OTLA Ontario Trial Lawyers Association

OTLA Submission to the Ministry of Finance and the Financial Services Regulatory Authority of Ontario

Proposed Fraud and Abuse Strategy for the Auto Insurance Sector

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The Ontario Trial Lawyers Association (OTLA) is pleased to provide input to the Ministry of Finance ("MOF") and the Financial Services Regulatory Authority of Ontario ("FSRA") regarding its Proposed Fraud and Abuse Strategy for the Auto Insurance Sector.

OTLA was formed in 1991 by lawyers acting for plaintiffs. Our purpose is to promote access to justice for all Ontarians, preserve and improve the civil justice system, and advocate for the rights of those who have suffered injury and losses as the result of wrongdoing by others while, at the same time, advocating aggressively for safety initiatives.

Our mandate is to fearlessly champion, through the pursuit of the highest standards of advocacy, the cause of those who have suffered injury or injustice. Our commitment to the advancement of the civil justice system is unwavering.

OTLA's members are dedicated to the representation of wrongly injured plaintiffs across the province and country. OTLA is comprised of lawyers, law clerks, articling students and law students. OTLA frequently comments on legislative matters, and has appeared on numerous occasions as an intervener before the Court of Appeal for Ontario and the Supreme Court of Canada.

INTRODUCTION

OTLA and its members support measures to combat insurance fraud in Ontario and, in particular, fraudulent claims relating to Statutory Accident Benefits (*SABS*).

OTLA is, however, concerned that the proposals set out in the MOF's Consultation Paper are much too broad. OTLA strongly recommends that the MOF first concentrate its efforts on defining and quantifying the type, size and scope of auto insurance fraud and abuse in Ontario. As the MOF noted in its Consultation Paper, "insurance fraud and abuse" is neither defined in legislation nor regulation, nor is there an accurate quantification of the size and scope of fraud and abuse".[1]

Fraud must be defined and the extent of the issue must be better understood before any efforts can and should be made to determine fraud management and enforcement tools beyond what already exists in the system. OTLA cautions adding new layers of regulation that could further discourage individuals, including accident victims and legitimate service providers, from participating in the system. The vast majority of auto insurance victims have a legitimate need for benefits. When people are injured in car crashes, their priority is to get better as soon as possible. They should not be thwarted in their recovery by an auto insurance system that inherently views every legitimate claim with skepticism and doubt. If our insurance system becomes too complicated or cumbersome for individuals to access services, they will not get the treatment they require. That will impact negatively on the individual, on the OHIP system that will be forced to provide long term medical care, and on the social welfare system that will support them financially.

[1] Ministry of Finance Fraud & Abuse Consultation Paper at page 1. - https://www.ontariocanada.com/registry/showAttachment.do?postingId=37747&attachmentId=49356

The overriding position of OTLA is three-fold:

1. Any work undertaken on the topic of insurance fraud and abuse should first seek to clearly define fraud and abuse in the auto insurance context and collect appropriate data to define the size and scope of the issue.

2. Once the issue is defined and data collected and analyzed, OTLA strongly recommends that existing systems designed to deal with fraud and abuse be studied and reviewed in order to determine whether further tools are in fact required.

   In 2012, the MOF established an Ontario Automobile Insurance Anti-Fraud Task Force Steering Committee which consulted with stakeholders, including OTLA, and issued a Final Report on October 16, 2012 (the "Final Report").[2] The Final Report included recommendations to create an integrated framework to address fraud and specific recommendations were made within the context of the proposed framework. OTLA strongly recommends that the MOF revisit that Final Report and the recommendations made within it to determine what follow-up and outcomes were achieved in response.

