatement*."

According to the Ontario Auto Insurance Anti-Fraud Task Force Interim Report released in December 2011, there is no correlation between the increase in claims costs and the number of personal injury collisions. Between 2005 – 2010 claims costs rose 92%, and the number of SABS claims rose by 14%, however the number of car accidents actually decreased by 3,500.

Personal injury fraud can be premeditated; that is specific actions can be carried out for the purpose of illegally collecting insurance benefits. These may include staged accidents, in which participants fake collisions, claim to be injured and fraudulently collect insurance benefits and fraudulent billing for medical services that have not been delivered. These staged accidents are often carried out by organized fraud rings.

While all insurance fraud must be condemned, it is organized auto insurance personal injury fraud in the form of staged collisions and/or fraudulent billing for medical services that result in the greatest economic and social costs.

In October 2010 The Globe & Mail reported:

> *"Staged accidents occur across Canada, but …. Southern Ontario – the largest insurance market in the country – has become a virtual haven for fraudsters as jurisdictions in the U.S. beef up their ability to crack down on fraud. Toronto is a hotbed, with organized crime being linked to several staged accidents"…. "Ontario's problem has flourished due to a combination of relatively rich benefits and rare or light punishments"…. "In 2004, FBI investigators cracked what they called the BORIS case – short for Big Organized Russian Insurance Scam – in New York and surrounding areas. That case saw more than 500 individuals indicted in 2003 in relation to more than 1,000 car accidents. Some of those participants, some of those targets, some of those people who were identified as suspects in that investigation, have and continue to have affiliations to operations here in Ontario, said Kirk Quinn, an injury ring investigator with the IBC"…."They need to know that if they get caught, something serious will take place."*

To address the issue of Ontario claims costs, we must consider the impact on insurance cost by all participants in the claims process, including paralegal advisors, lawyers and tow-truck operators to doctors and treatment clinics.

The Toronto Star reported in May 2011 that *"the multi-million dollar business of auto insurance fraud is a key factor driving up premiums in Ontario*[9]*."* The article discussed staged collisions and fraudulent rehab claims.

The extent of fraud in the Ontario auto insurance system has risen to the point that in April 2011 it was reported that an 18 year veteran police officer of the Peel Region Police was charged for allegedly facilitating the reporting of staged motor vehicle accidents as legitimate collisions – the alleged fraud involving the staging of motor vehicle collisions followed by insurance claims[10].

Ontario PC party leader Tim Hudak has said that *"if you want to achieve real savings with auto insurance premiums, you need to first start cracking down on the cheaters and clean up the system."* (2010).

Toby Barrett, the MPP (Haldimand-Norfolk), noted that fraud drives insurance premiums above normal levels (2010). He stated:

> *"Last year, the average cost per claim was nearly $53,000. That's up from about $30,000 five years ago. The average cost per claim in Alberta is $4,000. I don't think there is anything wrong with Ontario drivers. I don't think it's the condition of our roads -- I think the problem is insurance fraud."*

Finance Minister Duncan has stated that "*these costs have gone way out of all proportion to anything. It's abuse of the system"* (Oct. 4, 2010), *"we are fighting fraud in the system"* (Sept. 13, 2010), *"we are getting rid of abuse in the system."* (Sept. 28, 2010).

Appendix B

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*,

[9] The Toronto Star "How to Spot a Staged Auto Collision," by Sheryl Smolkin, May 1, 2012
[10] Toronto Sun, "Two Ontario Cops Charged in Separate Incidents," by Chris Doucette, April 14, 2011

(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.

Interpretation, retaliate

(2) Without limiting the meaning of "retaliate" in this section, the following constitute retaliation for the purpose of this section:

1. *Dismissing, suspending or disciplining an employee.*

2. *Imposing a penalty on any person.*

3. *Intimidating, coercing or harassing any person.*

Protection from legal action

(3) No action or other proceeding shall be instituted against any person for making a disclosure or giving evidence described in subsection (1), unless the person acted maliciously or in bad faith.