

ONTARIO AUTOMOBILE INSURANCE ANTI-FRAUD TASK FORCE

FINAL REPORT OF THE STEERING COMMITTEE

NOVEMBER 2012

October 16, 2012

Mr. Steve Orsini
Deputy Minister
Ministry of Finance
7 Queen's Park Crescent
Toronto, ON M7A 1Y7

Dear Deputy Minister:

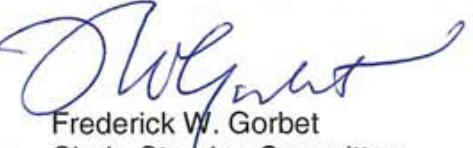
Please find attached the Final Report of the Ontario Automobile Insurance Anti-Fraud Task Force Steering Committee.

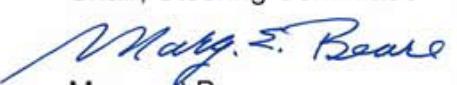
We are pleased to present this report to you, in accordance with our terms of reference, for onward distribution to the Minister of Finance. Our report answers the two questions posed in our terms of reference regarding the extent of auto insurance fraud in Ontario and recommended measures to deal with it.

We are grateful for the support and advice we have received from officials in your Ministry, and from officials in other ministries who worked with the Task Force over the past 16 months. We are particularly appreciative of the role that senior officers from Finance, the Financial Services Commission of Ontario and Community Safety and Correctional Services played in chairing the three Working Groups that supported the Task Force.

We believe that we have appropriately fulfilled our mandate and look forward to the government's response to our recommendations.

Respectfully submitted,


Frederick W. Gorbet
Chair, Steering Committee


Margaret Beare


George Cooke

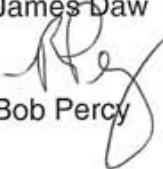

James Daw

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TABLE OF CONTENTS

Preface	1
Overview	3
Fraud is substantial and has a material impact on premiums	3
There are effective actions that can be taken to deal with fraud.....	11
Our recommendations create an integrated framework to address fraud.....	15
STEERING COMMITTEE RECOMMENDATIONS	18
Prevention.....	18
Consumer engagement and education.....	19
Essential information at critical times	21
Dedicated website	22
Anti-Fraud Awareness Implementation Group	23
Mandatory disclosure	26
Enhanced FSCO oversight.....	28
Reducing uncertainty and delay in providing auto insurance benefits	28
Effects of the September 2010 Reforms on SABS Benefits	29
Evidence-based treatment	30
Fixing the dispute resolution system	31
Requiring insurers to provide more complete reasons for claim denial	32
Province-wide regulation of the towing industry.....	32
Recommendation for province-wide regulation	37
Recommendations to address auto insurance fraud	40
Changes to the <i>Repair and Storage Liens Act</i>	41
Cancellation fee for missed medical examinations	42
Detection.....	44
Industry initiatives to identify suspicious claims	44
Making Health Claims for Auto Insurance a more effective fraud detection tool	47
Building on existing initiatives.....	48
Other potential opportunities	50

Regulation of health clinics and assessment providers	52
Features the regulatory model should include.....	53
Transparency	54
Accountability	56
Implementation.....	56
Making it easier for individuals to report suspected fraud.....	59
Enhancing FSCO's ability to get information	61
Changes to regulations governing insurer/claimant relations	62
Improving collision reporting forms	64
 Investigation and Enforcement.....	66
Enhancing FSCO's ability to investigate and impose sanctions for UDAPs....	66
Oversight and audit of regulated clinics	68
Sanctioning regulated clinics for improper business practices.....	69
Information sharing among fraud investigators.....	70
Joint-force police collaboration	72
Early assignment and continuity of Crown counsel	73
Changes to the SABS and UDAPs to increase the range of sanctions	75
Income Replacement Benefits related to fraudulent claims for Accident Benefits	76
 Regulatory Roles and Responsibilities.....	78
Financial Services Commission of Ontario	79
Law Society of Upper Canada	81
Regulated Health Profession Colleges	84
Independent medical assessments	86
 LIST OF RECOMMENDATIONS.....	89

APPENDICES

Appendix 1: Auto Insurance Anti-Fraud Task Force structure	97
Appendix 2: Individuals and groups who made representations to the Task Force.....	98
Appendix 3: Recent anti-fraud initiatives introduced in selected other jurisdictions.....	101
Appendix 4: Learning moments matrix	103
Appendix 5: Illustrative consent language for auto insurance application and claim forms	107
Appendix 6: Licensing and regulation of health clinics	112
Appendix 7: Proposals to increase FSCO's authority to obtain Information	117
Appendix 8: Enhanced investigation and enforcement authorities for FSCO	118
Appendix 9: Glossary of terms	121

Preface

This report presents the unanimous conclusions and recommendations of the Steering Committee of the Anti-Fraud Task Force, appointed 16 months ago to advise the Government of Ontario on the extent of automobile insurance fraud and what to do about it. The Steering Committee is made up of five individuals independent of government. We have benefited from the support and advice of many public servants from the ministries of Finance; Community Safety and Correctional Services; and the Attorney General, as well as from the Financial Services Commission of Ontario (FSCO). Three Working Groups composed of public servants and representatives of private sector groups assisted the Task Force. We have also had the privilege of more than 50 presentations and submissions from interested parties.¹ Last December we released an Interim Report, followed in July of 2012 by a Status Update that invited comment on potential responses to fraud in the auto insurance system. We are grateful for the input and advice we have received, but we take full responsibility for the conclusions and recommendations presented in this Final Report.

In the following Overview section, we set out in brief our answers to the two main questions we have been charged with — how much does fraud contribute to the cost of auto insurance and what can be done about it. We also provide a high-level summary of our findings and recommendations. These are elaborated in further sections of the report that deal, respectively, with Prevention, Detection, and Investigation and Enforcement. The final section of the report provides additional observations on the roles of the key regulatory agencies involved with auto insurance fraud: FSCO, the Law Society of Upper Canada (LSUC) and the health regulatory colleges.

¹ The Structure of the Task Force is set out in Appendix 1. Appendix 2 lists the individuals and groups who made submissions to the Task Force. Appendix 2 also provides hyperlinks to those submissions that are publicly available.

Overview

Insurers and regulators have long regarded fraud as a prevalent aspect of Ontario's auto insurance system. But a recent and unexplained surge in the number of claims and the billings for accident benefits brought the issue to the fore again. New research, described below, has reinforced suspicions that fraudulent activity is increasingly premeditated and well-organized — particularly in the Greater Toronto Area (GTA). We do not think that the costs or the risks of fraud should be ignored and we believe that government and other stakeholders can and should take a number of concrete and practical steps to deal with fraud.

Fraud is substantial and has a material impact on premiums

We were asked to provide our best estimate of the extent and geographic distribution of fraud in Ontario. This is not an easy task, since those engaged in fraud have every incentive to conceal their actions.

In our Interim Report last December² we noted that accident benefit payments and the costs of medical assessments greatly exceeded the level in 2010 that would have been expected by historical relationships between benefits and factors such as frequency and severity of collisions and inflation. We noted that from 2006 to 2010, the number of collisions, the number of persons injured in collisions, and the severity of injuries suffered all decreased. Yet costs related to accident benefits were \$2.4 billion higher in 2010 than they were in 2006. After accounting for health care inflation, the “unexplained” amount of accident benefits in 2010 amounted to \$2 billion (\$300 per registered passenger vehicle) in Ontario and \$1.7 billion (\$700 per registered passenger vehicle) in the GTA. We could not conclude that this was entirely due to fraud, but we did speculate that fraud played a significant role.

² The Interim Report is available at <http://www.fin.gov.on.ca/en/autoinsurance/interim-report.html>

In our Interim Report we conceptually identified three types of fraud:³

Organized Fraud: several participants with different roles within Ontario's auto insurance system create an organized scheme designed to generate cash flow through a pattern of fraudulent activity;

Premeditated Fraud: a participant within Ontario's auto insurance system, alone or with others consistently charges insurers for goods or services not provided, or provides and charges for goods and services that are not necessary; the participant is involved in a pattern of fraudulent activity, possibly at the expense of motor vehicle collision victims or possibly with their complicity; and

Opportunistic Fraud: an individual pads the value of his or her auto insurance claims by claiming for benefits or other goods and services that are unnecessary or unrelated to the collision that caused the claim.

We attempted to get a better estimate of the dollar impact of fraud by working with the Insurance Bureau of Canada (IBC) to commission research by KPMG. We also directly engaged Ernst & Young to provide an independent assessment of the methodology followed by KPMG in conducting this research.

³ For a more detailed description of the three categories of fraud and some examples, see the Interim Report, pp. 43–46.

The KPMG analysis consisted of reviewing previous studies of fraud in Canada, Ontario and other jurisdictions and, where appropriate, applying the conclusions of those studies to Ontario. KPMG also reviewed and compared three “proof-of-concept” exercises undertaken by a group of insurers that accounted, collectively, for 65 per cent of Ontario’s auto insurance market. These “proof-of-concept” exercises⁴ were undertaken to test whether a business case could be made for pooling data from multiple insurers and analyzing it with sophisticated analytical software to identify suspicious claims. KPMG was able to draw inferences from these exercises about the possible extent of fraudulent activity involving claims against multiple insurers that had elements of commonality — the first time that estimates of this type, focusing on the likely incidence of organized and premeditated fraud, have been developed in research studies into the extent of fraud.⁵

KPMG’s conclusions are discussed at some length in our Status Update.⁶ KPMG concluded that “there is insufficient information to provide a precise and statistically based estimate of auto insurance fraud in Ontario.” We acknowledge and agree with the difficulty of trying to put a dollar estimate on the amount of fraud. KPMG was asked, however, to do what it could to quantify the extent of fraud, as that was the mandate we were given. Its report provides a wide range for the cost of fraud, ranging from 9 per cent to 18 per cent of annual claims costs, which in 2010 would have amounted to between \$768 million and \$1.56 billion. It also provides an estimate of organized fraud, drawn from the “proof-of-concept” projects that ranged from \$175 to 275 million in 2010, and which KPMG concluded was likely underestimated for reasons detailed in its report.

⁴ A “proof-of-concept” exercise is used to confirm the approach undertaken to study a certain matter.

⁵ The KPMG methodology and detailed results are described at http://www.ibc.ca/en/Insurance_Crime/

⁶ See Status Update, pp. 22–25, at <http://www.fin.gov.on.ca/en/autoinsurance/status-report.html>

Ernst & Young reviewed KPMG's methodology on behalf of the Task Force, and concluded that:

- It was appropriate for KPMG to base its estimates of organized fraud on three recent tests of the latest data analysis techniques for detecting whether groups of connected individuals have submitted claims to multiple insurers in Ontario, and it was correct to conclude that the design of these trials would have resulted in a low estimate of organized fraud;
- KPMG's methodology also underestimated the extent of premeditated fraud, which Ernst & Young concluded could be conservatively estimated at between \$130 to \$260 million in Ontario during 2010; and
- KPMG's assessment of opportunistic fraud might be high, but on balance the best available assessment of total auto insurance fraud in Ontario in 2010 would be at least as great as the range calculated by KPMG.⁷

The Steering Committee has reviewed these research reports in detail with KPMG and Ernst & Young. 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. However, there is no doubt that even the lower end of the range is a very large number — in aggregate and in terms of the impact on premiums for Ontario families.

⁷ The Ernst & Young report prepared for the Task Force can be accessed at <http://www.fin.gov.on.ca/en/autoinsurance/forensic-review-ey.html>

Possible Impact of Fraud on Premiums (2010)

KPMG's estimate of fraud ranges from \$768 million to \$1.56 billion dollars in 2010. This amounts to between \$116 and \$236 per average premium paid in Ontario in that year.

Although the range of estimate is large, even at the lower end the amount is significant for Ontario families.

The impact is even greater in the GTA. As we noted in our Interim Report last December, 83 per cent of the increase in accident benefit costs in Ontario between 2006 and 2010 occurred in the GTA.

If we assume, for illustrative purposes, that 83 per cent of the estimated fraud also occurs in the GTA, the impact on average premium per insured vehicle in 2010 would have been \$267 at the low end of the range, and \$540 at the upper end of the range.

We believe that the work that KPMG and Ernst & Young did to identify and quantify the impact of organized and premeditated fraud is quite important. None of the previous studies reviewed by KPMG or the Task Force has been able to use focused and sophisticated methodology to get at this issue. We believe that the research we have commissioned has broken important new ground in this regard.

While we are pleased with the research results, given the inherent limitations on an exercise of this type, we stress that our conclusions about the extent and geographic incidence of auto insurance fraud are driven by more than the numbers. Over the past 16 months we have heard from many individuals and groups who have been involved on the ‘front lines’ of the fight against auto insurance fraud. Their stories of what is happening on the ground have added important context to the numbers that the research has provided. For example:

- We were informed by owners of rehabilitation clinics that they have been unable to attract patients who have been involved in automobile collisions without paying substantial referral fees to tow truck operators, body shops, paralegals and/or referring physicians. It was represented to us that this was not uncommon and that some registered health practitioners have ceased treating auto insurance claimants because they are unwilling to pay these fees. Such fees are clearly prohibited under the *Insurance Act* and lead to higher costs to insurers and all drivers.
- We have noted the results of a pilot project undertaken by Health Claims for Auto Insurance (HCAI), called the Professional Credential Tracker (PCT). This pilot, initiated at the request of the Task Force, is aimed at helping health care practitioners ensure that their identities are not being stolen and used by fraudulent clinics. In the pilot project involving the College of Psychologists of Ontario 14 per cent of the psychologists participating found that their credentials were being used by clinics they did not recognize.⁸
- In April of 2011, the Superintendent of the Financial Services Commission of Ontario (FSCO) issued a bulletin that warned insurers to be on the alert for bills for services that were never provided, and for any flood of requests intended to obstruct insurers’ usual review process prior to a regulated deadline so that approval to provide treatments and assessments could be achieved by default.⁹

⁸ There are approximately 1,200 unique psychologist records in HCAI. Of those 1,200, 160 agreed to participate in the pilot project and the response ratio was about 75 per cent. At a confidence level of 95 per cent, the 14 per cent finding should be interpreted as representing a range of about 7 per cent to 21 per cent in terms of the total sample (or between 87 and 249 psychologists uniquely identified within HCAI).

⁹ The Superintendent’s Bulletin is available online at http://www.fsco.gov.on.ca/en/auto/autobulletins/2011/Pages/a-02_11.aspx

- During the past sixteen months, we have read in the media about several enforcement actions that have led to over 500 charges being laid against over 100 individuals in five major police investigations. At the heart of each of these actions is the allegation that accidents have been staged to defraud insurance companies. We recognize that these allegations have yet to be tried in court (although in one instance some guilty pleas have been entered), but they are nevertheless serious allegations.
- We are aware that auto insurers have launched civil actions against a number of clinics for fraudulent misrepresentation (allegations that have yet to be tried in court); that the Superintendent of Financial Services has laid charges against 10 clinics for the offence of committing an unfair or deceptive act or practice; and that some Canadian life and health insurers have informed their policyholders that they will not honour claims from certain clinics.
- We have had submissions from insurance companies and investigators who have provided details on their experience in investigating fraudulent activity and how such activity has evolved over the past several years. One investigator told us how, some years ago, surveillance led to a police raid on a clinic and what was found by examining the books subsequent to the raid:

“The (sign-in) sheet for the first day of surveillance in which only 20 people were in and out had 98 names signed in. The clinic was charging \$150/visit which works out to \$14,700 for that one day...I was able to determine that 90 per cent of the referrals to that clinic came from one doctor in Toronto. Claimant files were completely empty except for a referral sheet from the doctor which included a map of how to get to the clinic along with a sheet on whom to invoice at the insurance company. Not one medical note in any of the files. The same clinic had a hand-written ledger. An employee listed as the “driver” received cash payments several times a month with no explanation. It was simply listed as “cash”. I was able to tally just how

much this “driver” was receiving and determined it to be anywhere from \$25,000 to \$37,000 a month — in cash — for well over a year. We could only assume that he was using all or part of this money to pay the kick backs required to get the clients sent there in the first place.”¹⁰

- We have noted, in the research we have commissioned on cross-jurisdictional scans that jurisdictions with auto insurance programs similar to that in Ontario are also grappling with increasing instances of fraud. Governments in New York State, Florida and the United Kingdom have all introduced tough new measures to crack down on auto insurance fraud.¹¹
- We have also recognized that most Ontarians believe that fraud is an important factor in the level of auto insurance premiums. In a Pollara poll conducted in 2011, 83 per cent of Ontarians who responded expressed their belief that auto insurance fraud is a “frequent or occasional occurrence in the province” and almost every respondent (96 per cent) saw the link between insurance fraud and higher premiums for drivers.¹²

On the basis of our assessment of the numbers, and the information provided to us we conclude that automobile insurance fraud in Ontario is substantial. It has been growing and is having a material impact on the premiums that individuals and families pay for insurance. The incidence of fraudulent behaviour appears to be much more concentrated in the GTA than in other parts of the province.

¹⁰ Submission to the Task Force by Sue Collings, dated August 9, 2012
http://www.fin.gov.on.ca/en/autoinsurance/submissions/Anti-Fraud_Task_Force_Input_en.pdf

¹¹ The cross-jurisdictional research commissioned by the Task Force is available at <http://www.fin.gov.on.ca/en/autoinsurance/juris-pdie.html>, <http://www.fin.gov.on.ca/en/autoinsurance/juris-cee.html> and <http://www.fin.gov.on.ca/en/autoinsurance/juris-rp.html>. Major anti-fraud initiatives introduced recently by jurisdictions with similar automobile insurance systems to Ontario’s are summarized in Appendix 3.

¹² The Pollara survey results are available at http://www.ibc.ca/en/Insurance_Crime/

We also believe that the impact of organized and premeditated fraud has been increasing relative to opportunistic fraud. This is a serious issue and one which concerns us greatly. Organized fraud often takes the form of staged collisions that increasingly pose real risks to unwitting victims.¹³ In addition to safety concerns and costs, when criminals accumulate large sums of money there is a risk they will divert the money toward furthering other criminal-type behaviour.

The problem is serious. But we believe there are actions that can be taken that will help deal with fraud in an effective way. The balance of this overview section sets out the considerations that have shaped our recommendations and a high level summary of the actions that we recommend government and other stakeholders should take to deal with the problem.

There are effective actions that can be taken to deal with fraud

There is no ‘silver bullet’ that will effectively eliminate fraud. There is too much money involved and there are too many innovative fraudsters. Our recommendations provide an effective framework to attack auto insurance fraud, but continued vigilance will be required on the part of government, and all interested parties, to ensure that anti-fraud measures continue to be robust and flexible.