   The Final Report notes that, in an attempt to get a better estimate of the dollar impact of fraud, the Working Group commissioned research by KPMG and an independent assessment of the KMPG methodology by Ernst & Young. KPMG concluded that *"there is insufficient information to provide a precise and statistically based estimate of auto insurance fraud in Ontario."* KPMG nonetheless attempted to quantify the dollar value of fraud and, in doing so, gave very broad ranges. The MOF Steering Committee stated in its Final Report, *"We acknowledge that the range of the estimates is very great, and it would be nice if agreed methodologies could provide a more exact assessment of the extent of fraudulent activity."* What confidence is there that the proposals in the MOF's Consultation Paper would yield better results than the extensive research undertaken by independent accounting firms in 2012?

   The Final Report also notes that the GISA numbers showed that accident benefits claim costs decreased significantly following the September 2010 reforms to accident benefits, reducing accident benefits claims costs from $3.9 billion in 2010 to $2 billion in 2011.

   At the time, and based on this information, OTLA, FAIR, the Association of Victims for Accident Insurance Reform and the Ontario Psychological Association made submissions to the effect that much of the problem of fraud may have already been solved with the 2010 reforms. The Steering Committee rejected this notion at the time but subsequent GISA data shows that accident benefits claim costs have remained relatively steady since 2011, averaging approximately $2.5 billion per year.[3]

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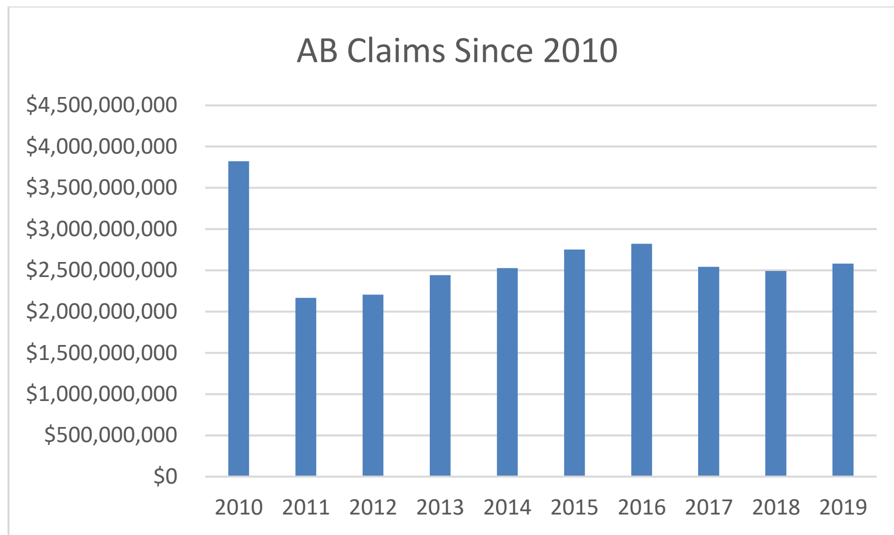
[2] Ontario Automobile Insurance Anti-Fraud Task Force Final Report of the Steering Committee - https://www.fin.gov.on.ca/en/autoinsurance/final-report.html#_Toc338942522

[3] 2019 Actual Loss Ratio Exhibit Private Passenger Automobile Excluding Farmers Ontario - https://www.gisa.ca/Documents/View/2338



There was also a recognition in the Final Report that Health Claims for Auto Insurance (HCAI) had anti-fraud potential and an HCAI Anti-Fraud Working Group was established. OTLA's understanding is that participation by health care providers in HCAI has rigorous requirements including, but not limited to:

- an anti-fraud committee that can remove a provider from the system
- a $5,000.00 per year licensing fee for members
- criminal background checks required for licensees
- audits
- a complaints process that now allows insurers to launch complaints (rather than just patients)

3. Once the issue is defined, the extent is determined, and existing fraud-prevention measures are studied, OTLA recommends further stakeholder consultations to determine what, if any, additional measures are required. OTLA also recommends that caution be exercised to ensure efforts to combat fraud do not make things worse for legitimate claimants. In particular, transparency, consumer protection and privacy concerns must remain at the forefront of the discussion.

OTLA's responses to the questions posed in the MOF Consultation Paper are below. OTLA has sought to provide general submissions in line with its overriding position, as set out above, and has answered direct questions only to the extent that OTLA has a position in response to questions posed.

