FAIR Association of Victims for Accident Insurance Reform
579A Lakeshore Rd. E., Box 39522, Mississauga, ON, L5G 4S6
fairautoinsurance@gmail.com

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Sent by email to: AutoInsurance@ontario.ca
Fraud and Abuse Consultation
Financial Institutions Policy Branch, Ministry of Finance
95 Grosvenor Street Floor 4, Toronto ON M7A 1Y7

FAIR submission to Proposed Fraud and Abuse Strategy - Auto Insurance Sector 21-MOF010

FAIR (Fair Association of Victims for Accident Insurance Reform) is a grassroots not-for-profit organization of MVA (Motor Vehicle Accident) victims who have been injured in motor vehicle collisions and who have struggled with the current auto insurance system in Ontario. We are the end users of the auto insurance product and we appreciate the opportunity to have our voices heard.

We acknowledge that there is often an element of fraud in every aspect of our lives, including auto insurance and that fraudulent behavior is not specific to just claimants or the plaintiff landscape.

We are concerned the Minister of Finance openly acknowledges that the auto fraud is not defined nor is the abuse referred to in the document given any context as a starting point for a meaningful discussion. The overall tone of the consultation materials suggests that fraud is only coming from consumers and it is only perpetuated by the sectors that serve the needs of injured Ontarians. This cannot be farther from the truth.

The bias against consumers is evident in the failure to include auto insurer's fraudulent activities and their failure to act on the fraud that emanates from their own business practices. Instead we see the Minister of Finance acknowledge there is no ***"accurate quantification of the size and scope of fraud and abuse"*** and the continued use of auto insurer's reported loss to fraud as if it is fact instead of unsubstantiated exaggeration (and isn't that itself evidence of a fraud upon the public?) and the Minister further suggests that the answer is to allow auto insurers more power, more latitude and more tools to fight the selective fraud insurers identify. It is akin to handing the car keys to a drunk driver and saying drive carefully.

Failure to acknowledge insurer fraud as a very real and expensive part of our insurance costs will guarantee that there will be no solution to high premiums. Those costs are padded by the insurer's fraud estimate that adds almost $300 to every Ontario premium.

We have included three current dictionary definitions of 'fraud' all of which all adequately describes what we see as insurer fraudulent behavior in claim handling practices in respect to medical file manipulations. This would fall under an ***"intentional deception made to secure unfair or unlawful gain or to damage another person"*** and it is accomplished ***"by deceit,***

falsehood or other fraudulent means" through medical file manipulations and dishonesty by deflating the seriousness of injuries.

It is disturbing to see the Minister of Finance, despite not knowing the extent of the fraud or acknowledging the participation of the largest stakeholders, give insurers a pass and ask the abusers, the insurers who are often the 'bad actors', to police themselves.

We have addressed the four points of interest below:

1. Define Insurance Fraud and Abuse.

See dictionary definitions below. We would point out that the Ministry document perspective seems to be that injured Ontarians and their treatment providers are inflating injuries and that is the only fraud of interest. We would point out that deflating injuries is also fraud and it has a deep level of damage to Ontario's patients in recovery and insurers need to be accountable for that. On the way to deflating injuries we see significant abuse by insurers via medical file manipulations and then by influencing the justice system and/or overuse of that system in order to intimidate and financially punish patients for holding their insurers to account. All of these insurer actions go beyond undermining health and recovery; they are undermining the fabric of our communities, our social supports, and trust in our institutions and ultimately in the government that mandates we purchase the product. Fraud is not a one way street and accountability must be expected from ALL participants.

2. Improve use of data in the industry's fraud and abuse management activities by enabling better collection, analysis and reporting of relevant data / information.

There is not enough data on the extent of the financial loss to fraud in part because insurers have generally been unaccountable and thus the government has no real idea where our premium dollars are going. The insurers inflated estimate of fraud may or may not include the costs of claims they deny and/or the ballooning legal costs they incur in the excessive denials of claims. This needs to be remedied and greater accountability and transparency for insurer finances should be built into our system of oversight.