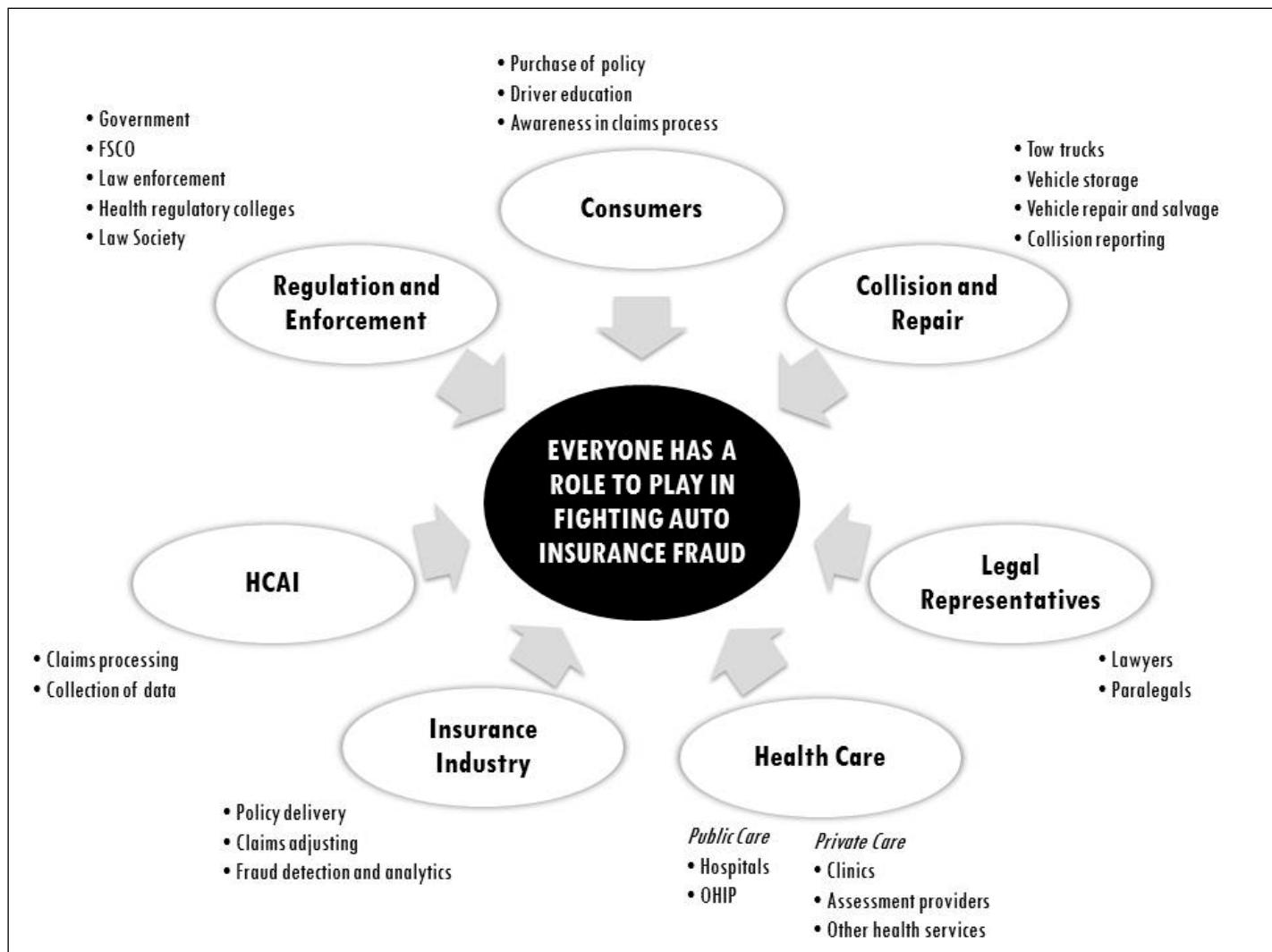
¹³ Staged collisions have undergone an evolution over the past few years. Initially there were no actual collisions, only reports of them having happened. In a second stage, vehicles were damaged to appear as though they were involved in a collision. As enforcement techniques advanced, so did the fraudsters, with the result that they began to involve unwitting victims in actual collisions. The impact on public safety is serious. See “The Evolution of the Paper Staged Accident” by The Board of Directors of the Canadian Association of Special Investigation Units (CASIU), Claims Canada (www.claimsbc.ca), April-May, 2011, pp. 30–31.

Our recommendations are responsive to four key considerations that have guided our work:

i) Everyone has a role to play

Ontario's auto insurance system consists of many inter-connected sectors (see Exhibit 1). In order for the integrated anti-fraud strategy we are recommending to be successful, organizations and individuals in each sector must be engaged and active in the fight against fraud.

Exhibit 1: Ontario's Inter-Connected Auto Insurance System



Government can and should lead the fight against fraud, but all Ontarians have a role to play.

Consumers need to become better educated about fraud and its impact, and more engaged in recognizing and reporting scams. Our recommendations propose a framework that will facilitate this.

Auto insurance companies must combat fraud by using the tools provided to them by Ontario's auto insurance system and investing in new technologies that will significantly enhance fraud detection and investigation. Our recommendations will enhance existing anti-fraud provisions and introduce more anti-fraud tools for companies to use. Our recommendations will also help facilitate the adoption of new anti-fraud technology.

We also call on those who are active in the auto insurance marketplace as health care practitioners, lawyers and paralegals, tow truck operators, collision repair facilities, and those in the insurance and brokerage industries to be vigilant in watching for, and helping to root out, those bad actors who tarnish the reputation of the many dedicated professionals working in this field. Our recommendations will assist in your efforts to prevent and detect fraudulent behaviour.

Organizations that regulate professional behaviour have particularly important roles to play in ensuring that those they regulate are disciplined in an effective and timely way if they do engage in fraudulent activity. In particular, the Law Society of Upper Canada and the regulatory colleges that oversee health practitioners have critical roles to play and our recommendations will propose ways in which they can increase their focus on these important issues.

ii) Our recommendations should not make things worse for legitimate claimants

The recent escalation in insurance costs has led the Ontario government and the industry to take action. Starting in September 2010 the government reduced the level of mandatory coverage for some benefits and capped at \$3,500 the funds available for assessing and treating most minor injuries. It also gave the industry greater discretion to reject claims for rehabilitation treatment, assessments and income replacement. An unintended consequence has been an increased backlog within the government's formal dispute resolution process. As a result, some legitimate claimants are undoubtedly experiencing increased uncertainty and delay with respect to the processing of their claims.

Our recommendations are targeted directly at fraudulent behaviour. They do not disadvantage legitimate claimants. Indeed, we believe that effective implementation will take pressure off the system, allowing legitimate claimants to experience less uncertainty and delay before obtaining the benefits to which they are legally entitled. We also believe that these proposed measures will reduce costs and translate directly into lower premiums for those Ontario drivers living in parts of Ontario where fraud has been most prevalent.

iii) Fraudsters should be vigorously pursued and prosecuted where evidence warrants

Vigorous pursuit and effective prosecution of those committing fraud will send a strong message to potential fraudsters, and to all Ontarians, about society's resolve to ensure that the auto insurance system works well, and in the interests of all. Investigation and the laying of charges has proved difficult in past years for a number of reasons, including the lack of effective data detection methods for organized fraud, and the constrained resources for law enforcement. More recently, as organized auto insurance fraud has evolved to staged collisions that pose clear dangers to the public, enforcement actions have intensified.

Our recommendations will increase the ability to detect organized and premeditated fraud and will help to reinforce effective law enforcement.

iv) The most effective way to deal with fraud is to cut off the flow of funds

While prosecution is an effective deterrent, it takes time and resources. Our view is that the most effective way to combat fraud in the short term is to find ways to cut off the flow of funds to fraudsters. If we can increase substantially the risk of detection relative to the rewards of fraud, the fraudsters may be deterred or will focus their efforts elsewhere.

Our recommendations will limit or curtail the ability of organizations and individuals who are abusing the system to invoice insurance companies.

Our recommendations create an integrated framework to address fraud

The balance of this overview section highlights our major recommendations that work together to combat fraud — from prevention, through detection, to investigation and enforcement of sanctions. Each of these recommendations — and how they work together — is discussed further in following sections of this report. Implementation of the proposals will require legislation, amendments to regulations, changes to industry practices, cross-organization sharing, new regulation of certain business practices, and coordination of various levels of government with private sector organizations.

With respect to prevention, our key recommendations include:

- Establish, through government and industry cooperation, a comprehensive consumer education and engagement strategy that will have well-defined objectives, clear accountabilities, and a built-in process for evaluation to assess effectiveness. The goal is to help consumers better understand automobile insurance and how to purchase it, and warn them about how to avoid potential scams. The strategy will also assist with detecting fraudulent activity that may exist.
- Provide greater clarity on a number of outstanding issues that are beyond our mandate but are critically important in creating a framework of certainty, where knowledge of the rules will make fraudulent behaviour more difficult. These issues include development of evidence-based treatment protocols for minor injuries and effectively addressing the current backlog of dispute resolution cases at FSCO.
- Establish a new licensing framework for the regulation of the towing industry, based upon province-wide standards that would increase road safety, enhance consumer protection, and ‘break the chain’ linking some tow truck operators to auto insurance fraud.

With respect to detection, our key recommendations include:

- Establish conditions that support the initiative now underway by the industry's Insurance Fraud Group (IFG) to create a new organization that will analyze auto insurance claims in a focused and sophisticated way, using advanced data analytic technology, now routinely used in other countries, to identify suspicious cases of organized and premeditated fraud for further investigation.
- Enhance the fraud-detection capabilities of Health Claims for Auto Insurance (HCAI) invoicing system to permit what was originally designed as a transactional database to be used effectively for fraud detection. Pilot projects undertaken under the auspices of the Task Force have proved very successful and we are recommending further developments to enhance the capability of HCAI to play a role in detecting fraudulent activity.
- License and regulate the business practices of clinics that treat auto insurance claimants and provide independent medical examinations.
- Create, within FSCO, a dedicated and visible fraud information hotline that would gather information from individuals who report possible fraudulent behaviour, and create a legal framework to protect those individuals who identify themselves from reprisal or retribution. FSCO would transmit information received by the hotline to the appropriate investigatory authorities and would follow up and report on actions taken.

With respect to investigation and enforcement, our key recommendations include:

- Enhance the authority of FSCO to conduct investigations, access relevant information, investigate more participants in the auto insurance system, and acquire the resources needed to do an effective job.

- Encourage a more robust and assertive FSCO to enter into information-sharing agreements with investigators at other provincial authorities engaged in providing medical benefits, in particular the Workplace Safety and Insurance Board (WSIB) and Ontario Health Insurance Plan (OHIP) so that information about suspected fraudulent activity in any one of these areas could be shared with investigators working in all of these areas. The Government of Ontario should support such information-sharing protocols and explore the possibility of establishing such protocols with relevant federal government agencies such as the Canada Revenue Agency (CRA).
- Early assignment and continuity of Crown counsel to large and complex fraud cases where there is a reasonable prospect of conviction and it is in the public interest to proceed.
- Use the HCAI system as an enforcement tool to cut off the flow of funds to those who are acting, within the system, in a fraudulent or abusive manner. Specifically, the regulatory regime for clinics should also give FSCO — as regulator of the business practices of these entities — the ability to direct HCAI to limit or curtail the ability of specific facilities to bill insurance companies.

Taken together, we are confident that the recommendations discussed and set out in the balance of this report will reduce the incidence and cost of auto insurance fraud, lead to lower premiums for Ontario drivers, and improve outcomes for legitimate claimants.

STEERING COMMITTEE RECOMMENDATIONS

Prevention

This section sets out our recommendations to address fraud prevention.

They are focused in five areas:

- consumer engagement and education
- reducing uncertainty and delay in providing auto insurance benefits
- province-wide licensing and regulation of the towing industry
- amendments to the *Repair and Storage Liens Act*
- cancellation fee for missed medical examinations

Consumer engagement and education

Recommendations

1. The government should join with insurers to form an Anti-Fraud Awareness Implementation Group to implement a consumer engagement and education strategy. This group should oversee the creation of:
 - a. educational material in different media that could instruct consumers at critical moments such as when they learn to drive, select an insurer, choose optional coverage, collide with another vehicle or make an insurance claim; and
 - b. a dedicated, multilingual website that would explain how to make an auto insurance claim, what to expect by way of treatment and recovery after an injury, and how to avoid, detect and report improper activity.
2. The government should:
 - a. require insurers to disclose publicly how they choose and assess the performance of businesses and professionals they recommend to consumers or refer them to see, such as independent medical examiners; and
 - b. require insurers to ensure their public information on how consumers may register a complaint is simple to understand and easy to locate.
3. The Financial Services Commission of Ontario should ensure when conducting an audit that insurers have complied with protocols and practices they have disclosed and promised to the public.

Our December, 2011 Interim Report recommended that the insurance industry measure the current state of consumer engagement and education. The Insurance Bureau of Canada (IBC) responded to this recommendation by conducting a survey of one thousand Ontarians through Pollara. The Pollara survey uncovered valuable results, including:

- eight in ten of those surveyed believe that insurance fraud is a frequent or occasional occurrence in Ontario;
- six in ten believe that fraud is influential or very influential on increasing the price of auto insurance;
- the majority of Ontarians would not know where to report insurance fraud observed in a health clinic treating auto insurance claimants; and
- only 20 per cent of Ontarians say they know exactly what to do if they were in a minor car accident.¹⁴

While it is clear that consumers need more education about how to protect themselves against fraud, the survey also reports that consumers support anti-fraud measures. We noted in the July Status Update that support for six potential anti-fraud initiatives tested by Pollara ranged from 64 per cent to 77 per cent. Consumers are willing to support actions to combat fraud and are motivated by the fact that they will be better off if fraud is reduced.

Engaging and educating consumers about what to expect in the case of an auto insurance claim makes them less vulnerable to exploitation by fraudsters. For example, a knowledgeable consumer will know what to do in the case of a minor motor vehicle collision and where to report any suspicious activity that could be linked to insurance fraud.

¹⁴ See Pollara report, pp. 11, 8, 23 and 30.

Our recommended consumer engagement and education strategy has two parts:

- provide information about the auto insurance system and fraud through key learning moments¹⁵ and a dedicated website; and
- give consumers better information about how insurance companies assess and recommend service providers and handle consumer complaints.

These two elements will provide consumers with important information at times when they are motivated to learn about the auto insurance system. With such information consumers can make better decisions about their insurance coverage and be more aware of potential warning signs of auto insurance fraud.

We recommend that the government work with the insurance industry to create an Anti-Fraud Awareness Implementation Group to oversee the implementation of the strategy. It will be vital that all its members contribute resources to its work to ensure that the synergies and momentum generated by our Consumer Engagement and Education Working Group are carried forward. We provide below further elaboration of how we see this important strategy moving forward.

Essential information at critical times

In the Status Update we presented a number of “learning moments”, identified by our Consumer Engagement and Education Working Group, as well as potential ways to deliver information at those moments.

Appendix 4 is an updated version of the learning-moments matrix, incorporating feedback from the public and continued input from the Working Group. Examples of key learning moments identified include:

- receiving or renewing a driver’s licence or vehicle registration;
- purchasing or renewing an insurance policy;
- reporting a collision; and
- making an auto insurance claim.

¹⁵ A “learning moment” is identified as a time when a recipient of information is particularly open to receiving and retaining it as a basis for action.

We expect the Implementation Group to use the illustrative examples found in Appendix 4 as a foundation for its mandate to deliver essential information to consumers at these learning moments.

The Implementation Group should also keep the following considerations in mind as it develops its strategy:

- certain learning moments may be more effective at providing anti-fraud information to consumers than others. For example, the Allstate Canada Group noted in its submission that learning moments occurring before or at the time of a claim, such as the renewal of a driver's licence or the reporting of a collision, are vital for communicating effectively with consumers;
- consumer engagement and education material used at key learning moments should be culturally and linguistically appropriate for the diverse population of the Greater Toronto Area (GTA); and
- the dedicated website for auto insurance claimants must be integrated into content created to engage and educate consumers at key learning moments.

Dedicated website

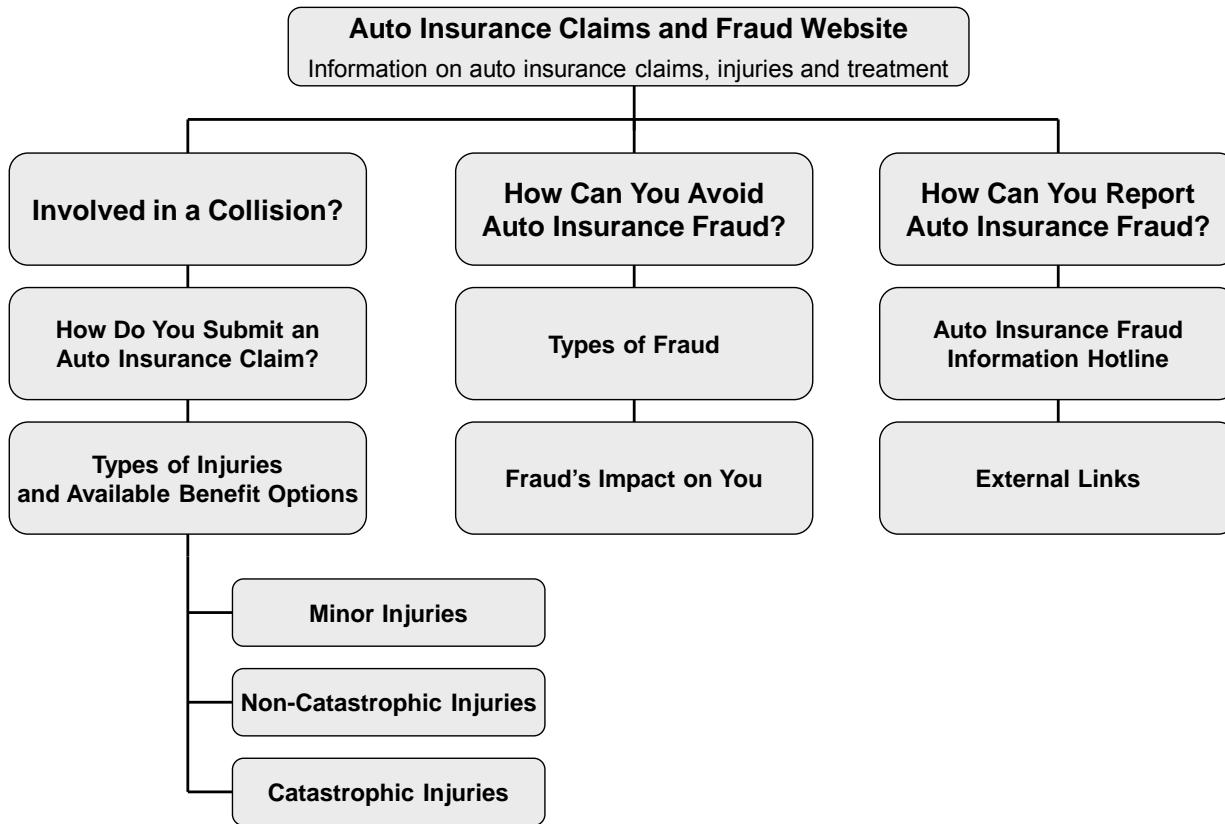
A dedicated website for auto insurance information would provide consumers with important information in an easily accessible setting. Developing, maintaining and promoting such a website will be the Implementation Group's second objective.