PART ONE: INSURANCE FRAUD AND ABUSE DEFINITION

Question #1: Based on the anticipated outcomes described in the ministry's F&A Strategy, what are important aspects of fraud and abuse that the definition should capture?

Question #2: Will a definition require multiple parts to account for different types of auto insurance fraud and abuse that can be committed?

Question #3: Do you have a suggestion for a proposed definition of insurance fraud and abuse?

An allegation of fraud is a very serious allegation with implications of criminality. For this reason, OTLA's position is that any definition of fraud should be clear and specific and not open to interpretation. For example, the definition should include specific examples of the types of activity that constitute fraud and abuse, such as staging collision(s), making false statements, and submitting invoices for goods or services that were not incurred to profit from insurance monies. OTLA submits that the *Unfair or Deceptive Acts or Practices Regulation*[4] under the *Insurance Act* includes some specific examples at section 3 and is but one mechanism already in place to deal with fraud and abuse.

OTLA recommends that the definition of fraud should be specific to organized and premeditated fraud. In the Final Report, the MOF identified and defined three types of fraud: organized fraud, premeditated fraud and opportunistic fraud. While OTLA agrees that organized and premeditated fraud should be included within the definition, OTLA submits that the term "opportunistic fraud" should not. Opportunistic fraud is defined in the Final Report as follows: "*an individual pads the value of [their] auto insurance claims by claiming for benefits or other goods and services that are unnecessary or unrelated to the collision that caused the claim*".

Legitimate claims that lead to inevitable disputes about treatment and care should not be labeled or seen as red flags for fraudulent claims, just because an insurer disagrees with the claims that are being submitted. Any definition of insurance fraud and abuse must be clear in its definition and scope and should leave ample room for legitimate disputes about entitlement to benefits. There is a significant danger that, if fraud and abuse are defined too broadly, the likely result will be wasted investigative resources and increased red tape for legitimate victims and their treatment providers.

Whether or not a benefit is "unnecessary" is the subject of regular disputes between insurers and their insureds. There is an established mechanism in the Licensing Appeals Tribunal (LAT) to deal with these disputes. This type of dispute is entirely different from the organized and premeditated fraud that ought to be the main focus of any detection and enforcement mechanisms being proposed by the MOF and FSRA.

Similarly, measures such as validity testing in neuropsychological assessments should not be seen as a fraud detection tool. Claimants who fail validity testing do so for a variety of reasons, including cultural differences, difficulty with language and unconscious amplification of symptoms in an attempt to convey the significance of one's suffering. The dispute resolution system, which includes

[4] O. Reg. 7/100 *Unfair or Deceptive Acts or Practices* - https://www.ontario.ca/laws/regulation/000007

the right to a hearing, with examination and cross-examination of witnesses, has adequate built-in checks and balances to deal with this type of failed measure.

It must be remembered that FSRA's mandate is to **protect** the rights of consumers. Any definition should not penalize accident victims who are, or deter accident victims from, accessing benefits to rehabilitate themselves.

PART TWO: FRAUD AND ABUSE DATA

While the concept of a centralized fraud repository may be appealing in its concept, as a tool to detect and manage fraud, it also raises significant privacy concerns as well as concerns about the integrity of the data collected.

The collection and sharing of data and information about insured persons between insurance companies enhances the risk of data breaches and misuse of information. This risk is even greater if fraud is too broadly defined.

If the MOF and FSRA do move forward with a centralized fraud repository, there must be increased transparency by insurance companies with respect to data collection and use and the true extent of fraud in auto insurance, as well as with respect to insurer profits and premiums.

> **Question #5: Is it a fair trade-off for consumers to have their information shared for the purposes of managing fraud and efforts to lower premiums? How can improved transparency support a fair trade-off?**

Without even having a clear definition of fraud and without knowing the scope and size of fraud in the Ontario auto system, the question as to whether it is a fair trade-off for consumers to have their personal information shared in exchange for managing fraud is premature. In order to determine whether it might be a fair trade-off, the nature and scope of the problem must first be clearly established. More importantly, there is no evidence to suggest that insurers are looking at the detection and management of fraud as a way to lower premiums.