Page 5 of the attachment brings in the issue of what information insurers are gathering about their customers ***"How can an insurer's plan be monitored and continuously improved, and what role can data and metrics (see above) play in that process?"*** and asks ***"What are high impact / high priority opportunities that the industry will benefit from improved sharing and / or use of data? What barriers are preventing action on those opportunities?"*** This opens up the discussion to a new area of concern about what information insurers are currently gathering and what are they doing with that data? What if any interaction has the Minister of Finance had with the Ontario Privacy Commissioner to protect the rights of Ontario consumers? We strongly suggest this is an area of great concern to Ontarians who may be giving up privacy without good information currently in a trade for premiums that don't seem to be coming down anyway. We would strongly suggest that the Privacy Commissioner be consulted on this point.

3. Mandate insured's cooperation with insurer F&A investigations.

Here again we see the anti-claimant, anti-consumer slant of the consultation language and an implied threat to make life even harder for those who make a claim. What sort of mandate is being considered to leverage Ontario consumers? Allowing auto insurers greater power over their injured customers at a vulnerable time does not sound like consumer protection but rather consumer intimidation. It also means consumers, especially those with cognitive deficits will need increased legal representation during a process initiated by their insurer whose claims handling is dictated by profit-making. This will likely save insurers money but will it improve the situation for car crash survivors or the taxpayers who pay when insurer don't?

• Enhance the use of insurer Preferred Provider Networks (PPN), and review/update processes for potential disagreements.

Ontario's court cases are rife with examples of how insurers have used medical opinion evidence to deny claims and been called out for their inability to adjust claims fairly by favoring one medical assessor over another or by ignoring or manipulating the medical evidence. There was no mention of the PPN in the Budget Blueprint so we suspect there is some pressure coming from insurers seeking greater profits through further influencing medical files.

Autonomy over medical care is one of the few controls Ontario car crash survivors have to influence their recovery outcome. Removing that basic right to choose a treatment provider, a right enjoyed by ALL Ontarians, would be to grant big business control over one's healthcare, something we have not seen in Canada and something we certainly should not support. One only has to look at how poorly insurers have done with their Insurer Medical Examinations (IMEs) to say with certainty that they should never have control over our medical care.

The intent of insurance is that auto insurers are to pay for treatment and the Insurance Act says nothing about granting insurers the right to decide what that treatment is or how Ontario patients should get that treatment. A medical license is required for that decision and having medical providers totally dependent on insurers for income will influence access to rehab resources in the same way as is happening with IMEs.

This leads us into an American style of healthcare, something Canadians have never supported, and it means that consumers would sign away any rehab or care options at time of purchase. That would mean injured Ontarians could not change treatment providers even if they found that provider was unsuitable. It would be their insurer, using a profit metric that would decide what care they should have or what care they deserve. This moves us further away from patient recovery.

• Allow insurers to exclude coverage for services provided by certain vendors, based on investigations and reasoned decisions, and review/update processes for potential disagreements.

This proposal allows insurers too much power over personal healthcare decision processes. It will open the door to auto insurers deciding those providers who decide patients need more care and act in accordance with their regulatory College mandates, are not suitable to use for their customers. This cannot lead to good patient outcomes. Insurers should always be able to

deny individual treatment providers who are not in good standing with their regulatory Colleges or who have been criminally convicted for healthcare fraud. It also means that insurers should not be denying claimant choices and access to providers based on putting profit before well-being.

4. Set up a whistleblower program and / or protection(s).

Whistleblowers are defined as someone, usually an employee, who exposes information or activity deemed illegal, illicit, unsafe, or a waste, fraud, or abuse of funds and we would support protection for those who speak out to protect consumers. More detail is needed.

• Establish expectations for fraud and abuse management plans.

"Provide clarity that insurers have the primary responsibility to manage fraud and abuse" supposes that the insurers are not involved in fraud themselves or that they are competent or qualified to manage what fraud they do see. Given that the IBC fraud estimate runs in the billions of dollars a year over decades, it becomes clear that the insurer management of fraud is a failure of gigantic proportions far beyond what any other reasonable business would tolerate. It becomes more likely the billions said to have been lost to fraud and the resulting $300 added to individual premiums is itself a fraud and an abuse of Ontario's captive consumers.