The website should provide consumers with relevant information about the auto insurance system, including:

- what to do if they've been involved in a collision;
- what to expect if they've been injured in a collision;
- the information they require to avoid and prevent fraud as they go through the claims process and recover from an injury; and
- links to existing information available on government, insurance industry and other appropriate websites.

The diagram below provides a map of the content the website could contain.

Exhibit 2: Illustrative Map of Dedicated Website Content



In order to promote the site, communications materials developed under the direction of the Implementation Group should link to the site or provide information about it. The site's content should offer multilingual information.

Anti-Fraud Awareness Implementation Group

The learning moments strategy and dedicated website described above should be implemented by the Anti-Fraud Implementation Group. The group should:

- incorporate other Task Force recommendations and findings into consumer engagement and education materials;
- develop new auto insurance consumer engagement and education initiatives;

- consider ways to educate new drivers about fundamental principles and practices in Ontario's auto insurance system;
- monitor the effectiveness of specific initiatives and the overall consumer engagement and education strategy; and
- submit a one-year Interim Report and a two-year Final Report to the Deputy Minister of Finance regarding its progress, and the success of the strategy.

The Implementation Group would be led by two co-chairs, the Insurance Bureau of Canada and FSCO, and would consist of at least four additional members. The group's membership should reflect our conclusion that combating auto insurance fraud must be a collaborative effort involving many partners in the auto insurance system. We recommend that the following organizations and individuals be invited by the government to form the group:

- Financial Services Commission of Ontario (Co-Chair)
 - Insurance Bureau of Canada (Co-Chair)
- FSCO, Ontario's insurance regulator, and IBC, the leading representative of the insurance industry, are two major sources of auto insurance communications experience and expertise. Government and industry co-chairs of the Implementation Group support our belief that many different groups in the auto insurance system must be engaged in order to address fraud effectively.
- a consumer representative
- Individual Ontario consumers will be the target of the Implementation Group's consumer engagement and education strategy. The group should include a consumer representative to get a pragmatic point of view regarding different anti-fraud initiatives it is considering.
- Insurance Brokers Association of Ontario (IBAO)
- Insurance brokers are important and trusted touch-points when consumers purchase or renew auto insurance policies. The Implementation Group should take advantage of the unique position brokers occupy in the auto insurance system and their own communities.

- Canadian Association of Direct Relationship Insurers (CADRI)
The industry association representing direct response insurers can offer the Implementation Group further communications expertise. It will also be valuable for the group to review practices in the other lines of business engaged in by the parent companies of many direct response insurers.
- Ministry of Finance
The Ministry of Finance can help coordinate the Implementation Group's contact with other government organizations that may be needed for advice on certain aspects of the consumer engagement and education strategy.

The Canadian Life and Health Insurance Association (CLHIA) should also be considered as a possible member of the Implementation Group. The life and health insurance companies that the CLHIA represents are also susceptible to auto insurance fraud. In Ontario, the benefit and disability plans offered by employers to their employees through life and health insurers, are required to pay for any healthcare eligible related costs arising from a motor vehicle collision as a first payer. Only if the expense is deemed not eligible, for example, the employer plan reaches a cap or other such limit, does the individual's auto insurer become liable for health claim costs. The CLHIA has informed us that they have recently formed a new Working Group on Auto Fraud and have been working with the Insurance Bureau of Canada on some joint projects. We believe that if the CLHIA is interested in participating they could add value to the Implementation Group.

We recommend that each member of the Implementation Group commit significant resources to the strategy. We also expect that the Implementation Group will consult with other organizations regarding its work, in particular other government ministries and service providers to auto insurance claimants.

The Implementation Group's Final Report, which will be made two years after it begins its work, should evaluate how successful it has been in raising awareness of auto insurance fraud among consumers and increasing consumer activism in combating fraud. The results of the Pollara consumer survey referenced in our July Status Update will provide a useful baseline for evaluating the success of the group's initiatives.

Mandatory disclosure

Auto insurance is a highly regulated product in Ontario. Certain requirements and regulations under the *Insurance Act*, such as the Statutory Accident Benefits Schedule, establish minimum coverage levels for consumers and minimum service standards insurers must meet when handling an auto insurance claim.

Because insurers in Ontario offer the same auto insurance coverage, consumers will generally consider only two factors when purchasing a policy:

- the price of auto insurance coverage, information that is easily accessible for consumers; and
- how an insurer treats its claimants, information that is not easily accessible for consumers.

We are recommending that auto insurers disclose certain claims handling business practices to give consumers a better understanding of how individual companies treat their claimants. Disclosure will provide meaningful information that will engage auto insurance consumers and encourage the insurance industry to identify and achieve best practices related to claims handling.

We recommend that the government amend the *Insurance Act* to enable regulations that would require insurers to disclose:

- *complaint-handling protocols*

Existing Superintendent's Bulletins from 1996 and 2001 already require companies to have complaint-handling protocols. We believe these requirements can be updated to ensure proper disclosure to all consumers in a simple and visible way. Each individual company should disclose its complaint-handling protocols and the way it has organized its operations to comply with those protocols on its website, in a way that allows consumers and analysts to make meaningful comparisons.

- *criteria for selecting service providers involved in auto insurance claims*

Insurers should disclose the criteria and processes they use to assess and select preferred service providers, including providers of: medical and rehabilitation treatment; independent medical examinations; vehicle towing services; vehicle storage services; vehicle repair services; and independent adjusting services. Where an insurer does not have preferred service providers, it should disclose the criteria and processes it uses to select providers involved with a claim.

In response to the proposal for disclosure in our July Status Update, several insurance companies raised concerns that such disclosure could reveal commercially sensitive information related to contractual relationships between insurers and service providers.¹⁶ We are not recommending the disclosure of commercial terms between insurers and their preferred service providers. We are recommending the disclosure of the criteria insurers use to first select the service providers they recommend to claimants and second to evaluate the performance of those providers to ensure that they are serving claimants properly.

Greater disclosure by auto insurers will provide helpful information to interested consumers. We are hopeful that the information disclosed by insurers will be reviewed by an objective third party willing to compare and contrast company practices to help consumers understand differences across the industry.

Mandatory disclosure of corporate governance practices has, over the past 20 years, led to increased transparency and higher standards of corporate governance. This improvement has been spurred by independent comment that has compared and contrasted the governance practices of firms. We are hopeful that mandatory disclosure of complaints-handling issues will lead, over time, to similar improvements by the industry.

¹⁶ For further information refer to submissions from Allstate Canada Group, The Co-operators Group, State Farm and the Insurance Bureau of Canada (see Appendix 2).

Enhanced FSCO oversight

Finally, we recommend that FSCO enhance its existing auditing of insurer behaviour with a greater focus on whether insurers are following the protocols and practices they disclose to the public. Where FSCO finds that practices fall short of what has been promised, it should report this publicly and be prepared to identify companies that fail to comply with their stated practices.

Reducing uncertainty and delay in providing auto insurance benefits

Recommendations

4. The government should reduce uncertainty and delay for those who have legitimate auto insurance claims by moving aggressively to:
 - a. address the current backlog of mediation cases before the Financial Services Commission of Ontario, and develop a more robust dispute resolution framework;
 - b. introduce treatment protocols for minor injuries that are based on scientific evidence; and
 - c. amend the Statutory Accident Benefits Schedule to make it clear that insurers are required to provide claimants with a full explanation when refusing to pay for treatment, assessment or other benefits.
-

Although our mandate does not include reviewing the structure of auto insurance benefits, or how the system is administered, it is clear to us that alternative choices can influence the incidence of fraud. We are particularly concerned that uncertainty in the system, due to lack of clear rules and a clogged dispute resolution system, facilitates fraudsters at the expense of legitimate claimants.

As noted in the Overview section, the 2010 program changes to address increased costs represented an “across-the-board” rather than “targeted” approach to deal with fraud. Important government initiatives that accompanied the change in structure — including the development of science-based treatment protocols and injury definitions — are still ongoing. And the greater discretion afforded to the industry to deny claims suspected of being fraudulent has been a factor in the dramatic increase of claims being disputed through mediation at FSCO.

The government should move quickly to reduce uncertainty in the system. It should actively promote the development of science-based treatment protocols; act aggressively to reduce the claims under dispute at FSCO and develop a more robust and timely dispute resolution approach; and amend the SABS regulation to require insurers to provide more information to claimants when denying a claim.

Effects of the September 2010 Reforms on SABS Benefits

Estimates of claims costs for all of 2011 are now available and the GISA numbers¹⁷ show that claims costs have decreased significantly as a result of the September 2010 reforms. In 2011, Accident Benefits claims costs in Ontario were estimated to be \$2 billion, compared with \$3.9 billion in 2010. In light of this information, some have represented to us that we should not urge¹⁸ the government to act aggressively on our recommendations, since much of the problem may already have been solved. We reject that approach for the following reasons:

- The 2011 estimates may still change significantly based on decisions flowing from claims made after September 2010 that are still in dispute. Until some of these cases make their way through arbitration, there will be considerable uncertainty within the industry about adequate reserving levels.¹⁹

¹⁷ The General Insurance Statistical Agency (GISA) provides information on auto insurance claims costs. Further information on GISA and its publicly available claims costs data are available at <http://www.gisa.ca/en/default.asp>. We have reviewed the most recent data from GISA, which was provided to the Standing Committee on Finance and Economic Affairs in September, 2012.

¹⁸ For further information refer to submissions from Ontario Trial Lawyers Association, Fair Association of Victims for Accident Insurance Reform and Ontario Psychological Association (see Appendix 2).

¹⁹ Court decisions could also significantly change claims costs estimates in the future.

- It is too early to tell how the reforms may have impacted the cost of liability claims for bodily injury because there is a two-year time period in which these claims can be reported.
- The fact that costs may have been reduced substantially does not — by itself — say very much about reductions in the incidence of fraud. Indeed, we have had presentations to us that suggest that one of the impacts of the 2010 SABS changes has been to redirect fraudsters away from claims for treatment and toward fraudulent claims for income replacement benefits.²⁰

Most important, we believe that the best way to deal with fraud is through a targeted approach aimed at fraudsters, rather than across-the-board changes to benefits. If a targeted approach, along the lines we recommend, can be implemented effectively there will be fewer unintended consequences and greater fairness for all participants in the auto insurance system.

Evidence-based treatment

Rules governing how a certain injury should be treated or what type of injury claim a certain claimant has can help reduce uncertainty about what injuries can be treated. The government is working to:

- review the definition of catastrophic impairment based on the work of a panel of scientific and medical experts; and
- develop evidence-based treatment protocols for minor injuries.

These initiatives will help create more certainty for auto insurance claimants and ensure that appropriate treatment is provided by appropriate health care practitioners. The development of evidence-based treatment protocols for minor injuries is of particular importance in preventing fraud. We urge the government to complete these tasks as quickly as possible.

²⁰ For further information refer the submission from Sue Collings (see Appendix 2).

Fixing the dispute resolution system

Disputes between insurers and claimants about benefits provided under the SABS are addressed through mediation and arbitration services offered by the Financial Services Commission of Ontario (FSCO). The informal mediation process is free of charge to the person claiming benefits and mandatory for any dispute regarding accident benefit claims. If mediation is not successful, the claimant may then choose to apply for FSCO arbitration or to have the matter determined in court or with the consent of the insurance company submit the dispute for private arbitration.

In our December 2011 Interim Report²¹ we noted that from 2006–07 to 2010–11, applications for FSCO mediation services grew by 136 per cent. This increase created a large backlog of mediation cases, which in turn significantly increased wait times for mediation applicants. When the Interim Report was released, an applicant was typically waiting ten months to be assigned a mediator.

The mediation backlog is a serious concern. It results in claimants waiting longer for benefits while insurers face greater uncertainty in predicting their claims costs. We understand that as of the end of August, 2012 there are still about 25,000 files at FSCO waiting assignment to a mediator. And although it is now more than two years since the September 2010 changes to the SABS were introduced, there has yet to be a single arbitration decision dealing with collisions occurring after September 1, 2010.

We are hopeful that recommendations from this report will reduce claims going to dispute resolution by reducing the number of fraudulent or abusive claims that go through the process and allowing insurers and claimants to focus on resolving legitimate disputes in good faith. We are also aware that FSCO has retained a private firm to increase its capacity to handle mediation files and reduce the backlog. But that is not enough. Action needs to be taken to eliminate the backlog and to develop a more robust dispute resolution framework for the future.

The government committed to address these issues in the 2012 Budget. We urge that it do so expeditiously.

²¹ See pp. 11–12 of the Interim Report.

Requiring insurers to provide more complete reasons for claim denial

The September 2010 reforms provided insurers with additional discretion when determining entitlement to medical and rehabilitation benefits. The reforms allowed flexibility for insurance adjusters to deny claims that were considered excessive or not reasonable without requiring an independent examination.

However, Section 38(8) of the Statutory Accident Benefits Schedule (SABS) requires insurers, within 10 days after receiving a treatment and assessment plan, to provide claimants with a notice stating “*the medical and any other reasons*” (emphasis added) why the insurer considers any goods, services, assessments or examinations or the proposed costs of them not to be reasonable or necessary.”

We have heard reports that, in some cases, insurers are denying payments of medical and/or rehabilitation benefits without providing adequate reasons for the denial, for example, by providing a limited, non-specific explanation, such as “not medically reasonable or necessary.”

We therefore recommend that the government revise the current SABS section 38(8) to clarify that a claim denial describing a claimant’s request for goods, services or assessments as “not reasonable or necessary” is not sufficient to be compliant with section 38(8), which requires a claim denial notice to list the “medical and all other reasons.”

Province-wide regulation of the towing industry

Recommendations

5. The government should implement a province-wide licensing scheme for the towing industry, to be administered by an Administrative Authority. Fraudulent practices should be addressed along with road safety and consumer protection issues.
6. Insurers should collect information about towing expenses to facilitate analysis of relationships between tow operators, collision repair facilities and health care clinics.

We have been told repeatedly by participants in the auto insurance system that some towing operators are engaged in organized or premeditated auto insurance fraud. These operators may be part of a larger organized ring that manufactures false claims or inflates existing claims through referrals to particular auto body storage and repair shops, health care clinics and legal service providers or they may be acting alone by charging excessive fees to motor vehicle collision victims. From an anti-fraud perspective, tow truck operators can serve as a critical “first-link” in a chain of fraudulent activity that starts at the scene of a collision, where consumers are most vulnerable. The Task Force spent considerable time and effort considering how this issue might best be addressed.

As we became more familiar with the issues and the existing regulatory framework, it became apparent that concerns about the current state of the industry were much broader than auto insurance fraud, and included:

- road safety concerns (such as speeding or unsafe driving to collisions and poor incident management at the scene of collisions);
- consumer protection concerns (such as lack of clarity around fees and demanding payment in cash only, and preventing consumers from tracking or directing their vehicle to a destination); and
- mechanical, operating and employee training concerns (such as improper equipment, insufficient employee training and inadequate towing procedures).

We are particularly concerned with the road safety issues raised by the public and the towing industry. Tow operators play an important role in managing collision scenes by clearing damaged vehicles from roadways quickly and safely. This helps prevent secondary collisions and traffic congestion. However, industry estimates for 2007 provided to us show that Ontario’s tow trucks had a 21 per cent collision rate, compared to 4.7 per cent for private passenger vehicles or 1.4 per cent for commercial vehicles.²² High collision rates for tow trucks endanger the tow truck operators and other drivers.

²² Presentation by Ontario Recovery Group (ORG) Inc. and Provincial Towing Association (Ontario) Inc. to the Regulatory Practices Working Group, November 3, 2011 — industry estimates based on 2007 road collisions data and approximate number of towing vehicles in Ontario.

Our Status Update proposed, for discussion, a number of regulatory and non-regulatory options to deal with these issues. Much of the feedback we received, particularly from those in the industry, supported action to move to a province-wide regulatory regime. The existing municipal licensing model was identified by many as being inconsistent - creating a regulatory vacuum in areas where no municipal authority or program exists or a source of potentially burdensome, over lapping fees and requirements in others.

The situation was summed up by the Executive Director of the Provincial Towing Association (Ontario) Inc., who wrote that:

“The towing industry in Ontario carries a very poor reputation due to the number of inexperienced persons of low morals whose only goal is to make a quick dollar at the expense of the public and insurance companies. It should also be noted however that there is also a large number of very professional operators that operate their businesses with honesty and integrity...It is also true that the professional operators get caught in the stigma of being part of an industry that carries a very poor reputation due to a “guilty by association” attitude by both the public and insurance industry. The many professional operators in Ontario are convinced there is no future in this industry as it is today and it is urgent that things change immediately.”²³

We were also informed by a large independent operator who was not a member of the Association that he would support moving to province-wide licensing and regulation, if it were a replacement for municipal licensing and not an add-on.²⁴

²³ Submission of the Ontario Recovery Group (ORG) Inc. and Provincial Towing Association (Ontario) Inc. to the Task Force, August 8, 2012, p. 1.

²⁴ Meeting with John Paul Cruz, August 22, 2012.

We believe that province-wide regulation of the towing industry, through a delegated Administrative Authority (AA) offers the best approach to deal with the issues that have been raised with us. Legislative authority and precedents for delegated Administrative Authority exist and we believe they are relevant and, in principle, appropriate (see the box on following page). But we recognize that creating such an Administrative Authority will take time, require some capacity-building in the industry and should be the subject of further consultation. In the remainder of this section, we set out a framework and a process for establishing province-wide regulation in a reasonable time frame.

We also recommend immediate action by insurers to improve their data collection and tracking systems to provide additional information that can be helpful in preventing fraud by tow truck operators.

Overview of an Administrative Authority

What is an AA?

Under the AA model, a Minister delegates operational responsibility for administering a set of regulatory requirements to a not-for-profit, private corporation known as an Administrative Authority. The AA model is designed to leverage industry knowledge and experience in developing and administering regulatory standards, while ensuring appropriate oversight and consumer protection. Government retains overall accountability, and legislative and regulatory control over the Authority and the regulated sector.

How is an AA funded?

Once fully established, the AA is self-funded through fees charged to the regulated sector.

How is an AA governed?

An AA is governed by an independent board of directors. Government may appoint less than a majority (49 per cent or fewer) of directors. The AA is responsible for electing the majority of board members.

What does the AA do?

An AA implements all day-to-day decision-making and aspects of regulatory service delivery, including:

- registration and licensing of businesses or individuals
- monitoring, inspections, investigation and enforcement
- responding to consumer complaints
- disciplining registrants/licensees
- enhancing industry professionalism
- public and industry education and awareness
- liaising with government and industry
- setting and collecting fees to the regulated sector
- managing financial and operational affairs of the organization
- establishing industry or stakeholder advisory committees to provide advice as needed

What are some current examples?