> **Question #6: What role, if any, should MOF, FSRA and industry play in the establishment of a centralized fraud reporting repository?**

According to its website, FSRA's authority is as "an independent regulatory agency created to provide more effective financial services regulation in Ontario for consumers".[5] With FSRA's mandate to "protect the rights of consumers by promoting high standards of business conduct and transparency within the financial services" regulated by it, FSRA must provide oversight to any centralized fraud reporting repository that may be established. FSRA's oversight should include strict compliance with privacy rules as well as oversight on the collection and sharing of data and information only with respect to acts that clearly meet the yet-to-be-defined test of fraud.

[5] FSRA Guidance Framework - https://www.fsrao.ca/regulation/guidance/fsra-guidance-framework

PART THREE: FRAUD MANAGEMENT TOOLS

As indicated above, before the efficacy of any fraud management tools can be meaningfully considered, auto insurance fraud and abuse must be clearly defined. Without a clear definition and accurate quantification of fraud and abuse, any consideration of fraud and abuse management tools runs the risk of "putting the cart before the horse".

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

Question #1: Would this tool help insurers manage fraud and abuse in a way that protects and advances consumer interests?

OTLA agrees that there must be reasonable cooperation by an insured during a fraud and abuse investigation and that such cooperation cannot be unreasonably withheld. OTLA does not, however, believe that any additional initiatives are required to ensure the cooperation of insureds.

Contrary to the suggestion made in the MOF Consultation Paper that insurers are lacking in investigatory powers and are limited in their ability to compel insureds to cooperate with investigations, auto insurers already have very broad powers to investigate a claim and the cooperation of insureds is already mandated. For instance, an insured is not only mandated by the *SABS* to provide information to the insurer within 10 days of receiving a request from the insurer, they must also submit to an examination under oath when requested by the insurer. The obligation to provide information applies to "**[*a*]*ny information reasonably required*** to assist the insurer in determining the applicant's entitlement to a benefit."[6] [emphasis added]. Similarly, the scope of an examination under oath is also exceedingly broad and applies to all matters that are relevant to an insured's entitlement to benefits, which would include allegations of fraud.[7] The Ontario Automobile Policy (OAP 1) also mirrors these existing obligations on an insured where loss or damage to an automobile occurs, with an insurer being able to mandate that an insured submit to an examination under oath and to produce for examination "all documents in the insured's possession or control that relate to matters in question".[8]

The consequences of non-compliance by an insured under existing legislation are significant; indeed, an insurer can refuse to pay any benefit in respect of any period during which the insured fails to comply with these existing obligations. This amounts to a suspension of benefits, which is a significant consequence to an insured. This tool is already frequently utilized by insurers to compel cooperation.

[6] O. Reg. 34/10: Statutory Accident Benefits Schedule - Effective September 1, 2010, Section 33 - https://www.ontario.ca/laws/regulation/100034#BK45

[7] See e.g. *Drew v. Travelers Insurance Company of Canada*, 2021 CanLII 30525 at para. 31 (ON LAT), where the LAT iterates the very broad scope of examinations under oath already available to insurers, noting that "an EUO can touch on any topic an insurer chooses, so long as the topics are 'matters that are relevant to the applicant's entitlement to benefits'…an insurer must only establish some connection between the topics at an EUO and the benefits available to an applicant." [emphasis in original]

[8] Ontario Automobile Policy (OAP 1) Owner's Policy at pg. 38. - https://www.fsco.gov.on.ca/en/auto/forms/Documents/OAP-1-Application-and-Endorsement-Forms/1215E.3.pdf