• Review and update/introduce FSRA investigation and enforcement tools.

More information is needed in regards to current tools and what is lacking. In the past decade sanctions for insurers that behave badly have been removed through legislation. Costs such as the $40,000 deductible payable by claimants has been indexed and increased as has the court threshold that triggers it. All while funding for treatments has declined. Other disincentives such as a 'special award' for claimants when insurers behave badly are now very rare and consumers are routinely left without their legal costs at LAT AABS which has made denying claims even more attractive to insurers. A recent LAT AABS decision awarded a blind 84 year old man with language difficulties a mere $250.00 when Aviva *"acted in bad faith, especially when it ignored the material change in circumstances and pressed on with this motion when it was obvious it lacked any merit."* This illustrates how insurers are 'helped' at the LAT. It shows us how badly insurer accountability is needed to curb customer abuse. How are we to believe that a $250.00 sanction will in any way affect how insurers treat their customers? What it does say is that Ontario auto insurers are in need of meaningful accountability because they manipulate the system with impunity.

• Facilitate FSRA's ability to share F&A information with other regulators.

There is serious privacy issues associated with sharing F&A information while protecting a confidential source. More information is needed.

When the starting point to a consultation to improve the system begins from a place where one element is exempt from scrutiny it is unlikely to produce the changes needed to reduce premiums and reduce fraud. As Minister of Finance asks how insurer's plans can be monitored

and improved it is most striking that the consultation is even taking place given the premise the insurers are being asked to self regulate based on fraud they cannot substantiate.

Ultimately we can't answer many of the questions posed by the Ministry when the consultation ignores insurer fraud which starts with the insurers inflated and unsubstantiated calculation of what that fraud number is and as one member put it – BS is apparently indexed because the IBC fraud estimate is still going up while accidents are going down.

We hope that the Ministry will meet with the various stakeholders to further discuss a better starting point and perspective regarding the fraud and abuse of Ontarians.

Thank you for your attention and for the opportunity to voice our concerns. We look forward to participating in future discussions.

FAIR Association of Victims for Accident Insurance Reform

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1) Merriam-Webster Dictionary: Definition of *fraud* https://www.merriam-webster.com/dictionary/fraud

1a: DECEIT, TRICKERY *specifically* : intentional perversion of truth in order to induce another to part with something of value or to surrender a legal right was accused of credit card *fraud*

b: an act of deceiving or misrepresenting : TRICK automobile insurance *frauds*

2a: a person who is not what he or she pretends to be : IMPOSTOR He claimed to be a licensed psychologist, but he turned out to be a *fraud*. *also* : one who defrauds : CHEAT

b**:** one that is not what it seems or is represented to be The UFO picture was proved to be a *fraud*.

2) The Financial Consumer Agency of Canada (FCAC) ensures federally regulated financial entities comply with consumer protection measures, promotes financial education and raises consumers' awareness of their rights and responsibilities. 12.1.2 Types of fraud: Definitions https://www.canada.ca/en/financial-consumer-agency/services/financial-toolkit/fraud/fraud-1/3.html

Scam: A confidence game, swindle or other fraudulent scheme, especially for making a quick profit

Fraud: An intentional deception made to secure unfair or unlawful gain or to damage another person

Scams and frauds are schemes or deceptions designed to secure unfair or unlawful gain or to damage another person. They are crimes. We use the words interchangeably.

3) Section 380 of the *Criminal Code* is defined as follows: http://www.criminal-code.ca/criminal-code-of-canada-section-380-1-fraud/

Fraud 380(1) Every one who, by deceit, falsehood or other fraudulent means, whether or not it is a false pretence within the meaning of this Act, defrauds the public or any person, whether ascertained or not, of any property, money or valuable security or any service, []

Tribunal File Number: 19-009565/AABS Adel Ahmed and Aviva Insurance Company
https://www.bogoroch.com/wp-content/uploads/Ahmed-v-Aviva-Insurance-Decision.pdf