Electrical Safety Authority, Real Estate Council of Ontario, Travel Industry Council of Ontario, Ontario Motor Vehicle Industry Council, Technical Standards and Safety Authority, and the Retirement Home Regulatory Authority (currently operating as an interim authority).

Recommendation for province-wide regulation

The existing approaches to addressing road safety, consumer protection and other concerns related to the towing industry have led to an inconsistent and confusing patchwork of requirements and enforcement levels. This inconsistent approach can help facilitate fraud.

We are persuaded that province-wide regulation is the best approach and that an Administrative Authority is the preferred model for province-wide regulation.

As municipalities currently have business licensing authority over the towing industry, the Task Force initiated separate informal discussions with staff of the City of Toronto, select municipalities, and the Association of Municipalities of Ontario. Initial staff comments about proposals for changes to the existing framework were mixed:

- some saw value in greater, more consistent oversight of the towing industry while others questioned the need for action in all communities;
- some favoured minimum standards for municipal licensing while others saw provincial business licensing as more effective;
- others proposed alternative approaches such as increasing requirements for driving and vehicle licences, rather than a business licensing approach; and
- some thought it would be necessary to regulate the auto repair and auto storage industries, as well as the towing industry.

Key municipal concerns around any potential changes focused on impacts on municipalities, the ability of a provincial entity to provide sufficient local consumer protection and enforcement on highly mobile tow truck operators, the ability of the towing industry to participate in an oversight body, and regulation of the towing industry in isolation from auto repair and storage facilities.

We do have two concerns that should be addressed in moving forward. The first is whether the industry, as now structured, has the ability to lead and support this type of administrative oversight body. And the second is how best to achieve the change we believe is necessary with the greatest support of the municipalities.

We believe that ways can be found to deal constructively with both of these concerns, but doing so will require further engagement with the industry and municipalities as the recommendation is implemented.

We discuss this further below in elaborating our recommendation for how to proceed with this issue.

Recommended licensing scheme — framework

A province-wide licensing scheme should mandate that drivers, owners and operators meet defined standards regarding:

- registration and licensing eligibility;
- training and safety standards for operations and equipment;
- collision incident management practices and procedures;
- staff training;
- prohibitions on paid referrals to or from other business or services;
- prohibitions on unsolicited referrals to automobile repair facilities or vehicle storage facilities;
- transparent and traceable billing practices; and
- general consumer safety and protection measures, such as a code of conduct that would include getting informed and freely given consumer consent before towing a vehicle and the requirement to provide information about the destination of the tow.

The licensing scheme should also consider the setting of local rates or fee schedules, which has been strongly suggested to us during our consultations. Licensing requirements could also be tailored to the different types of business models in the towing industry. For example, individual owner-operators could use a less burdensome licensing process than a large company with multiple vehicles.

Recommended licensing scheme — administration

An Administrative Authority (AA) or a similar not-for-profit private corporation should administer the provincial licensing scheme for the towing industry. Government would retain ultimate accountability and control over the AA and the regulated sector.

The regulatory regime should be enforceable, and the AA should be adequately equipped with sufficient powers and tools to be effective. For example, the AA should have the authority to revoke or suspend licences or levy administrative monetary penalties. The AA should also have the ability to contract with municipalities or other bodies to administer its regulations.

The governance model for a towing industry AA should reflect recent trends in the establishment of third-party entities to administer regulations. The majority of the board members should be selected by an interim, government-appointed board on the basis of skills and/or competencies rather than primarily on industry membership. For instance, skills and competencies can include: previous board experience, experience in the industry sector, regulatory experience, or practical experience in operating a business. Government should retain the authority to establish qualifications and rules for the election of non-government appointees. Consideration should be given to banning representation by employees or directors of towing industry associations.

The AA model can deliver regulations and services more efficiently, and provide focused expertise and administration in specific sectors. This can result in reduced costs to taxpayers, greater administrative flexibility and ongoing investment in operational areas, such as technology systems or educational programs. An AA model will also improve oversight of the towing industry by creating a ‘one-window’ entity to register licensees, enhancing industry professionalism, educating industry participants and consumers, responding to consumer and insurer issues, liaising with government authorities, and ensuring monitoring, investigation, and discipline.

Recommended licensing regime — consultation and engagement

Development of a new regulatory model based on our recommendations will require time, resources, extensive consultation, collaboration and appropriate legislation. The government should take an immediate leadership role in this process by establishing an inter-ministerial forum with the following objectives:

- develop a new regulatory regime for the towing sector and an oversight and governance framework for an Administrative Authority or alternative province-wide regulatory model;
- help develop the internal capacity of the towing industry for future participation in the potential governance framework of an Administrative Authority; and
- report back to the Ministers of Finance and Transportation by the end of 2013 on recommendations and progress.

The inter-ministerial forum should involve many different organizations:

- Ministry of Transportation
- Ministry of Consumer Services
- Ministry of Community Safety and Correctional Services
- Ministry of Finance
- Ministry of Municipal Affairs and Housing
- Ministry of Labour
- representatives of provincial and local police forces

The forum could also establish sub-groups to engage other important groups, such as municipalities, insurers and the towing industry, to benefit from their knowledge and experience.

Recommendations to address auto insurance fraud

Insurers should improve the tracking of towing expenses related to auto insurance claims. Towing expense data should be collected and managed by insurers in a way that allows the detection of any suspicious patterns or relationships between tow truck operators and other service providers in the auto insurance system, such as collision repair shops and health care clinics.

Better data collection and analysis will be vital to establish the extent of fraud in the towing industry. It will also allow the industry and government to track the effectiveness of anti-fraud measures and gauge the need for additional action.

Changes to the *Repair and Storage Liens Act*

Recommendation

7. The government should amend provisions in the *Repair and Storage Liens Act* to reduce unreasonable storage costs for vehicles damaged in a collision.

Abuse of the *Repair and Storage Liens Act* (RSLA) affects auto insurers and premium payers by increasing the costs for storage of a vehicle damaged in a collision. Addressing provisions of the RSLA as they relate to the storage of vehicles will reduce the amount of revenue available to fraudsters and help prevent Ontario's auto insurance system from being targeted by unscrupulous storage facilities.

In the present regulatory framework, a damaged vehicle may be taken to a storage facility after a collision. The facility will begin charging for its storage services immediately, but the owner of the vehicle may be unaware of these accumulating charges. We have been told that in some cases a daily rate of up to a thousand dollars has been charged.

The RSLA gives a facility 60 days to hold the vehicle before notifying the owner. Facilities attempting to maximize their revenue may wait all 60 days to notify the owner and allow storage costs to increase to unreasonably high levels. The vehicle's insurer may be liable for these inflated costs, which lead to higher claims costs and higher premiums for honest drivers.

In a presentation to the Task Force the Ontario Bar Association (OBA) indicated that it was preparing a submission to the Ministry of Consumer Services and the Ministry of Government Services. The OBA said that its submission will recommend changes to the RSLA that will help address unreasonable storage costs by changing the notice period related to vehicles from 60 to 15 days. We support the recommendation the OBA presented to us although we wonder whether with modern technology, even 15 days is too long. We encourage the government to act in this area and any others identified in the pending submission that can be helpful in reducing abusive behaviour with regard to auto storage.

Cancellation fee for missed medical examinations

Recommendation

8. The government should permit insurers to collect a cancellation fee for claimants who fail to attend a medical examination at the agreed time, without reasonable notice or explanation.

We have been informed that it is not uncommon for claimants to fail to appear at a scheduled medical examination, without providing notice that they are unable to attend. We have also been told that in some cases they have been counselled to do so by their legal advisers. Intentional non-attendance adds costs to the auto insurance system and increases premiums for all drivers. It also takes valuable time away from insurance adjusters who could be using it more effectively on other claims, and medical professionals who could be examining other patients or claimants. A sample of nine insurers, accounting for about 40 per cent of the industry, suggests that the average cost of a missed appointment is about \$800 and most of the nine companies were incurring annual costs in excess of \$1 million for appointments cancelled without adequate notice. (The range was from \$250,000 to more than \$1.7 million).

We recommend that the government amend the SABS to permit insurers to collect a cancellation fee of \$500 for those claimants who fail to attend a scheduled appointment after agreeing to do so, then failing to provide adequate notice or provide a reasonable explanation.

The regulation should also require the company to ensure that the claimant is advised, when the appointment is confirmed, of the cancellation fee and the steps necessary to avoid having it levied.

Detection

This section sets out our recommendations to address fraud detection. They are focused in seven areas:

- industry initiatives to identify suspicious claims
- making HCAI a more effective fraud detection tool
- licensing and regulation of health clinics and assessment providers
- making it easier for individuals to report suspected fraud
- enhancing FSCO's ability to get information
- changes to regulations governing insurer/claimant relations
- improving collision reporting forms

Industry initiatives to identify suspicious claims

Recommendations

9. Insurers should move aggressively to establish an organization that would pool and analyse claims data in order to identify potential cases of organized or premeditated fraud.
10. The Government of Ontario should urge the Government of Canada to move quickly to secure passage of amendments to the *Personal Information Protection and Electronic Documents Act* that are now before the House of Commons in Bill C-12. The goal should be to remove any undue limitations on the ability of insurers to pool claims information to combat fraud.
11. The Financial Services Commission of Ontario should amend the forms consumers use to apply for auto insurance and accident benefits to make it clear to them that insurers may pool and analyse such information to detect fraudulent activity.

In our Status Update we reported that the insurance industry planned an industry-wide initiative to use highly sophisticated data analysis tools to identify suspected fraudsters that target multiple insurers. We understand that substantial progress is being made on developing a new, not-for-profit entity that would allow for the pooling of claims data and the analysis of that data to identify suspected cases of organized or premeditated fraud. Such cases would then be followed up for investigation by insurance companies and by the Insurance Bureau of Canada's (IBC) Investigative Services Division (ISD), working as appropriate with FSCO and law enforcement authorities.

This initiative has evolved from the proof-of-concept exercises that were undertaken by a group of insurance companies representing about 65 per cent of the Ontario auto insurance market. These were referred to in the Overview section where we described the role these exercises played in the research undertaken by KPMG.

We believe that the successful launch of this new entity is critical to assist the detection of organized and premeditated fraud and we support its timely creation. We also urge the industry to include as much claims data as possible, as the ability to identify suspicious activity is enhanced greatly by increasing the number of cases that can be examined. We have had specific representations from the Associated Canadian Car Rental Operators who would like to be sure that claims against their insurers are also included in the exercise.

We understand that some companies feel that the current privacy regime inhibits their ability to share such information to the extent that would be desirable. We believe that it would be helpful, and in the public interest, to provide greater assurance that pooling of claims information for such purposes would be permitted under the applicable privacy legislation. That legislation is the *Personal Information and Electronic Documents Act* (PIPEDA) which is federal legislation that governs personal information generally and came into effect in stages, from 2001 to 2004 as well as the *Personal Health Information Protection Act, 2004* (PHIPA), which is Ontario legislation governing personal health information.²⁵ PIPEDA is administered by the federal Office of the Privacy Commissioner of Canada whereas PHIPA is administered by the Ontario Office of the Information and Privacy Commissioner.

In September 2011, the Government of Canada introduced amendments to PIPEDA, in the form of Bill C-12, which would facilitate the detection of fraud. In particular,

“Subsection 7(3) of PIPEDA already permits organizations to voluntarily disclose to a government institution personal information without consent when an organization has reasonable grounds to believe that a contravention of the laws of Canada, a province or a foreign country is being, has been, or is about to be committed. Bill C-12 would allow disclosure without consent to organizations in general, presumably including other companies, if necessary to investigate a breach of an agreement or a contravention of laws (as above), or to ‘prevent, detect or suppress’ fraud. In the case of fraud, the bill further permits disclosure without consent of an individual’s personal information when notifying the individual could be reasonably expected to frustrate attempts to deal with fraud [clause 6(9)].”²⁶

Our understanding is that enactment of these provisions would provide the certainty that would be desirable to make this initiative to detect organized and premeditated fraud as effective as possible.

²⁵ Section 4 of PHIPA broadly defines “personal health information” to include information about an identifiable individual’s health status, health care, and eligibility for and receipt of payments for health care.

²⁶ http://www.parl.gc.ca/About/Parliament/LegislativeSummaries/bills_ls.asp?ls=c12&Parl=41&Ses=1&source=library_prb&Language=E

We therefore urge the Government of Ontario to make appropriate representations to the Government of Canada to move quickly to secure the passage of Bill C-12.

In addition, we have explored whether other mechanisms, under the direct control of the Government of Ontario, might be available to achieve the greater certainty we feel is desirable. We have concluded that a more limited and focused approach to auto insurance fraud detection in Ontario could be achieved by amending the consent provisions on the application form for auto insurance benefits to provide for the pooling of relevant information related to auto insurance claims for the purposes of preventing, detecting or suppressing fraud. The application for an auto insurance policy should also be amended to notify consumers that they will be asked for consent to allow for the pooling of relevant information if they do make a claim for accident benefits under their policy.

We recommend that the Superintendent of FSCO move to make such amendments, after consultation with the Ontario Privacy Commissioner to ensure that the purposes of the amendments can be achieved in a way that is most protective of individual privacy. We have developed an illustrative example of consent language that we believe would strike an appropriate balance, and we provide it in Appendix 5 for further consideration.

Making Health Claims for Auto Insurance a more effective fraud detection tool

Recommendation

12. The government and industry should take advantage of the unique nature of Health Claims for Auto Insurance and its potential use as an anti-fraud tool by building on existing initiatives and by exploring other potential opportunities.

Health Claims for Auto Insurance (HCAI) is an electronic system used to send auto insurance claim forms between insurers and healthcare facilities in Ontario. HCAI's original purpose was to be a transactional database, but its anti-fraud potential has been recognized by many different groups, including health care practitioners, the insurance industry and government.

We created an HCAI Anti-Fraud Working Group to bring these groups together to consider ways that HCAI might be used to combat fraud. The recommendations in this section are based on opportunities identified by the Working Group.

The implementation of these recommendations will require additional resources and funding, as well as further collaboration between HCAI, health care practitioners, the insurance industry and the government.

Building on existing initiatives

In the Status Update we discussed two ongoing HCAI initiatives:

- the Professional Credential Tracker (PCT); and
- business-to-business statements.

Professional Credential Tracker

The PCT is a pilot program to help health care practitioners prevent their identities from being stolen by fraudulent health care facilities. Practitioners who use the PCT can see which facilities use their professional credentials to bill insurers and can report any suspicious activity to their health regulatory colleges.

We are recommending the continuation of the PCT pilot project with the objective of gradually moving to full adoption by all regulated health practitioners.

Eventually, regulated health practitioners should be able to check the use of their credentials themselves at any time. A self-service solution could be a Personal Identification Number, as discussed in our Status Update or another method of secure entry into the PCT for individual providers.

A full, self-service version of the PCT would give practitioners information about:

- who has their credentials;
- when those credentials have been used;
- for what purpose the credentials were used; and
- how practitioners should report suspicious activity involving their credentials.

Once the full, self-service version of the PCT is developed and fully adopted, additional features should be considered. Those features could include:

- regular mandatory practitioner reviews of the use of their credentials; and
- a method for a practitioner to electronically request removal from the roster of a specific health care clinic.

We have been extremely encouraged by the work done on credential tracking by HCAI and the interest shown in the tool by health practitioners. We are hopeful that this good work and cooperation can continue.

Business-to-business statements

HCAI business-to-business statements summarize monthly invoicing activity between an insurer and health care provider. The statements allow insurers and health care facilities to identify irregularities in their monthly invoicing.

We support the use of business-to-business statements by health care clinics and insurers as a means of identifying any suspicious billing activity. Insurers should incorporate the business-to-business statements into their business processes to provide greater certainty when their Chief Executive Officers attest to the adequacy of their cost, fraud and abuse controls.²⁷ The statements should also be used to support our recommended regulatory regime for clinics that treat and assess auto insurance claimants.

²⁷ In October, 2011 the Superintendent of FSCO began requiring the Chief Executive Officers (CEOs) of auto insurance companies to attest, personally and annually, that the SABS cost controls they have in place, including those to address fraud and abuse, are effective, reviewed on a regular basis and ensure that legitimate claimants are treated fairly and in accordance with the law. If the CEO of a company provides false attestation, the CEO can be personally liable for a fine of up to \$100,000. Subsequent offences can lead to fines of up to \$200,000.

Other potential opportunities

HCAI is a relatively new tool in the auto insurance system. We support the government's commitment in the *2011 Ontario Budget* to work with industry to find more anti-fraud uses for HCAI. A process of continuous improvement should be in place to fulfil this commitment, and the HCAI Working Group has identified specific opportunities to enhance HCAI's anti-fraud capabilities that should be considered as part of that process.

- 1. Review and enhance the data currently sent to HCAI for opportunities to facilitate automated reports and other data analysis projects*

HCAI contains a vast amount of information that can be used to analyze trends in the auto insurance system. The analysis of data could be expanded so that trends that might indicate fraudulent behaviour could be better understood.

The government should also consider expanding the type of information that insurers must submit to HCAI to include all medical and rehabilitation expenses.

- 2. Streamline how HCAI processes transactions*

HCAI should complete the transition from manual, paper-based forms to electronic transactions. Doing so will allow for simple and consistent processing within HCAI and prevent potential abuse of the system.

3. Explore opportunities for interaction with the regulatory model for clinics that treat and assess auto insurance claimants

The Overview section of this report briefly identified how limiting access to HCAI should be used as an enforcement tool in the regulation of clinics operating in the auto insurance system. There may be further opportunities for interaction between HCAI and the regulatory regime for clinics to:

- require greater information from clinics registered with HCAI about the practitioners they employ. HCAI could be used to check whether the services invoiced match the qualifications of the provider that billed them;
- explore how HCAI could receive electronic information regarding a clinic's registered practitioner roster and individual practitioner credential information from regulatory colleges; and
- use the business-to-business statements to verify the accuracy of a clinic's billing activity.

4. Explore additional data collection opportunities

The value of HCAI could be further enhanced with additional data not currently funneled through the system. Information about claimant-submitted expenses outside of medical and rehabilitation benefits, such as income replacement benefits, could create a better understanding of auto insurance cost trends.

Expanded data collection should be pursued based on four objectives:

- give policymakers a complete picture of costs related to Statutory Accident Benefits with a breakdown of distinct medical and rehabilitation costs by individual health care practitioner;
- facilitate immediate analysis of the effect of regulatory changes;
- increase the value of publicly available reports that identify the cost of Statutory Accident Benefits treatment and assessment plans; and
- provide a basis for meaningful comparisons of treatment duration and costs for similar conditions; this could be particularly useful in an environment where evidence-based treatment protocols for minor injuries are available.

Regulation of health clinics and assessment providers

Recommendation

13. The government should require the licensing of health clinics that treat and assess auto insurance claimants and empower the Financial Services Commission of Ontario to regulate their business practices.