Accordingly, the suggestion in the MOF Consultation Paper that there seem to be "limitations on an insurer's ability to cancel a policy" for failure to cooperate is inaccurate. Given the similar deprivation of substantive rights, the suspension of policy benefits and the cancellation of a policy likely amounts to a "distinction without a difference". Insurers are already able to eliminate substantive rights under a policy by suspending policy benefits for a failure to cooperate generally, which is much broader and applies beyond a fraud and abuse investigation. For good reason, there are strict requirements on an insurer who seeks to cancel a policy for non-payment. Automobile insurance in Ontario is compulsory. Any further authorization provided to insurers to cancel policies for alleged fraud must take into consideration the seriousness of an allegation of fraud and the potential impact on an insured who is required to carry automobile insurance under the *Compulsory Automobile Insurance Act*.

OTLA recommends that due consideration be given to the already existing tools available to insurers to investigate claims, including the ability to suspend policy benefits, as well as the existing broad obligations on insured persons to cooperate with claims investigations.

Question #2: What are some concerns and mitigations to protect consumers from being unfairly targeted by insurers?

A purported "failure to cooperate" and the concept of "reasonable cooperation" are, naturally, vulnerable to interpretation. Arbitrary cancellations of policies by insurers would be unavoidable. Just as there are disagreements over the reasonableness of claims, which lead to the unilateral denial of benefits, disagreements over the reasonableness of cooperation by an insured are inevitable, similarly leading to the unilateral cancellation of policies. The difference is that the insured has access to a dispute resolution process in the case of a denial of a benefit, allowing for a LAT adjudicator to make an independent, impartial finding as to the reasonableness and necessity of a benefit. In the case of a cancellation of a policy, there is no such oversight. Making an insurer the "final arbiter" as to whether there has been reasonable cooperation goes against the very nature of auto insurance legislation, which is remedial consumer protection. Consumers should not be left at the mercy of insurers. If consumer protection is to be prioritized, investigating and determining whether policy fraud and abuse has occurred (as well as the appropriate remedy) should be left with independent and impartial decision makers.

Question #3: What is considered an adequate level of cooperation?

The existing framework of investigative tools and obligations on insureds (as outlined above) already achieves a broad and adequate level of cooperation.

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

Question #1: Would this tool help insurers manage fraud and abuse in a way that protects and advances consumer interests?

In our member's experience, PPNs do not always act in the best interest of the insured. Many make efforts to conserve insurer costs at the expense of the medical and treatment needs of claimants or are slow or ineffective in responding to the claimant's treatment needs. OTLA is concerned that

offering insureds a choice, at the point of sale, to agree to exclusively use a PPN in the event of a claim will do nothing to assist in the management of fraud and abuse and will harm consumer interests.

This tool could lead to consumer confusion and may not protect the consumer in the event they require medical care as a result of a motor vehicle collision. Many consumers will not understand the consequence of their choice at the point of sale and will only fully understand the impact of this choice at the time they attempt to seek medical care.

Insurers are already using PPNs and have been doing so for many years, but without providing transparency to consumers and their insureds. Adjusters frequently provide the name of a physiotherapy clinic, for example, without advising the insured that they have the right to choose their own treatment provider. The lack of transparency can lead to fraud and abuse in the system by insurers and PPNs who feel beholden to an insurer.

It is also unclear how any treatment provider would qualify to become a PPN for an insurer. Without that clarity and transparency, there is risk that the treatment providers will be put into a situation of conflict, particularly if there is some incentive for the PPN associated with their contract with the insurer which may conflict with the best interests of the insured. OTLA members have expressed concerns about OCF-3 (Disability Certificates) having been completed by PPN health care providers which have omitted diagnoses or omitted pre-existing health issues which would result in the insured being removed from the MIG. The fact that the provider belongs to a PPN could lead to an appearance of conflict, whether real or not, and thus lead to a disruption in the therapeutic relationship and cause a lack of faith in the system.

Consumer protection and consumer interests cannot be advanced by interfering with the therapeutic relationship between an insured and their treatment provider. Protecting and advancing consumer interests cannot include limiting a consumer's rights to be treated by medical professionals of their own choosing or being treated by those recommended by their primary care physician. This would be inconsistent with a concept of a system that protects consumer interests.

Choice of treatment provider is particularly important when it comes to psychological counselling and social work, for example. Both require that the insured connect with the provider and form a therapeutic relationship. Being forced to retain the services of only a select few providers, determined by the insurer, could result in an inability to obtain appropriate treatment. The therapeutic relationship is not only important for counselling but this is true where there is any relationship of trust, such as occupational therapy and speech language pathology. At times, a new or specialized approach to treatment may be required after a time even with physiotherapy, as another example. If an insured is limited by an insurer to a PPN, they may not be able to obtain adequate or appropriate treatment. This cannot advance consumer protection or interest.

Finally, OTLA is concerned that enhancing, increasing and legitimizing the use of PPN providers will impact accessibility of care. This is particularly true in rural or remote areas which are already underserviced by healthcare providers. Requiring an insured to seek treatment through a PPN may prove particularly difficult if those PPNs are located primarily or exclusively in urban centres. Consumers require timely and convenient accessible treatment.

Similar concerns exist with respect to insureds who do not speak English or for whom English is not their first language. These individuals will often seek out treatment providers who can communicate with them in their first language. This is integral to effective treatment and likely cannot be accommodated through the use of PPNs.

Question #2: Do PPNs help insurers manage fraud and abuse in a way that protects and advances consumers' interests?

No. The negative consequences associated with PPNs as described above would far outweigh any benefit of having a limited pool of providers to monitor. Furthermore, the mandatory requirement for all treatment providers to apply for regulation and licencing through HCAI provides the insurer with sufficient guarantees to prevent fraud and abuse. All providers wishing to be licensed on HCAI must go through a rigorous process to become eligible which includes a criminal background check. After paying costly licensing fees, providers can be subject to complaints by insurers, audits and suspension of their HCAI license.

Question #3: What consumer outcomes should enhancements to the use of PPNs target, and what mechanisms (e.g. disclosure, transparency, regulatory oversight) should be in place to facilitate achievement of those outcomes?

OTLA is opposed to the establishment of PPNs, particularly at the point of sale. The negative consequences of enhanced PPNs for consumers far outweigh any potential benefits. Further, PPNs will do little to nothing to advance the cause of fraud detection and management. The cost of treatment is regulated under the *SABS* and thus PPNs should not exist for the purpose of providing insurers with reduced costs, particularly if this cost-savings is not returned to the consumer through equivalent premium reductions. A reduced fee scenario may not be in the best interest of consumers as it may well (and has per our members' experience) result in substandard treatment. It is unclear why PPNs are currently being used on an informal basis. OTLA recommends that all current and future agreements be made publicly available.

Should the use of PPN's continue, OTLA recommends significant oversight and clear transparency of all PPN contracts. Oversight should include, at a minimum, yearly review by FSRA of all contracts with PPNs to ensure that conflicts of interest are not being created by the terms of those contracts. This would include requiring all PPNs to disclose their financials to FSRA for yearly audit.

In addition, consumers require significant education with respect to their right to choose their own treatment providers as opposed to using the PPN recommended by the insurer. Should the PPN program be enhanced, consumers would also require education regarding what treatment providers are part of their insurer's PPN, why they are part of the PPN, and where they are located, at point of sale. Consumers should also be warned about the consequences of choosing to use a PPN including, but not limited to:

- A PPN provider may not be available near their home and significant travel may therefore be required;
- A PPN provider may not be available to provide treatment in the insured's first language;

- A conflict of interest could exist between the consumer and the provider as a result of an agreement between the PPN provider and the insurer; and
- The consumer is giving up their right to choose their own healthcare provider or to seek treatment from a healthcare provider recommended by their doctor, if that healthcare provider is not part of a PPN.