In our Status Update we reported our conclusion that a licensing and regulation regime for the business practices of health clinics treating auto insurance claimants is appropriate and necessary. Although the Update did not outline a specific model it did point to four objectives that a licensing/regulatory regime should achieve:

- transparency in ownership, assessment costs and conflicts of interest;
- accountability for practitioners and clinics;
- assessment of market conduct and business practices by a regulator; and
- sanctions for fraudulent behaviour.

The first two objectives of the regulatory model, transparency and accountability, will enhance fraud detection in the auto insurance system. Assessment of market conduct and sanctions for fraudulent behaviour will support more effective investigation and enforcement.

Our recommendations regarding the regulation of business practices used by clinics that treat and assess auto insurance claimants are informed by the work of Willie Handler and Associates,²⁸ an advisory firm with considerable expertise on Ontario's auto insurance system. We have also benefited from the positive and constructive input received from interested parties in response to the Status Update.

²⁸ The Final Report from Willie Handler and Associates is available online at <http://www.fin.gov.on.ca/en/autoinsurance/reg-health.html>

Features the regulatory model should include

Although most health professionals are regulated, the facilities in which they work are not. As well, the health regulatory colleges' mandates typically cover public protection and quality of service, rather than the business practices of the clinics that employ health professionals.

Health clinics treating and assessing auto insurance claimants range from sole practitioners to publicly traded companies, from public hospitals to private offices, from regulated professionals to unlicensed providers. Information about these service providers is limited to the number of facilities that have registered with Health Claims for Auto Insurance (HCAI) and the number of providers working in the facilities. We believe more information and more oversight is necessary.²⁹

A review of approaches to licensing and regulating the business practices of health clinics treating auto insurance claimants in other jurisdictions shows that many are struggling with the same issues. It is important for Ontario to be proactive in this area and avoid becoming a safe haven for fraudulent clinics.

Our recommendation is centred on the objectives of transparency, accountability, assessment and sanctions set out in the Status Update. At its core, this regulatory model aimed at enhancing fraud detection would:

- license health clinics that treat auto insurance claimants and health clinics that conduct independent medical examinations of claimants;
- take a risk-based approach to regulation of business practices by providing different types of licences based on a clinic's size and scope of practice;

²⁹ As we noted in our Interim Report last December, the use of HCAI to bill insurance companies became mandatory in Ontario in February, 2011. At that time, the number of registered facilities was 5,501. By September, 2011, it had increased 37 per cent to 7,545. As of September, 2012, there were 9,037 registered facilities.

- make the ownership, cost of services and potential for conflicts of interest within licensed clinics more transparent and allow the regulator to ensure that owners are likely to conduct a clinic's business practices with integrity; and
- regulate the business practices of licensed clinics to deter fraud, and require that licensed clinics designate a regulated health professional who would be accountable for the business operations of a health clinic when a health clinic owner is not a regulated health professional.

The Financial Services Commission of Ontario (FSCO) is the organization best-positioned to implement and oversee the regulatory regime we are recommending. FSCO should be assisted in its responsibilities by an advisory committee consisting of participants in the auto insurance system with an interest in the regulation of health clinics.

The remainder of this section provides further details regarding the regulatory model we are recommending in the areas of transparency, accountability and implementation.

Transparency

Little is known about clinics that treat and assess auto insurance claimants in Ontario. The first step in ensuring a clinic is operating honestly would be to gather information about a clinic's ownership, staff and operations through a licensing process. More information will allow FSCO to determine that the owners are suitable to operate a clinic in the auto insurance system and audit the business practices of the clinic against the information provided at the time of licensing.

The licensing regime will recognize different types of clinics and will require different information depending upon the type. In general, the information requested of an applicant will fall into one of five categories:

- facility
- ownership
- designated regulated health professional

- professional staff
- attestations signed by the owners and the designated professional³⁰

The information submitted by a clinic will allow FSCO to make sure that the clinic will be operated with integrity by its owners and its designated health professional. This information should include confirmation that neither the owners nor the designated professional has a criminal or serious *Provincial Offences Act* conviction.

Part of our recommendation to increase clinic transparency is to mandate that clinics disclose real or potential conflicts of interest to FSCO and to claimants. In the Status Update we raised for consideration whether individuals that have conflicts should be allowed to own clinics. We have concluded that restricting ownership is not necessary or desirable, if there are strong conflict of interest disclosure provisions in the legislation. Failure to disclose conflicts of interest could result in the suspension or revocation of a clinic's licence.

Finally, we noted in the Status Update that we were considering additional transparency requirements for clinics conducting independent medical examinations. We have had representations to us that suggest that this industry is consolidating, and a practice seems to be arising of charging different insurers different prices for similar assessments. We have also heard that consolidation is leading to higher margins and, within the existing cap, the amounts available to assessors are declining. We are concerned that these trends, if widespread, can affect the effectiveness and trustworthiness of independent assessments. We do not believe that the government should be regulating corporate structure, profit margins, or specific fees. But we do believe that greater transparency will help the market work better and that is why we recommend that clinics providing independent medical examinations should be required to disclose the schedule of fees paid to regulated health professionals for providing such assessments.

³⁰ The information that will be required under each category is elaborated on further in Appendix 6.

Accountability

In order to deter fraud, the regulatory model should have a clear accountability focus. A designated regulated health professional that is onsite at the clinic at least three days a week should be responsible for the integrity of its business practices. This designated professional could be the owner of the clinic or another individual in a clinic where the owner is not a regulated health professional.

The designated professional will be responsible for ensuring and periodically attesting that the clinic's business practices are in line with standards developed by FSCO. Appendix 6 contains twelve business practice standards we are proposing based on the Willie Handler and Associates report. Where the designated professional is not the owner of the clinic, but an employee, that individual should be empowered to ascertain from other employees of the clinic any information necessary to permit the designated health professional to sign the attestation. For example, one of the business standards relating to assessments is that the assessor be qualified and assessing within his or her scope of practice. We are not asking the designated health professional to make clinical judgements about these issues, but to take what steps are necessary to satisfy himself or herself that they are being observed, including receiving attestations from others.

Implementation

Types of licences

There are many different types of professionals and facilities operating in the auto insurance sector. The report by Willie Handler and Associates indicated that the majority of professionals in the auto insurance system are regulated health professionals, however there are professionals transitioning to regulated status and unregulated providers in the system as well. Clinics and facilities in the auto insurance system can range from sole practices with one type of professional to multi-disciplinary facilities that employ many types of regulated and unregulated individuals.

The regulatory model should licence all clinics and facilities submitting invoices through the HCAI system. Vendors who provide medical and rehabilitation goods and services that are excluded from the HCAI system, such as assistive devices or vehicle and home modifications, should be required to register with HCAI and be licensed through FSCO.

We noted in the Status Update that we were mindful of the need to strike a balance so that the regulatory model we recommend does not overburden sole practitioners, small clinics and those clinics whose major activity is not in the area of auto insurance. A single health professional that only submits a handful of invoices in a year should not require the same type of oversight as a clinic billing insurers for \$1 million every month.

With this in mind we are proposing three types of licences:

- Facility Licence

Clinics and sole practitioners that have billed more than \$200,000 over the past year (based on HCAI data) would require a Facility Licence. We expect applicants for Facility Licences to be multi-disciplinary treatment and assessment clinics.

- General Licence

Sole practitioners that are regulated health professionals and facilities that have low billing volumes would apply for a General Licence. The billing threshold for a General Licence should be less than \$200,000 in annual invoices through HCAI. The application process for a General Licence should be much simpler than the process for applying for a Facility License or Restricted Licence.

- Restricted Licence

Unregulated providers who are not employed by a facility with a Facility Licence or General Licence should require a Restricted Licence. A Restricted Licence should include some of the requirements for other licence types but would also restrict the types of goods and services that a licensee could provide to auto insurance claimants.

Facilities with a Restricted Licence will employ only unregulated providers. This would make it challenging for those facilities to designate a regulated health professional to be responsible for business practices. Clinics with Restricted Licences should therefore be required to name a “designated contact” within the facility instead of a designated regulated health professional to be accountable for business practices.

Responsible organization

The Financial Services Commission of Ontario has broad experience in this area and is already responsible for overseeing the market conduct of insurance companies, insurance agents, independent adjusters and mortgage brokers. In the past, FSCO also had regulatory responsibility for paralegals in the auto insurance system before oversight was transferred to the Law Society of Upper Canada.

In assuming these roles, FSCO will face challenges, but we believe from our conversations with senior FSCO officials that they can meet them and perform effectively. In the Status Update, we recognized the need for the government to make sure that hiring constraints do not prevent FSCO from acquiring the necessary staff and expertise it requires to carry out its new responsibilities. We continue to regard this as critical and reiterate that recommendation in this Final Report.

The Superintendent of FSCO should establish an advisory body, consisting of interested participants in the auto insurance system, to assist FSCO with its new regulatory responsibilities in this area. The advisory body could provide FSCO with advice on licensing requirements, business practice standards, licence application processes, disciplinary processes and audit functions.

Role of the Health Regulatory Colleges

Health regulatory colleges are an important part of Ontario’s auto insurance system. The colleges focus their resources on issues related to patient care and safety, which are critical for claimants being treated by regulated health professionals. Our recommended regulatory model has a clear focus on the business practices of health clinics and not the standards of practice for individual professionals.

Communication between the colleges and FSCO is necessary to ensure that this split responsibility is effective and does not result in regulatory gaps or resource duplication. Regulatory colleges should inform FSCO of changes in the status of their members and any disciplinary action taken and FSCO should inform the necessary regulatory college when a facility that employs one of their members is being investigated by FSCO. FSCO should also ensure that any information it receives in its role as a business practices regulator regarding inadequate patient care or standards of practices is forwarded to the appropriate regulatory college.

Making it easier for individuals to report suspected fraud

Recommendations

14. The Financial Services Commission of Ontario (FSCO) should create an “Auto Insurance Fraud Information Hotline” to promote and facilitate the flow of information about suspicious activity in the auto insurance system. FSCO should report on the follow-up of information submitted.
15. The government should introduce legislative protection prohibiting reprisal or retribution against individuals who, in good faith, provide information about suspected fraud.

One of the objectives of our consumer engagement and education strategy is to inform individuals about potential fraud situations and encourage them to provide information to appropriate investigative authorities where they feel this is warranted. As we noted earlier, the majority of Ontarians do not know where to report insurance fraud observed in a health clinic treating auto insurance claimants. We believe that the system should be simplified and made transparent for those wishing to make such reports.

We did note in our Status Update that the Insurance Board of Canada (IBC) was working with the Ontario Association of Crime Stoppers to develop a partnership that would assist in the reporting of potential auto insurance fraud. We encourage such a partnership but we believe that more is required.

We recommend that the government provide a legislative framework that prohibits any reprisal or retaliation for the provision of information about suspected auto insurance fraud, where such information is provided in good faith. One way in which this might be done is to make reprisals or retaliations in such situations an unfair or deceptive act or practice (UDAP).

We also recommend that FSCO create an “Auto Insurance Fraud Information Hotline”. This Hotline would be available to receive information about auto insurance fraud or the commission of a UDAP. The information may be submitted anonymously or not.

The Superintendent should ensure that the Hotline is staffed in a way that allows FSCO to:

- engage in a triage process in relation to information received about suspected fraud, the possible commission of a UDAP or any act of reprisal by forwarding the information to the appropriate parties, such as FSCO investigators, an insurance company, a professional college, a regulatory body or any other person or institution as may be appropriate;
- follow up any action initiated because of a call or e-mail and respond appropriately; and
- report semi-annually to the public regarding the number and nature of the calls and e-mails made to the Hotline and the outcome of those contacts.

FSCO’s Auto Insurance Fraud Information Hotline should be visible to the public. Information on how to reach the Hotline should be well-known in the industry and easily accessible for the public on FSCO’s website, as well as the dedicated website that we are recommending as part of our consumer engagement and education strategy.

Enhancing FSCO's ability to get information

Recommendation

16. The government should amend the *Insurance Act* to enhance the Financial Services Commission of Ontario's powers to obtain additional information to better conduct investigation and enforcement.

The Financial Services Commission of Ontario (FSCO) is well-positioned to assist in the detection of auto insurance fraud, and enhanced authorities would increase its effectiveness. We note that most of the existing authorities in the *Insurance Act* were drafted many years ago and more recent statutes in other areas (for example, the regulation of mortgage brokers) contain provisions that would be beneficial to detect auto insurance fraud. Our assessment of the extent and scope of fraud also suggests that FSCO needs the ability to secure more information from a greater range of actors in the auto insurance marketplace if it is to be effective in detecting fraud.

The government has taken important steps to enhance and modernize FSCO's authorities through the provision of legislative authority to levy administrative monetary penalties. This process of legislative modernization needs to be extended to FSCO's ability to get information (discussed here) and to pursue investigations and enforce penalties (discussed in the Investigation and Enforcement section of this report).

We therefore recommend that the scope of information that the Superintendent can request be broadened.

Sections 29 to 32 of the act provide important information-gathering powers. The duty to furnish information in section 31 is limited to licensees, officers and agents of an insurer, and other persons "engaged in the business of insurance". It is arguable that this language not only leaves out other persons who were formerly or never licensed, but also leaves out persons who have relevant information.

The scope of conducting “inquiries” under section 29 is even narrower than section 31 by allowing inquiries to be directed only to insurers. The authorities provided to FSCO in these sections should be enhanced and made consistent.

Current legislation makes many references to persons “engaged in the business of insurance”. Under some interpretations, this language can be read to include only entities and individuals who are licensed or who provide insurance services. We believe that the net should be wider rather than narrower, and it would seem appropriate to clarify the language to provide greater certainty about the persons FSCO can obtain information from, examine, and sanction for unfair or deceptive acts or practices.

Appendix 7 contains a list of our proposed changes in this area.

Changes to regulations governing insurer/claimant relations

Recommendations

17. The government should amend rules so that claimants play a more active role in helping to detect and prevent fraud. Specifically it should:
 - a. require claimants to confirm attendance at treatment facilities and receipt of goods and services billed to insurers; and
 - b. require insurers to itemize the list of invoices they have received when they provide a benefit statement to a claimant every two months.
 18. Insurers should have the ability to examine a claimant under oath, where this is necessary to determine which insurer should be responsible for coverage, without prejudice to the right for an examination under oath that now exists.
-

Well-informed claimants are one of the best ways to detect auto insurance fraud as soon as it occurs. Our consumer engagement and education strategy, outlined in the Prevention section, will inform consumers about Ontario’s auto insurance system, but we have also considered opportunities for further regulatory changes that would make it easier for claimants to detect fraudulent schemes.

Three of the changes to the Statutory Accident Benefits Schedule (SABS) identified in our Status Update as potential recommendations were related to the detection of fraud. These changes will provide collision victims with more information about their claim that can be reviewed for suspicious activity.

1. Require claimants to confirm attendance at treatment facilities

The SABS should be amended to require health care providers and assessment facilities to ask claimants to sign a form each time they receive a treatment. Copies of these forms would be kept on file and made available for inspection at the time of audit.

2. Require claimants to confirm receipt of goods and services billed to insurers

The SABS should be amended to require providers of goods and services to ask claimants to sign a form when they receive goods, such as back supports or orthotic shoe inserts. Copies of the forms would be kept on file and made available for inspection at the time of audit.

3. Require insurers to include an itemized list of incurred and allocated expenses, as well as the amount of coverage remaining, in the benefit statement sent to claimants every two months

The SABS requires insurers to send claimants a benefit statement every two months. Adding an itemized list of expenses to the benefit statement would allow claimants to review specific expenses incurred or allocated under their claim and identify any suspicious activity. Insurers are already required to include the amount of coverage remaining on the benefit statement, but should continue to do so and ensure that the information is provided to claimants in an accessible and understandable way.

Insurers should also include information about how suspicious activity on the benefit statement can be reported so that claimants can take action to stop the misuse of their benefits by fraudsters.

In the Status Update we also suggested that it could be desirable to provide for a second examination under oath. This met with considerable opposition and we are not prepared to recommend it in the form we had proposed. In coming to understand the issue better, however, we recognized that there are circumstances where the examination under oath that is now permitted is required and used at the beginning of a claim to determine which insurance company is liable for benefits. This issue of settling priority does not arise often, but when it does it typically involves individuals who may be injured in collisions and covered by different companies than that of the driver, or not covered directly at all. In many cases, where fraud is suspected, the establishment of priority is important and may require examination under oath. In such cases, an insurer who uses an examination under oath at the initiation of a claim to determine priority would be unable to examine the claimant under oath at a later date, as the claim has matured and more information about treatment and other factors becomes available.

We therefore recommend that the regulation under the *Insurance Act* that deals with establishing priority be amended to provide the opportunity for an insurer to examine a claimant under oath for the purposes of determining priority, should that be deemed desirable, and that such examination under oath be without prejudice to the examination under oath provision that currently exists.

Improving collision reporting forms

Recommendation

19. The Ministry of Transportation should continue its work on the Electronic Collision System project and continue to engage stakeholders, including the insurance industry, regarding the system's development.

Under the *Highway Traffic Act*, individuals involved in a motor vehicle collision that results in injuries and/or damage are required to report to the nearest police service. Police services are required to collect this information for the Registrar of Motor Vehicles.

A driver involved in a collision where no physical injuries have been suffered and the damage is more than \$1,000 may report the collision to a Collision Reporting Centre (CRC), a facility created to help motorists report collisions when their vehicle has been damaged but no physical injuries have been suffered. Ontario has two Collision Reporting Centre models — those run by police services and those run by a private company, Accident Support Services International Limited (ASSI), which collects the required information when a police service has delegated the requirement to collect information. Private insurers pay a fee to ASSI for access to the Collision Reports and ASSI is required to comply with privacy legislation in the sharing of information with insurers.

We have been informed that the Ministry of Transportation (MTO) has a project under way which will eventually replace paper-based collision reporting forms with a new Electronic Collision System, designed to accept statements from witnesses, drivers, and police officers as well as a variety of documents, including photos and diagrams. The project, expected to be complete in fall 2012, will accommodate electronic transfer of collision reports and provide a web application for interested police services to use in-station and, in future, in-car for direct entry of collision data. The objective is to provide a flexible electronic reporting system that can meet the needs of many stakeholders and allow more extensive data capture of information about the collision than the current paper based forms allow.

MTO has been working with police services and stakeholders in the development of this tool. MTO should continue its work on the Electronic Collision System project to improve timelines and accuracy in collision reporting and continue to engage stakeholders, including the insurance industry, regarding future improvements for collision reporting.

Investigation and Enforcement

This section sets out our recommendations to address fraud investigation and enforcement. They are focused in seven areas:

- enhancing FSCO’s ability to investigate and impose sanctions for unfair or deceptive acts or practices (UDAPs)
- oversight and audit of regulated clinics
- sanctioning regulated clinics for improper business practices
- information sharing among fraud investigators
- joint-force police collaboration
- early assignment and continuity of Crown counsel
- changes to SABS and UDAPs to increase the range of sanctions

Enhancing FSCO’s ability to investigate and impose sanctions for UDAPs

Recommendation

20. The government should amend the *Insurance Act* to enhance the Financial Services Commission of Ontario’s powers to investigate and sanction unfair or deceptive acts or practices.