Lastly, a system would need to be developed to ensure that all consumers have timely, appropriate and easily accessible treatment regardless of where they live and regardless of their first language. Exceptions to the rule will likely have to be created in order to achieve timely, appropriate and easily accessible treatment for all consumers. Finally, a mechanism would have to be developed to address scenarios where a therapeutic relationship is not formed with a PPN provider, or more specialized treatment is required.

OTLA recommends there be a mechanism established to allow an insured the right to access treatment outside of the PPN should it be established (by the insured's physician) that the consumer cannot easily access timely and appropriate treatment with a PPN provider. If a therapeutic relationship is not formed or convenient access is not possible, consumers should be afforded an opportunity to use a healthcare provider of their own choosing. An insurer should only be required to establish that they do not feel a therapeutic relationship can be formed with any treatment provider by simply stating so in writing and should then be entitled to access treatment with a provider of their choosing. Any complicated appeal processes would only delay treatment.

Question #4: What would be an appropriate process for service providers and auto insurers to resolve their disputes regarding their PPN status?

The application process should be fair and transparent. OTLA recommends that healthcare providers who wish to be included on a PPN not be excluded unless there are valid reasons to do so. Excluding providers from a PPN list would result in fewer choices for consumers and less accessibility.

Treatment providers should have the ability to appeal to a body such as the LAT to dispute the denial of inclusion on the PPN list.

Question #5: Should exclusive use of PPNs be available to consumers as an option when buying auto insurance? Should other choices (e.g. obligation to use PPN for common injury claims) be available? And how can this program benefit consumers without reducing consumer choice?

No, for all the reasons noted above.

Question #6: Should other enhancements to the use of PPNs be considered?

No. The use of PPNs is currently unregulated and insurers and PPN participants have failed (and refused) to provide disclosure of the PPN agreements when requested by OTLA members. As such OTLA cannot recommend any use of PPNs and sees no benefit for the consumer, nor does OTLA see the use of PPNs as a means to combat fraud. On the contrary, the use of PPNs has the risk of

putting consumers at a disadvantage and interfering with appropriate and timely access to health care.

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

Question #1: Would this tool help insurers manage fraud and abuse in a way that protects and advances consumer interests?

OTLA submits that this tool is not required. Insurers already have significant powers through sections 33 and 44 of the *SABS* to approve all, some, or none of any proposed treatment. If the insurer has any questions it wishes to direct to the healthcare provider, the insurer can utilize the mechanisms already available to it, including requiring a statutory declaration from the provider. That declaration, if proved to be false, could then be used by the insurer, with all of the existing powers that it has, to report the matter to FSRA which could result in the provider losing their licence on HCAI. The insurer also has the ability to report the matter to the police and/or the providers regulatory body for further investigation. FSRA and insurers should not usurp the authority of these regulatory bodies to receive complaints, investigate and administer disciplinary action, where appropriate.

Question #2: What criteria is appropriate for excluding service providers?

It would be appropriate to exclude a service provider who is found to be engaged in clearly fraudulent billing practices. Again, an allegation of fraud is very serious and, therefore, the definition of what constitutes fraud should be very clear and specific. For example, the creation of false invoices by clinics and/or healthcare providers for services that have never been provided to an accident victim would be a clear example of fraud and would warrant exclusion.

Question #3: What methods/avenues could service providers and auto insurers use to resolve their disputes?

Should a dispute arise between a service provider and an auto insurer, either party should be able to apply to the LAT to resolve the dispute.

Question #4: How can this program benefit consumers without reducing consumer choice?

OTLA submits that this tool is not required for the reasons noted above. Consumer choice regarding healthcare providers should be paramount, in the absence of clear fraud such as that outlined above.

To the extent that insurers' powers might be extended to allow for excluded service providers, it is OTLA's recommendation that the insurer should have to provide the clinic and/or healthcare provider with a detailed explanation as to what prompted the investigation that was undertaken, the outcome of the investigation and, in the case of an exclusion, fulsome reasoning for the decision, to allow the provider to challenge the decision, should they choose to do so.

PART FOUR: REGULATOR TOOLS

ii. Establish expectations for fraud and abuse management plans.