We have reviewed the acts and practices that are currently defined in Ontario Regulation 7/00 as “unfair or deceptive”, as well as the powers and authorities of the Superintendent to investigate them and impose appropriate sanctions under the *Insurance Act*.

A number of acts and omissions are currently defined as unfair or deceptive acts or practices (UDAPs) when committed by persons who provide goods or services that are payable, directly or indirectly, out of the proceeds of insurance. This includes health care practitioners, tow truck operators, vehicle storage service providers and collision repair service providers.

We want to ensure that the range of unfair or deceptive acts or practices is as comprehensive as it needs to be, that FSCO can effectively investigate potential instances of unfair or deceptive acts or practices and that penalties associated with these practices are appropriate disincentives. Appendix 8 contains a description of some of the proposed provisions that we are recommending in this regard. We have highlighted a few illustrative examples below.

With regard to FSCO's authority to investigate UDAPs, section 440 of the *Insurance Act* provides that the Superintendent can "examine and investigate the affairs of every person engaged in the business of insurance in Ontario". We recommend expanding the power to investigate UDAPs so that it specifically includes *prescribed persons in prescribed circumstances*. Regulations could authorize FSCO to investigate persons who may not be considered to be engaged in the insurance business, but still could be engaged in UDAPs. This could include, for example, health care providers providing goods or services to SABS claimants.

Part XIX of the *Insurance Act* governs "examination and enforcement", and is the primary source of authority for investigations under the act. It provides the authority for the Superintendent to, for example, attend at a place of business to obtain information, interview officers and employees, obtain books and records, enter non-residential dwellings and obtain search warrants. This Part of the act should be modernized. The powers of examination and enforcement should be enhanced to reflect more recent legislation and adopt more current legal language, such as that found in the *Mortgage Brokerages, Lenders and Administrators Act, 2006*. These changes would have an added benefit of harmonizing powers across the sectors regulated by FSCO.

Oversight and audit of regulated clinics

Recommendation

21. The government should give the Financial Services Commission of Ontario the authority to oversee and audit the business and billing practices of health clinics and individual practitioners who invoice auto insurers.

In the Detection section, we set out the regime we are recommending to regulate the business practices of clinics that treat and assess auto insurance claimants. In order for this regime to be successful, it must provide for a designated health professional (either the owner or an employee of the clinic if the owner is not a regulated health professional) to attest to the integrity of the clinic's business practices, and allow for auditing of the clinic's business practices to verify that attestation. The business-practice standards for which we are recommending attestations be required at least annually are set out in Appendix 6. The nature of the attestation will require the accountable individual to make inquiries and secure information that permits the attestation to be made. Attestations may be subject to audit and where attestations are found not to accord with the facts sanctions may be imposed.

We recommend that there be a requirement to attest at least annually, through filing an electronic Annual Information Return (AIR), with regard to the integrity of the business practices and their consistency with the standards established by FSCO. There should also, in general, be requirements to attest quarterly to the accuracy of the clinic's billings to auto insurers. The business-to-business statements introduced recently by HCAI and highlighted in our Status Update and this report can help clinics verify the accuracy of their billing activity for the attestation process.

FSCO should have the ability to conduct risk-based audits. The essence of a risk-based approach to audits is that FSCO resources will be focused on clinics where the risk of non-compliance is high. Risk may be determined by such factors as past behaviour, historic billing patterns, complaints, or other considerations that suggest an audit would be helpful. FSCO should also be able to investigate such clinics, using the investigatory powers under the *Insurance Act*, where it is appropriate to do so.

Licensed clinics should be required to maintain records available for inspection by FSCO to allow for information disclosed in the licensing process or subsequent attestations to be verified.

Sanctioning regulated clinics for improper business practices

Recommendation

22. The government should provide a range of sanctions for the Financial Services Commission of Ontario (FSCO) to apply in cases where clinics are not following FSCO's business-practice standards, including giving FSCO the ability to limit or curtail a regulated facility's access to the Health Claims for Auto Insurance system.

If FSCO finds that a licensed clinic's business practices are improper, the regulatory model should allow it to sanction the clinic. Because the most important sanction we can recommend for combating fraud is one that cuts a clinic off from receiving income from insurance companies, we recommend that FSCO should be able to use the Health Claims for Auto Insurance (HCAI) system as a tool for delivering meaningful sanctions.

As part of the licensing regime, the government should require that a facility billing auto insurers through HCAI have a licence from FSCO. FSCO should also have the power to direct HCAI to limit or curtail a facility's ability to use the HCAI system to bill insurers.

Limiting or curtailing the right to bill is a serious sanction, and not one that FSCO should use lightly. There should therefore be a range of enforcement actions available to FSCO, including cease and desist orders and administrative penalties. Clinics may be charged under the *Provincial Offences Act* based on information gathered by FSCO. FSCO should also forward suspected criminal activity to the police.

Clinics facing administrative sanctions should be given an opportunity to appeal FSCO decisions. Appeals should be made through the Financial Services Tribunal, which is an independent adjudicative body that has exclusive jurisdiction to determine all questions of fact or law that arise in a proceeding before it.

Information sharing among fraud investigators

Recommendations

23. The government should endorse and require the development of protocols for active information sharing about suspicious cases among the investigative divisions of the Financial Services Commission of Ontario, Workplace Safety and Insurance Board, and Ontario Health Insurance Plan.
24. The Financial Services Commission of Ontario (FSCO) should explore the development of protocols to permit FSCO investigators to exchange information with investigators from relevant federal entities (such as the Canada Revenue Agency).
25. Auto insurance fraud investigators working in the private sector should provide information to the Financial Services Commission of Ontario where it would be relevant to detecting, investigating and enforcing sanctions against those engaged in organized or premeditated fraud.

Fraud, and especially organized fraud, is not isolated to Ontario's auto insurance system. Individuals or groups committing auto insurance fraud may also be defrauding government organizations such as the Workplace Safety and Insurance Board (WSIB) and the Ontario Health Insurance Plan (OHIP).

While FSCO regulates the auto insurance sector, which provides medical benefits to motor vehicle collision victims, WSIB and OHIP are directly engaged in providing medical benefits to injured individuals.

All three of these organizations investigate activity within the benefit systems they administer or regulate. And we are proposing that FSCO's investigative role be strengthened. It is critical that fraud investigators at these organizations share information so that suspected fraudulent activity in one sector can be made transparent to investigators in other sectors.

We do not believe there is any barrier to the sharing of information, including personal information, among provincial investigators about suspicious cases that are under investigation. And we understand that some sharing of this type does now occur. We also understand, however, that the sharing of information tends to be responsive to requests about specific situations and may not always be forthcoming or timely.

We believe that investigators in these areas should be more proactive in sharing information. In particular, we would urge that on a regular basis there be opportunities for investigators to meet and exchange information about specific cases they may be pursuing, with a view to alerting and possibly assisting one another. We think that this type of arrangement can work best if there are formal protocols or Memoranda of Understanding developed among FSCO, WSIB and OHIP and we urge the government to endorse and require the development of such protocols.

In addition to promoting transparency and cooperation, such protocols would also help ensure that all information sharing is done in compliance with applicable privacy legislation governing the collection, use and disclosure of personal information.

Further information sharing at different levels of government could also increase the effectiveness of FSCO's auto insurance fraud investigations. For example, the WSIB shares information with the Canada Revenue Agency (CRA) to identify non-compliant employers. FSCO should explore whether similar information-sharing agreements could be put in place with the CRA or other relevant federal agencies.

Finally, we have considered the issue of information-sharing between investigators in the private sector and government investigatory agencies, including not only FSCO but law enforcement. We do not believe it is appropriate to extend to private investigators the active type of information-sharing we recommend among government entities. We do, however, encourage private fraud investigators working in the private sector to provide information to FSCO where it would be relevant to detecting, investigating and enforcing sanctions against organized or premeditated fraud.

Some in the industry have asked us to recommend enhanced immunity from civil prosecution for the transmission of such information to FSCO, or to law enforcement agencies. We have considered this and have concluded that the existing protection provided by Section 446 of the *Insurance Act* provides adequate protection with regard to FSCO.³¹ With regard to allegations of suspicious activity made to police, our view is that if allegations are to be taken seriously by the police there ought to be sufficient evidence to support such allegations. We do not, therefore, see the need for blanket immunity provisions.

Joint-force police collaboration

Recommendation

26. Police services should consider joint-force collaboration when an organized fraud ring operating in multiple jurisdictions is discovered by insurance investigators or advanced data analytics technology.
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Our Status Update noted that the work of the Task Force has created synergies that should encourage police forces in the province, including the OPP, to consider working together on major auto insurance fraud issues.

³¹ Section 446 provides that: “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.”

We have concluded that joint force collaboration among police services would be beneficial when there is clear evidence of substantive organized fraud crossing many jurisdictions. The enhanced use of pooled claims and data analytics will reveal connections where particular individuals or other entities show up frequently with claims against multiple insurers. Such patterns may be suggestive of organized criminal activity that would warrant joint-force collaboration. We recommend that the forces be open to such suggestion where evidence warrants.

Early assignment and continuity of Crown counsel

Recommendation

27. The Ministry of the Attorney General should continue to ensure early assignment and continuity of Crown counsel in large complex auto insurance fraud prosecutions, wherever possible.

Insurance industry representatives have urged the government to establish an insurance fraud investigation and prosecution bureau with designated Ministry of the Attorney General prosecutors to promote consistency of Crown counsel for the entirety of a case. In the Status Update, we explained why we are not prepared to accept that recommendation.

Ontario's system is not designed or resourced to provide such 'dedicated' Crown counsel, except in rare and special circumstances. Crown counsel and police have separate and distinct roles in the investigation and prosecution of crime, and the separation of the investigative and prosecutorial roles of the state is an important safeguard to promote independence, impartiality and fairness in the administration of criminal justice.

We also recognize the reality that, while prosecution is an effective deterrent against fraud, it takes time and resources. However, we do believe that fraudsters should be vigorously pursued and prosecuted where evidence warrants. For several years the Criminal Law Division of the Ministry of the Attorney General has followed best practices with respect to major case management. A major case is a prosecution, or series of related prosecutions, requiring a substantial investment of prosecutorial resources, which can be expected to occupy a significant amount of court time.

Major cases typically involve serious offences such as murder and large complex cases. Because of many factors, including the expected length of criminal proceedings, the number of charges, the number of persons charged, the complexity of evidence and the anticipated legal issues, major cases present particular challenges. These challenges may need to be addressed at an early stage of the proceedings and require a flexible response. For example, where there is a reasonable prospect of conviction and it is in the public interest to proceed, such cases are assigned to a Crown early, and efforts are made to retain the assigned Crown counsel until the prosecution is completed, absent exceptional circumstances.

Other major case management best practices include police and Crown pre-charge collaboration on investigative procedures, substantive issues, and the preparation of disclosure; ongoing oversight by the local Crown Attorney to ensure that Crowns prosecuting complex criminal cases receive support and advice from the most experienced Crown counsel; and debriefings at the conclusion of cases to ensure lessons learned are not lost.

While we do not believe that ‘dedicated’ Crown counsel are required or essential, we do recognize that investigations take time, that Crown counsel are available to provide pre-charge advice to police when necessary, and that once charges are laid the continuity of Crown counsel is important. We urge the Ministry of the Attorney General to continue to ensure early assignment and continuity wherever possible and particularly in large, complex fraud cases.

Changes to the SABS and UDAPs to increase the range of sanctions

Recommendations

28. The government should add the following to the list of activities described as unfair or deceptive acts or practices subject to sanctions under the Statutory Accident Benefit Schedule:
 - a. charging insurers much more for goods or services than the ordinary retail price; and
 - b. requesting a claimant to sign a blank form.
29. The government should consider amending the Statutory Accident Benefits Schedule to allow insurers to suspend Income Replacement Benefits when there is compelling evidence the claimant has submitted a fraudulent claim for medical or rehabilitation accident benefits. Any such amendment should be considered in conjunction with efforts to create an effective, timely and robust dispute resolution system.

Two of the changes to the Statutory Accident Benefits Schedule (SABS) identified in our Status Update as potential recommendations were related to the enforceability of current anti-fraud measures. Measures the government has taken to prevent over-charging for medical devices and the signing of blank claims forms in the auto insurance system can be strengthened further with these changes. There was no negative feedback on these proposals during our consultations and we recommend proceeding with them quickly.

1. *Strengthen enforceability of the Cost of Goods Guideline by making direct reference to its application in the Statutory Accident Benefits Schedule*

In our December 2011 Interim Report, we recommended that the Superintendent of FSCO should create a guideline to address the issue of insurers being invoiced for medical devices at prices considerably higher than their normal retail value. The Superintendent released a “Cost of Goods Guideline” addressing this recommendation in January, 2012.

The current SABS does not include a direct reference to the Guideline. For enforceability and as a technical matter, the SABS should refer directly to the Cost of Goods Guideline.

2. *Make it an unfair or deceptive act or practice to request a claimant or injured person to sign a claim form that has been left blank or incomplete*

Insurers report that claimants are at times asked to sign claims forms before the items to be billed to the insurer have been entered. The claimants are often unaware that it is against the rules for them to sign what amounts to a blank form. Signed blank forms make it easier to exaggerate, misrepresent or fraudulently bill for treatments or for goods and services without the claimant's knowledge. Presenting a blank or incomplete form for signature should be made a violation under regulations governing unfair or deceptive acts or practices.

Income Replacement Benefits related to fraudulent claims for Accident Benefits

Under the current system, if an insurer believes that a claim is fraudulent, it has the ability to deny payment of the claim. But it has been brought to our attention that if a fraudulent claim for medical or rehabilitation benefits is associated with Income Replacement Benefits (IRBs)³², there is no ability to curtail the IRBs unless the information submitted in connection with the IRB claim is itself fraudulent.

³² IRBs cover claimants who cannot work as the result of a motor vehicle collision. The basic weekly IRB is 70 per cent of a claimant's gross income up to \$400, and additional coverage can be purchased to increase this limit to \$600, \$800 or \$1,000. Claimants are required to claim wage loss benefits from existing disability plans or workplace benefits before claiming for IRBs.

In principle, a claimant who makes a fraudulent claim for medical or rehabilitation benefits would not be expected to be in need of IRBs, unless there is some legitimate reason for the claimant not to be working. We recognize, however, that the determination of fraud is not always clear cut. That is why dispute resolution processes exist, and the current ones are not working in a timely manner. In the absence of effective and robust dispute resolution processes we are not prepared to recommend that insurers have the ability to automatically curtail IRBs when a claim is denied on grounds of fraud. We do, however, believe that the principle is a good one and we encourage the government to look at this issue once again in conjunction with efforts to create an effective, timely and robust dispute resolution system.

Regulatory Roles and Responsibilities

As we considered the totality of our recommendations, it became apparent to us that although they represent an integrated framework that fits together and can be effective, implementation on the ground will require the dedicated and focused attention of those organizations, and individuals within them, who have particularly important roles to play.

FSCO is an obvious case in point. Our recommendations expand FSCO's role in many dimensions; indeed we would argue that they change its role in some fundamental ways. If the anti-fraud measures we believe are necessary and desirable are to work, FSCO will have to recognize that it will no longer be "business as usual". Similarly, we had extremely constructive conversations with representatives of the Law Society of Upper Canada (LSUC) about their disciplinary role with respect to lawyers and paralegals who might engage in fraudulent activity. We believe that they recognize that they can make a greater contribution through more regular engagement with others who are concerned about fraudulent activity. It would also be helpful if the colleges that regulate health professionals pay greater attention to situations where their members are engaged in fraud.

This section elaborates our conclusions and recommendations with regard to FSCO's role. It also makes some recommendations to the LSUC and the regulatory colleges that we hope they will accept, recognizing the constructive spirit in which they are put forth.

Financial Services Commission of Ontario

Recommendations

30. The government should consider changes to the Financial Services Commission of Ontario's mandate to reflect the new responsibilities it will be assuming as a result of these recommendations.
 31. The government should ensure that government-wide hiring constraints do not delay or prevent the Financial Services Commission of Ontario from acquiring the necessary staff and expertise it requires to carry out these responsibilities.
 32. Consistent with the broadened mandate of the Financial Services Commission of Ontario, the government should consider broadening the terms of reference for the required review by the Superintendent of Part VI of the *Insurance Act*, now required at least every five years.
 33. The Minister of Finance should, at an appropriate time, commission an independent review of how well Financial Services Commission of Ontario is carrying out its new responsibilities.
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The totality of our recommendations with regard to Financial Services Commission of Ontario (FSCO) suggests to us that there is an important change in its role that should be explicitly recognized.

To date, FSCO has acted — in accordance with its mandate — as the regulator of the auto insurance industry. We believe that it should see itself in future as the regulator of the auto insurance marketplace — a broader view that reflects the enhanced powers and authorities we are recommending it have; and one that should put the consumer front and centre in its focus and approach. FSCO has been moving in this direction in recent years, with its heightened focus on fraud, its introduction of CEO attestations, its program to audit insurance companies against these attestations, and the ability it now has in law to levy administrative monetary penalties against insurance companies.

Our recommendations take it much further down this road and perhaps quite quickly. We are asking FSCO to:

- play a critical role in consumer engagement and education as co-chair of the Anti-Fraud Awareness Implementation Group;
- work quickly with the government to bring greater clarity to the auto insurance marketplace through elaboration of minor injury guidelines, effective resolution of the dispute resolution backlog, and implementation of a robust dispute resolution framework for the future;
- act as a centre for receiving information from individuals about suspected fraud, in a much more high profile way than today, and with accountabilities to triage concerns, follow-up and report on actions taken;
- license and regulate the business practices of health care clinics that treat and assess auto insurance claimants;
- develop and implement appropriate sanctions for such clinics that do not follow proper business standards, as set out by FSCO; and
- play a much more active role in investigating fraud — making use of expanded information gathering, investigative and enforcement powers; and through building and using information networks with other fraud investigators in the public and private sectors.

There will be challenges for FSCO in taking on these roles, but we believe from our conversations with senior FSCO officials that they can meet them and perform effectively. In the Status Update we recognized the need for the government to ensure that hiring constraints do not prevent FSCO from acquiring the necessary staff and expertise to carry out its new responsibilities. This continues to be critical and we reiterate that recommendation in this Final Report.

We also recommend that the government consider, as part of its review of all of these recommendations and the role of FSCO, whether FSCO's mandate should change with regard to auto insurance to make its responsibilities clearer, as suggested above.

One particular issue that we flag in this regard is the requirement introduced in 2003 for the Superintendent to review, at least every five years, Part VI of the *Insurance Act*, which deals with Statutory Accident Benefits Schedule (SABS), dispute resolution, auto insurance policies and court proceedings. We would suggest that the government might consider the terms of reference of this review in light of the additional authorities and accountabilities being recommended for FSCO. We believe it would make sense to broaden the terms of reference beyond Part VI of the *Insurance Act*, to encompass some of the other areas of responsibility that FSCO would take on, including the regulation of clinics, the Anti-Fraud Information Hotline, and investigation of fraud activities.

Finally, we believe that it would be desirable for the Minister of Finance to commission an independent review of how well FSCO is implementing its new responsibilities, after a reasonable time period — perhaps two to three years after the implementing legislation is effective.

Law Society of Upper Canada

Recommendations

34. The Law Society of Upper Canada should engage with the Financial Services Commission of Ontario and continue to stay informed and be responsive to issues related to lawyers and paralegals practicing in the auto insurance system.
 35. Auto insurance system participants with concerns regarding the conduct of a lawyer or paralegal should report their concerns to the Law Society of Upper Canada.
 36. The government should clarify the exemption for lawyers and paralegals in the unfair or deceptive acts or practices regulation so that it applies to lawyers and paralegals only when they are acting in a legal capacity.
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Lawyers and paralegals are important to the operation of an integrity-based auto insurance system. If lawyers and paralegals do not act in the best interests of their clients and consistent with the Law Society of Upper Canada's requirements, fraudulent practices could result.

During our consultations, we received many useful and informative presentations from the legal community.³³ Our recommendations focus on the Law Society as the body responsible for the oversight of lawyers and paralegals, although we believe all of the presenters from the legal profession were interested and motivated to combat fraud.

We have also heard about a number of concerns that touched on both lawyers, and paralegals, causing us to wonder:

- has the Law Society encountered examples of auto insurance fraud;
- where does the Law Society stand on the issue of referral fees to or in relation to non-licensees;
- what processes exist for cases involving individuals providing legal services without a license; and
- would the Law Society be open to receiving more information regarding trends in auto insurance fraud?

We are impressed with the work that the Law Society has done in relation to mortgage fraud involving its members, from a regulatory, educational and disciplinary point of view. The Law Society primarily reacts to complaints but it also uses proactive tools such as practice reviews and audits of members

We are aware of the Five Year Review, a report dated June 28, 2012.³⁴ Phase Two of the report is due some time in November, 2012 and will make recommendations on options for enhancing the effectiveness of paralegal regulation.

³³ The presenters included the Law Society, the Ontario Bar Association, the Advocates' Society and the Ontario Trial Lawyers Association. For more information see Appendix 2.

³⁴ The Five Year Review was mandated when the Law Society first took over governance of the paralegal profession. The report is available online at <http://www.lsuc.on.ca/with.aspx?id=2147486410>

The Rules of Conduct developed by the Law Society for lawyers and paralegals set out expectations for conduct and prohibited inappropriate behaviour. These Rules are explicit and forceful in the pursuit of professionalism and the absolute lack of tolerance for fraud. Specifically, there are provisions in the Rules that:

- prohibit or restrict the giving or receiving of referral fees in relation to non-licensees,³⁵
- discourage unreasonable fees;
- avert conflicts of interest; and
- ban unauthorized practice.

We were impressed by the commitment from senior representatives of the Law Society to learn more about the auto insurance sector, including the role of lawyers and paralegals. We were interested to hear about how the Law Society has dealt with mortgage fraud over recent years. The Law Society made it a priority to learn about the issues and moved to stricter rules of conduct, more education and stronger enforcement.

We recommend that the Law Society increase its education about and engagement with auto insurance fraud issues, and that there be regular meetings between representatives of the Law Society, FSCO and perhaps the Insurance Bureau of Canada (IBC) as well, to exchange information about trends in auto insurance, including issues surrounding the practice of law and paralegal practice in this area.

The Law Society has the tools to respond to complaints, and we recommend that FSCO and others, including members of the public and insurers, bring to the attention of the Law Society any instances where the behaviour of lawyers or paralegals is inconsistent with the Rules of Professional Conduct.

³⁵ The Rules of Professional Conduct for lawyers are under review and a Report to Convocation, May 24, 2012 called for input on proposed amendments. Paralegals are not permitted to give or receive referral fees in relation to non-licensees. Lawyers are not permitted to give to non-licensees but are permitted to receive referral fees from non-licensees provided that full disclosure has been made to the client and consent obtained.

The Law Society's Professional Regulation Division puts out a Quarterly Report regarding complaints the Law Society receives and how those complaints are addressed. In order to build on the transparency provided by the Quarterly Report, the Professional Regulation Division should begin identifying the number of complaints they have received about suspected auto insurance fraud in its reporting. The Law Society should also continue to monitor allegations of auto insurance fraud and communicate its findings.

We also examined the regulation that defines acts as unfair or deceptive in the auto insurance system (UDAP). The current UDAP exempts lawyers and paralegals from FSCO oversight. While that exemption is understandable in light of the Law Society's responsibilities, we believe that it would be useful to clarify that the exemption does not apply to lawyers and paralegals when they are not acting in a legal capacity but acting as business persons in such endeavours.

Regulated Health Profession Colleges

Recommendations

37. Health regulatory colleges with members that regularly work with auto insurance claimants should enhance their understanding of the consequences associated with auto insurance fraud and ensure that complaints of fraud are investigated and lead to disciplinary action where appropriate.
38. Health regulatory colleges should work together to develop professional standards, guidelines and best practices to improve the quality of independent medical assessments of auto insurance claimants conducted by their members.

There are currently 21 self-governing health professions, each with its own legislative framework under the umbrella of the *Regulated Health Professions Act, 1991*. Legislation has been passed, but not yet proclaimed, authorizing 5 more. The regulated professions count among their members more than 300,000 health professionals in fields that range from psychology to massage therapy. Each college is governed by a Council made up of elected professional members, academics and members of the public appointed by the Government. Colleges are funded by their members.

The Task Force had a presentation from the Federation of Health Regulatory Colleges of Ontario (FHRCO) in January, 2012 and the Federation explained to us the disciplinary processes, and major preoccupations of the colleges while stressing that priorities and focus will differ depending upon the college. For example, only about ten of the colleges have members that regularly deal with auto insurance matters.³⁶

The colleges have been supportive of the work the Task Force has been doing and, in particular, have been active in the Professional Credential Tracker (PCT) pilot project, undertaken by HCAI. The College of Audiologists and Speech-Language Pathologists and the College of Psychologists both participated in the PCT pilot-project.

We believe that the ten colleges who have members that regularly treat auto insurance claimants have the opportunity to play an even greater role in helping to combat auto insurance fraud in Ontario. We have recommended that the Superintendent of FSCO establish an advisory committee to assist in the task of licensing and regulating clinics and we hope that representatives of select colleges will be invited to contribute to that process.

³⁶ These include physicians, nurses, physiotherapists, occupational therapists, chiropractors, massage therapists, psychologists, speech-language pathologists, pharmacists, and dentists. Presentation of FHRCO to Regulatory Working Group of Task Force, January, 2012, slide 8.

We also urge the colleges to play a greater role in disciplining those of their members who engage in fraudulent activity. We understand that the disciplinary processes of the various colleges are complaint-driven, and not proactive; and we understand as well that, with limited resources, a greater focus tends to be put on those disciplinary instances that involve patient safety and quality of care, rather than fraud.

We hope that through the advisory committee to FSCO, and through other opportunities that can be created, the colleges will engage in dialogue that will help them better understand the concerns and consequences associated with auto insurance fraud. We are recommending that FSCO, in its regulatory oversight of clinics, inform the appropriate college of any improper behaviour it becomes aware of that is undertaken by any registered health professional. And we urge that, on the basis of that better understanding, colleges take such information seriously, investigate it appropriately and, where discipline is administered, ensure that the penalties serve as an effective deterrent to bad behaviour.

Independent medical assessments

Independent medical examinations and assessments are often regarded with suspicion. Some aggrieved claimants accuse medical professionals of producing reports and conclusions that are callous, unprofessional, and biased.³⁷ Likewise insurers point to identical reports submitted for different claimants, with forged signatures, in relation to collisions that were staged and injuries that never occurred. Unfortunately, the Task Force could neither reliably test the veracity of such complaints, nor gauge their frequency based on the anecdotal evidence we received. There are rulings by judges and arbitrators on the public record. But the number of times that medical experts have been castigated for the quality, or independence, of their work has been minimal relative to the tens of thousands of claims paid and injuries reported after vehicle collisions each year. It is not known how many disputes over medical assessments are among the near 25,000 benefit claims that are up for mediation before the Financial Services Commission of Ontario.

³⁷ For further information refer to submission from the Fair Association of Victims for Accident Insurance Reform, dated August 27, 2012 (see Appendix 2).

We did learn, however, that the cost of medical examinations and assessments — either incurred or budgeted — rose by 228 per cent from \$57 per insured vehicle in 2006 to \$187 per insured vehicle in 2010. At that rate, the cost of assessments would soon have overtaken the cost of medical and therapeutic treatments borne by auto insurers. That amount was \$221 per insured vehicle in 2010. It would make no sense to spend more to assess the nature of injuries than to treat them, particularly when most injuries resulting from collisions are minor sprains, strains, dislocations, cuts and bruises.

The provincial government moved in September 2010 to cap the fees insurers' may pay for one assessment at \$2,000, to cap the fees insurers may pay to treat and assess most minor injuries at \$3,500, and to relax a requirement that insurers would have to pay for one or more assessments before they could confidently rule that a proposed course of treatment would be neither reasonable nor necessary. The ultimate impact of these measures during 2011 was not known at the time the Task Force was completing this final report, in part, because the outcome of dispute resolution procedures may not be known for months.

Some of our recommendations and the measures we have proposed — for insurers, the Financial Services Commission of Ontario and health colleges — should help eliminate fraudulent medical assessments and staged or deliberate collisions. But, in the interest of patient protection and society in general, we think that health colleges should do more to help allay suspicions and protect the reputation of their members. We would suggest they work together to:

- develop professional standards and training for those who examine individuals injured in vehicle collisions;
- set guidelines for how to conduct an examination in an efficient and caring manner, then to succinctly report the results to an insurer or legal representative;
- prescribe best practices for maintaining professional independence and a reputation for fairness;

- establish a process for reviewing complaints and imposing sanctions if it is found that those conducting and reporting on medical examinations do not deserve the public's trust; and
- work with the province to develop scientifically-based protocols for treating and assessing injuries that result from vehicle collisions.

It would be in society's best interest, and it should be the goal of both those providing treatment and assessing injuries, to encourage a speedy return to normal activity and to reduce the risk of prolonged disability, pain and dependence on medication.

LIST OF RECOMMENDATIONS

Recommendation	Page
PREVENTION	
1. The government should join with insurers to form an Anti-Fraud Awareness Implementation Group to implement a consumer engagement and education strategy. This group should oversee the creation of: <ol style="list-style-type: none"> educational material in different media that could instruct consumers at critical moments such as when they learn to drive, select an insurer, choose optional coverage, collide with another vehicle or make an insurance claim; and a dedicated, multilingual website that would explain how to make an auto insurance claim, what to expect by way of treatment and recovery after an injury, and how to avoid, detect and report improper activity. 	19, 103 (Appendix 4)
2. The government should: <ol style="list-style-type: none"> require insurers to disclose publicly how they choose and assess the performance of businesses and professionals they recommend to consumers or refer them to see, such as independent medical examiners; and require insurers to ensure their public information on how consumers may register a complaint is simple to understand and easy to locate. 	19
3. The Financial Services Commission of Ontario should ensure when conducting an audit that insurers have complied with protocols and practices they have disclosed and promised to the public.	19

Recommendation	Page
4. The government should reduce uncertainty and delay for those who have legitimate auto insurance claims by moving aggressively to: <ul style="list-style-type: none"> a. address the current backlog of mediation cases before the Financial Services Commission of Ontario, and develop a more robust dispute resolution framework; b. introduce treatment protocols for minor injuries that are based on scientific evidence; and c. amend the Statutory Accident Benefits Schedule to make it clear that insurers are required to provide claimants with a full explanation when refusing to pay for treatment, assessment or other benefits. 	28
5. The government should implement a province-wide licensing scheme for the towing industry, to be administered by an Administrative Authority. Fraudulent practices should be addressed along with road safety and consumer protection issues.	32
6. Insurers should collect information about towing expenses to facilitate analysis of relationships between tow operators, collision repair facilities and health care clinics.	32
7. The government should amend provisions in the <i>Repair and Storage Liens Act</i> to reduce unreasonable storage costs for vehicles damaged in a collision.	41
8. The government should permit insurers to collect a cancellation fee for claimants who fail to attend a medical examination at the agreed time, without reasonable notice or explanation.	42

Recommendation	Page
DETECTION	
9. Insurers should move aggressively to establish an organization that would pool and analyse claims data in order to identify potential cases of organized or premeditated fraud.	44
10. The Government of Ontario should urge the Government of Canada to move quickly to secure passage of amendments to the <i>Personal Information Protection and Electronic Documents Act</i> that are now before the House of Commons in Bill C-12. The goal should be to remove any undue limitations on the ability of insurers to pool claims information to combat fraud.	44
11. The Financial Services Commission of Ontario should amend the forms consumers use to apply for auto insurance and accident benefits to make it clear to them that insurers may pool and analyse such information to detect fraudulent activity.	44, 107 (Appendix 5)
12. The government and industry should take advantage of the unique nature of Health Claims for Auto Insurance and its potential use as an anti-fraud tool by building on existing initiatives and by exploring other potential opportunities.	47
13. The government should require the licensing of health clinics that treat and assess auto insurance claimants and empower the Financial Services Commission of Ontario to regulate their business practices.	52, 112 (Appendix 6)
14. The Financial Services Commission of Ontario (FSCO) should create an “Auto Insurance Fraud Information Hotline” to promote and facilitate the flow of information about suspicious activity in the auto insurance system. FSCO should report on the follow-up of information submitted.	59
15. The government should introduce legislative protection prohibiting reprisal or retribution against individuals who, in good faith, provide information about suspected fraud.	59

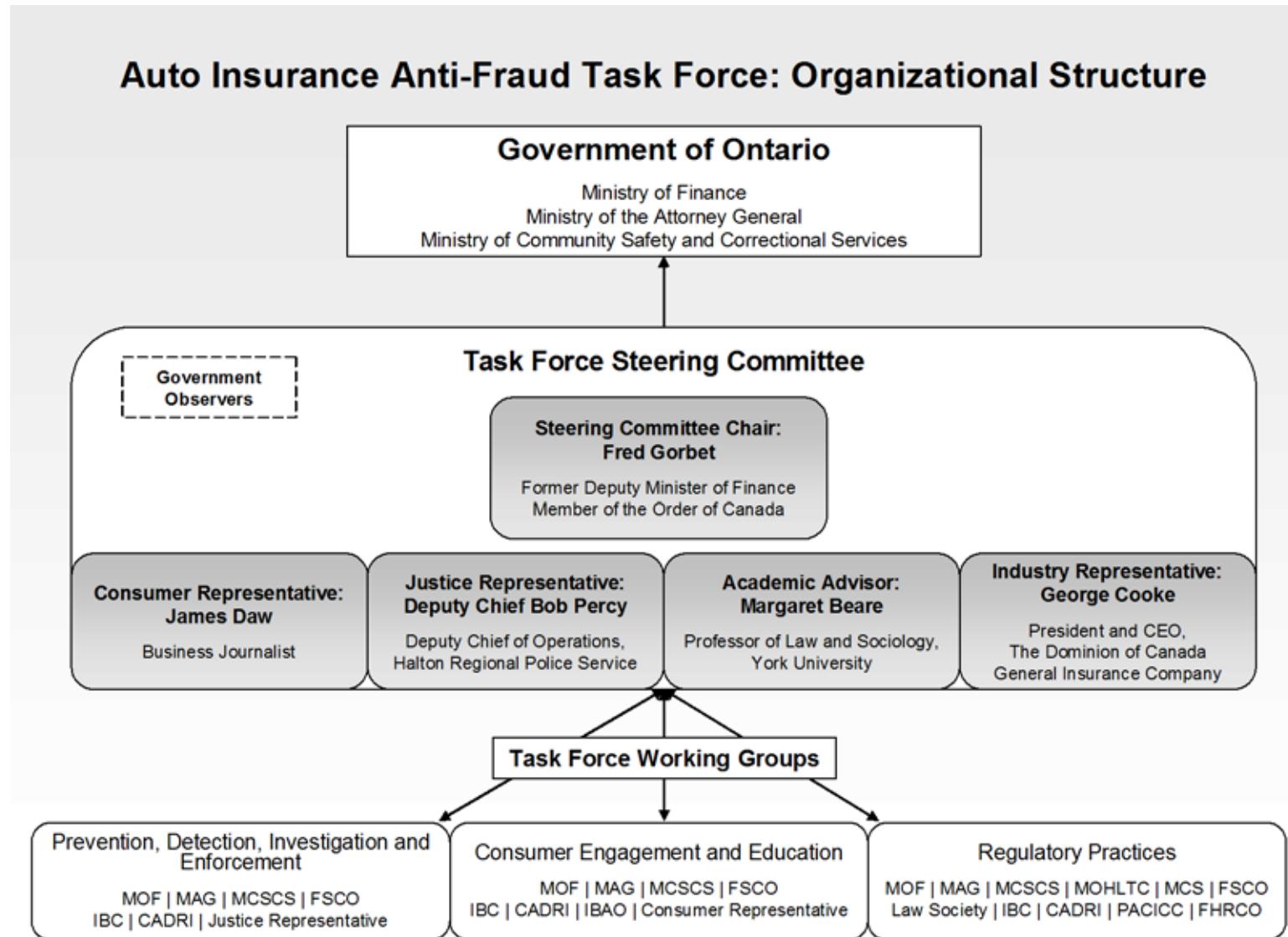
Recommendation	Page
16. The government should amend the <i>Insurance Act</i> to enhance the Financial Services Commission of Ontario's powers to obtain additional information to better conduct investigation and enforcement.	61, 117 (Appendix 7)
17. The government should amend rules so that claimants play a more active role in helping to detect and prevent fraud. Specifically it should: <ul style="list-style-type: none"> a. Require claimants to confirm attendance at treatment facilities and receipt of goods and services billed to insurers; and b. Require insurers to itemize the list of invoices they have received when they provide a benefit statement to a claimant every two months. 	62
18. Insurers should have the ability to examine a claimant under oath, where this is necessary to determine which insurer should be responsible for coverage, without prejudice to the right for an examination under oath that now exists.	62
19. The Ministry of Transportation should continue its work on the Electronic Collision System project and continue to engage stakeholders, including the insurance industry, regarding the system's development.	64
INVESTIGATION AND ENFORCEMENT	
20. The government should amend the <i>Insurance Act</i> to enhance the Financial Services Commission of Ontario's powers to investigate and sanction unfair or deceptive acts or practices.	66, 118 (Appendix 8)
21. The government should give the Financial Services Commission of Ontario the authority to oversee and audit the business and billing practices of health clinics and individual practitioners who invoice auto insurers.	68, 112 (Appendix 6)