1. **What best practices currently exist that could be used as a reference or model?**
2. **How can an insurer's plan be monitored and continuously improved, and what role can data and metrics (see above) play in that process?**
3. **Should management plans be proportionate with the size / profile of an insurer's business? Should there be consequences for insurers that do not or cannot establish and carry out a reasonable and proportionate fraud management plan?**
4. **How can the approach to fraud management plans best reflect the competitive nature of the auto insurance industry?**
5. **What barriers or gaps currently exist that prevent insurers from effectively implementing fraud and abuse management plans?**

It is OTLA's position that these questions cannot be answered until such time as fraud and abuse are properly defined and the extent of the issue is quantified and better understood. It appears from the GISA data noted above that much of the issues associated with fraud and abuse in the system have been effectively resolved. Further, insurers currently have broad powers to investigate and address allegations of fraud and there exists no evidence that additional regulator tools are required.

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

Question #1: Other provinces have provided enhanced investigation powers, such as the British Columbia Financial Services Authority (BCFSA). Should FSRA have similar powers?

OTLA does support expanding FSRA's regulatory powers to include investigation or enforcement tools. The resources in place, which are described above, provide insurers with sufficient protections to investigate and prosecute fraud.

Question #2: Should FSRA have the tools and mandate to investigate and sanction fraud and abuse within the auto insurance sector by non-licensees? If so, which non-licensees? If not, who should?

It is unclear what is meant by the term "non-licensees". HCAI was created to prevent the insurer from having to pay for any services unless the provider is licenced.

Additional tools are not required to sanction licensees or non-licensees. As noted above, insurers already have broad powers to investigate and address potential fraud and abuse. They also have recourse to the various regulatory bodies of providers, as well as the police.

Question #3: What regulatory sanctions should be available to deter and address fraud and abuse in the auto insurance sector? Who should they apply to?

It is OTLA's view that there should be no sanctions available to be applied from FSRA, aside from the current powers. Those powers, which include barring a licensee from using HCAI, and reporting

fraud to regulatory bodies and the police, provide the insurance industry with sufficient safeguards to protect against any concerns.

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

Question #1: What are some concerns and mitigations to protect privacy and data security related to data sharing?

As noted above under Part 2, Question #5, it is difficult to address this question without a clear definition of fraud and abuse and without knowing the scope and size of fraud in Ontario. Ontarians have a right to privacy. That right should not be violated unless there is a legitimate basis for same and clear and detailed parameters as to what data can be shared and under what circumstances.

CONCLUSION

While OTLA supports measures to combat insurance fraud in Ontario, additional anti-fraud measures and tools cannot be considered or initiated until fraud and abuse is properly defined, its scope determined, and existing anti-fraud measures studied to determine their efficacy and whether additional measures are required.

More specifically, OTLA recommends as follows:

1. Any work undertaken on the topic of insurance fraud and abuse should first seek to clearly define fraud and abuse in the auto insurance context and collect appropriate data to define the size and scope of the issue.

2. Once the issue is defined and the extent has been determined, the existing systems designed to deal with fraud and abuse should be studied and reviewed in order to determine whether further tools are in fact required.

3. Once the issue is defined, the extent is determined, and existing fraud-prevention measures are studied, further stakeholder consultations should be held to determine what, if any, additional measures are required. OTLA also recommends that caution be exercised to ensure efforts to combat fraud do not make things worse for legitimate claimants. In particular, transparency, consumer protection and privacy concerns must remain at the forefront of the discussion.

The GISA data since 2010 supports the prior assertion of stakeholders, including OTLA, that much of the problem with fraud in Ontario was addressed by the 2010 amendments to the *SABS*. This coupled with the existing measures that insurers and FSRA have to investigate and address fraud and report allegations of fraud to regulatory bodies and the police appear to be more than sufficient to address any ongoing issues that may exist.

OTLA appreciates the opportunity to respond to the MOF Consultation Paper and is available to further discuss these submissions.