Recommendation	Page
22. The government should provide a range of sanctions for the Financial Services Commission of Ontario (FSCO) to apply in cases where clinics are not following FSCO's business-practice standards, including giving FSCO the ability to limit or curtail a regulated facility's access to the Health Claims for Auto Insurance system.	69, 112 (Appendix 6)
23. The government should endorse and require the development of protocols for active information sharing about suspicious cases among the investigative divisions of the Financial Services Commission of Ontario, Workplace Safety and Insurance Board, and Ontario Health Insurance Plan.	70
24. The Financial Services Commission of Ontario (FSCO) should explore the development of protocols to permit FSCO investigators to exchange information with investigators from relevant federal entities (such as the Canada Revenue Agency).	70
25. Auto insurance fraud investigators working in the private sector should provide information to the Financial Services Commission of Ontario where it would be relevant to detecting, investigating and enforcing sanctions against those engaged in organized or premeditated fraud.	70
26. Police services should consider joint-force collaboration when an organized fraud ring operating in multiple jurisdictions is discovered by insurance investigators or advanced data analytics technology.	72
27. The Ministry of the Attorney General should continue to ensure early assignment and continuity of Crown counsel in large complex auto insurance fraud prosecutions, wherever possible.	73

Recommendation	Page
28. The government should add the following to the list of activities described as unfair or deceptive acts or practices subject to sanctions under the Statutory Accident Benefit Schedule: a. charging insurers much more for goods or services than the ordinary retail price; and b. requesting a claimant to sign a blank form.	75
29. The government should consider amending the Statutory Accident Benefits Schedule to allow insurers to suspend Income Replacement Benefits when there is compelling evidence the claimant has submitted a fraudulent claim for medical or rehabilitation accident benefits. Any such amendment should be considered in conjunction with efforts to create an effective, timely and robust dispute resolution system.	75
REGULATORY ROLES AND RESPONSIBILITIES	
30. The government should consider changes to the Financial Services Commission of Ontario's mandate to reflect the new responsibilities it will be assuming as a result of these recommendations.	79
31. The government should ensure that government-wide hiring constraints do not delay or prevent the Financial Services Commission of Ontario from acquiring the necessary staff and expertise it requires to carry out these responsibilities.	79
32. Consistent with the broadened mandate of the Financial Services Commission of Ontario, the government should consider broadening the terms of reference for the required review by the Superintendent of Part VI of the <i>Insurance Act</i> , now required at least every five years.	79

Recommendation	Page
33. The Minister of Finance should, at an appropriate time, commission an independent review of how well Financial Services Commission of Ontario is carrying out its new responsibilities.	79
34. The Law Society of Upper Canada should engage with the Financial Services Commission of Ontario and continue to stay informed and be responsive to issues related to lawyers and paralegals practicing in the auto insurance system.	81
35. Auto insurance system participants with concerns regarding the conduct of a lawyer or paralegal should report their concerns to the Law Society of Upper Canada.	81
36. The government should clarify the exemption for lawyers and paralegals in the unfair or deceptive acts or practices regulation so that it applies to lawyers and paralegals only when they are acting in a legal capacity.	81
37. Health regulatory colleges with members that regularly work with auto insurance claimants should enhance their understanding of the consequences associated with auto insurance fraud and ensure that complaints of fraud are investigated and lead to disciplinary action where appropriate.	84
38. Health regulatory colleges should work together to develop professional standards, guidelines and best practices to improve the quality of independent medical assessments of auto insurance claimants conducted by their members.	84

Appendix 1: Auto Insurance Anti-Fraud Task Force structure



Appendix 2: Individuals and Groups who Made Representations to the Task Force

List of Interested Parties Making Representations to the Task Force (July, 2011 to July, 2012)

Stakeholder	Level of Presentation
Working Group, Steering Committee or Both	
Able Translations	Working Group
Accident Support Services International	Working Group
Alliance of Medical and Rehabilitation Providers	Working Group
Andrew Shaul, Psychologist	Steering Committee
Associated Canadian Car Rental Operators	Steering Committee
Canadian Association of Special Investigation Units	Steering Committee
Canadian Life and Health Insurance Association	Steering Committee
Canadian Society of Medical Evaluators	Steering Committee
City of Toronto (Licensing and Enforcement)	Working Group
Coalition Representing Regulated Health Professionals in Auto Insurance Reform	Steering Committee
Dr. John Clifford	Steering Committee
Federation of Health Regulatory Colleges of Ontario	Working Group
Health Claims for Auto Insurance	Steering Committee
Insurance Brokers Association of Ontario	Working Group
Insurance Bureau of Canada	Both
Insurance Fraud Group	Both
Law Society of Upper Canada	Working Group
Lawrence Gold, Vehicle Storage Expert	Working Group
Michael Seaton, Digital Marketing Expert	Working Group
National Insurance Crime Bureau	Both
Ontario Association of Crime Stoppers	Working Group
Ontario Bar Association	Working Group
Ontario Provincial Police Anti-Rackets Branch	Both
Ontario Trial Lawyers Association	Working Group
Police Panel (Peel, Hamilton, York Region)	Working Group
Provincial Towing Association of Ontario	Working Group
RBC Insurance	Working Group

Stakeholder	Level of Presentation
	Working Group, Steering Committee or Both
Robin Ingle, Ingle Insurance	Working Group
State Farm Insurance	Both
The Dominion	Both
Workplace Safety and Insurance Board	Steering Committee

**List of Parties who Made Representations to the Task Force
(August, 2012 to October, 2012)**

Met with the Steering Committee

Alliance of Community Medical and Rehabilitation Providers

<http://www.fin.gov.on.ca/en/autoinsurance/submissions/propos1.pdf>

Associated Canadian Car Rental Operators

http://www.fin.gov.on.ca/en/autoinsurance/submissions/2012.08.16_Steering_Committee_status_update_comment.pdf

Canadian Automobile Association of South Central Ontario

Canadian Life and Health Insurance Association

[http://www.fin.gov.on.ca/en/autoinsurance/submissions/CLHIA_Submission_Regarding_Steering_Committee_Status_Update_\(ID%2069064\).pdf](http://www.fin.gov.on.ca/en/autoinsurance/submissions/CLHIA_Submission_Regarding_Steering_Committee_Status_Update_(ID%2069064).pdf)

Collision Industry Information Alliance

http://www.fin.gov.on.ca/en/autoinsurance/submissions/Anti_Fraud_Task_Force_report_August_2012_copy_for_presentation-1.pdf

Council of Private Investigators – Ontario

http://www.fin.gov.on.ca/en/autoinsurance/submissions/Status_Report_Response_August_17_2012.pdf

Fair Association of Victims for Accident Insurance Reform

http://www.fin.gov.on.ca/en/autoinsurance/submissions/Fraud_Task_Force_FAIR_final_submission_Aug_27_12.pdf

JP Towing Services

Law Society of Upper Canada

<http://www.fin.gov.on.ca/en/autoinsurance/submissions/Gorbet,Fred.AutoAnti-Fraud.082312.pdf>

Ontario Bar Association

[http://www.fin.gov.on.ca/en/autoinsurance/submissions/OBA-July_2012_presentation_to_OAAT_\(2\)_updated.pdf](http://www.fin.gov.on.ca/en/autoinsurance/submissions/OBA-July_2012_presentation_to_OAAT_(2)_updated.pdf)

Ontario Psychological Association

http://www.fin.gov.on.ca/en/autoinsurance/submissions/OPA_Response_anti-fraud_report_SENT_Aug_17_12.pdf

Met with the Steering Committee

Ontario Trial Lawyers Association

http://www.fin.gov.on.ca/en/autoinsurance/submissions/OTLA's_Response_to_the_Anti-Fraud_Task_Force_Status_Update.pdf

Provincial Towing Association of Ontario

<http://www.fin.gov.on.ca/en/autoinsurance/submissions/Submission-ProvincialTowingAssocOnt.pdf>

Sue Collings

http://www.fin.gov.on.ca/en/autoinsurance/submissions/Anti-Fraud_Task_Force_Input_en.pdf

The Advocates' Society

http://www.fin.gov.on.ca/en/autoinsurance/submissions/Submissions_to_Anti-Fraud_TF_re_Expansion_of_UDAP_to_Apply_to_Lawyers_FINAL.pdf

Made a Submission Electronically

Allstate Canada Group

http://www.fin.gov.on.ca/en/autoinsurance/submissions/ACG_Submission_to_Steering_Ctee_Anti_Fraud_Task_Force.pdf

Aviva

http://www.fin.gov.on.ca/en/autoinsurance/submissions/Sharp_MFD@avivacanada%20com_20121018_100621.pdf

Canadian Society of Medical Evaluators

<http://www.fin.gov.on.ca/en/autoinsurance/submissions/CSME20AUG12AFSubmission.pdf>

Ontario Association of Crime Stoppers

http://www.fin.gov.on.ca/en/autoinsurance/submissions/OACS_Submission_to_the_Steering_Committee_on_Anti-Fraud.pdf

Insurance Bureau of Canada

http://www.fin.gov.on.ca/en/autoinsurance/submissions/Fraud_Task_Force_Submission.ATTACH.170812.FINAL.pdf

State Farm Insurance

http://www.fin.gov.on.ca/en/autoinsurance/submissions/StateFarm_Response_to_Status_Update.pdf

The Co-operators Group Limited

http://www.fin.gov.on.ca/en/autoinsurance/submissions/The_Co-operators_Submission_Task%20Force%20_Final_29Aug2012.pdf

TD Insurance

http://www.fin.gov.on.ca/en/autoinsurance/submissions/TDI_Submission_to_the_Anti-Fraud_Task_Force_Steering_Committee_Status_Update_Aug_2012.pdf

Appendix 3: Recent Anti-Fraud Initiatives in Selected Other Jurisdictions

Other jurisdictions with auto insurance systems similar to Ontario's have taken action to crack down on auto insurance fraud. The timeline below is limited to steps taken by New York, Florida and the United Kingdom (UK) in 2012.

- January, 2012:** The City of London Police announces the launch of the Insurance Fraud Enforcement Department, a police unit dedicated to combating insurance fraud. The unit is funded by the UK's insurance industry and consists of a team of 34 detectives and financial investigators that target both organized and opportunistic insurance fraud, including auto insurance fraud.³⁸
- February, 2012:** Law enforcement officials in New York announce charges against 36 defendants for an organized scheme to defraud auto insurers of over \$279 million.³⁹
- May, 2012:** New York State introduces regulatory reforms to address loopholes in its no-fault auto insurance system and prevent health care practitioners from being paid for services that were not actually provided to claimants.⁴⁰
- Florida introduces legislation that targets auto insurance fraud by introducing strict requirements for health clinic ownership and strengthening billing practices in the auto insurance system.⁴¹

³⁸ <http://www.cityoflondon.police.uk/CityPolice/Media/News/IFEDlaunchestoday3012012.htm>

³⁹ <http://www.fbi.gov/newyork/press-releases/2012/manhattan-u.s.-attorney-announces-charges-against-36-individuals-for-participating-in-279-million-health-care-fraud-scheme>

⁴⁰ <http://www.dfs.ny.gov/about/press/pr1205011.htm>

⁴¹ http://www.myfloridacfo.com/fraud/Annual%20Report/Aug2012_PIPReport.pdf

- July, 2012:** The Florida Highway Patrol partners with the Florida Division of Insurance Fraud and the National Insurance Crime Bureau to combat staged collisions by raising public awareness and providing specific training to law enforcement officers.⁴²
- September, 2012:** The UK insurance industry announces the creation of an Insurance Fraud Register containing details of persons who have committed insurance fraud. The Insurance Fraud Register builds on the industry's existing use of data sharing and analytical software to combat insurance fraud.⁴³

⁴² <http://www.myfloridacfo.com/fraud/press/HSMVPR073112.pdf>

⁴³ <http://www.theifr.org.uk/en/>

Appendix 4: Learning Moments Matrix

Learning Moment	Objective	Potential Delivery Mechanism
Learning about Driving and Insurance	<ul style="list-style-type: none"> • Ensure new drivers are aware of the consequences of fraud and how they can protect themselves from being used in an organized scheme • Reach new drivers and the school-age population with messages about the consequences of fraud and how they can protect themselves from being used in an organized scheme • Teach new drivers about the fundamentals of Ontario's auto insurance system 	<ul style="list-style-type: none"> • Ministry of Transportation Driver's Handbook • Beginner driver education courses • Enhancing existing learning modules on auto insurance developed for classroom lessons • Career education days involving insurance industry organizations • Financial literacy programs including insurance-related content • Printed materials distributed at public events through government service delivery partners
Renewing a Driver's Licence or Vehicle Registration	<ul style="list-style-type: none"> • Ensure new drivers and vehicle owners are aware of the consequences of fraud and how they can protect themselves from being used in an organized scheme 	<ul style="list-style-type: none"> • Licence and registration renewals • Printed materials provided at vehicle dealership, maintenance and repair facilities
Purchasing or Renewal of a Policy	<ul style="list-style-type: none"> • Engage consumers on the subject of fraud when they are reviewing their coverage levels and premiums 	<ul style="list-style-type: none"> • Printed materials provided to policyholders by insurers, brokers and agents upon time of policy purchase or renewal • Small "what to do if in an collision" pamphlet to be kept in the insured vehicle sent to policyholders

Learning Moment	Objective	Potential Delivery Mechanism
Having a Vehicle Towed	<ul style="list-style-type: none"> · Inform claimants regarding potential fraud schemes directly after a collision has occurred 	<ul style="list-style-type: none"> · Printed materials distributed to collision victims by tow truck drivers · Awareness posters around entrances to CRCs and other areas tow trucks may take damaged vehicles · Hotline for consumers to call with concerns about their towing service printed on all towing invoices
Visiting a Collision Reporting Centre (CRC)	<ul style="list-style-type: none"> · Help ensure collision victims are aware of fraud possibilities that exist around time of collision · Spread messages on specific types of organized fraud schemes collision victims should avoid · Engage collision victims as a valuable source of accurate information about a collision that can help prevent fraud 	<ul style="list-style-type: none"> · Printed materials for collision victims · Anti-fraud posters and videos · Further training for CRC staff that work directly with collision victims

Learning Moment	Objective	Potential Delivery Mechanism
Making an Auto Insurance Claim	<ul style="list-style-type: none"> • Provide claimants with information that can help them detect fraud and protect their benefits • Inform claimants about what they should do when they become aware of suspicious activity involving their claim • Ensure brokers and insurance company staff are equipped to discuss fraud issues with policyholders 	<ul style="list-style-type: none"> • Benefit statement (itemized information, advice on what to do if suspicious activity is detected) • Additional anti-fraud messaging in claims welcome packages • More substantive anti-fraud warnings on claims forms • Better training for auto insurance adjusters regarding specific fraud issues • Anti-fraud information, professional development courses or seminars for insurance brokers
Receiving Medical Treatment	<ul style="list-style-type: none"> • Help people become more aware of the types of scams that could occur when they are receiving medical or rehabilitation treatment • Promote better education of providers on fraud to help them answer questions from patients 	<ul style="list-style-type: none"> • More substantive anti-fraud warnings on claims forms • Printed materials made available to claimants through health care practitioners and clinics
Tips Hotline	<ul style="list-style-type: none"> • Provide an anonymous tips hotline • Resolve the issue of individuals not knowing where to report suspicious behaviour related to an auto insurance claim 	<ul style="list-style-type: none"> • Partnership between IBC and Crime Stoppers on tips hotline

Learning Moment	Objective	Potential Delivery Mechanism
News and Public Interest Events	<ul style="list-style-type: none"> · Take advantage of publicized events (such as road safety crackdowns) that can be linked to auto insurance fraud 	<ul style="list-style-type: none"> · News releases and social media campaigns from insurance industry and government organizations · Public Safety Announcements created for television viewers
Exposure to Multimedia Campaign	<ul style="list-style-type: none"> · Create widespread awareness of auto insurance fraud and its costs 	<p>Month long campaign possibly involving:</p> <ul style="list-style-type: none"> · Targeted newspaper advertisements · Subway advertisements · Television or radio commercials

Appendix 5: Illustrative Consent Language for Auto Insurance Application and Claim Forms

This Appendix contains current wording and an illustrative set of changes to the Ontario Application for Auto Insurance and the Ontario Application for Accident Benefits to provide for the pooling of relevant information for the purposes for preventing, detecting, or suppressing fraud. We have illustrated the changes we are proposing by:

- **highlighting new language**
- ~~striking through language to be deleted~~

We offer these suggestions as a basis for further consideration by FSCO.

Ontario Application for Auto Insurance (OAF 1)

Section 11

Declaration of Applicant — Read this section carefully before you sign.

I understand that to qualify for a driver's licence, drivers:

- must not suffer from any mental, emotional, nervous or physical disability that significantly interferes with the driver's ability to safely drive an automobile of the class they are licensed for;
- must not be addicted to alcohol or a drug to the extent that it significantly interferes with the driver's ability to safely drive an automobile; and
- must notify the Ministry of Transportation immediately if the driver becomes physically or mentally disabled to the extent that it might interfere with the driver's ability to safely drive an automobile.

To the best of my knowledge,

- all listed drivers are qualified and hold a driver's licence, and
- the details in Sections 1 to 6 and 9 are correct.

Inspection:

My Insurer may require my automobile to be inspected. If I do not co-operate with any reasonable arrangements to inspect my automobile, I understand my optional loss or damage coverages under Section 7 may be cancelled, and any claims under that section may be denied.

Warning — The *Insurance Act* provides that where:

(a) an Applicant for a contract, (i) gives false particulars of the described automobile to be insured to the prejudice of the Insurer, or (ii) knowingly misrepresents or fails to disclose in the application any fact required to be stated therein; or (b) the Insured contravenes a term of the contract or commits a fraud; or (c) the Insured wilfully makes a false statement in respect of a claim under the contract, a claim by the Insured, for other than such statutory accident benefits as are set out in the Statutory Accident Benefits Schedule, is invalid and the right of the Insured to recover indemnity is forfeited.

Warning — Offences

It is an offence under the *Insurance Act* to knowingly make a false or misleading statement or representation to an Insurer in connection with the person's entitlement to a benefit under contract of insurance, or to wilfully fail to inform the Insurer of a material change in circumstances within 14 days, in connection with such entitlement. The offence is punishable on conviction by a maximum fine of \$100,000 for the first offence and a maximum fine of \$200,000 for any subsequent conviction.

It is an offence under the federal Criminal Code for anyone to knowingly make or use a false document with the intent it be acted on as genuine and the offence is punishable, on conviction, by a maximum of 10 years imprisonment.

It is an offence under the federal Criminal Code for anyone, by deceit, falsehood or other dishonest act, to defraud or to attempt to defraud an insurance company. The offence is punishable, on conviction, by a maximum of 10 years imprisonment for fraud involving an amount over \$5,000 or otherwise a maximum of 2 years imprisonment.

Consent

I am applying for automobile insurance based on the information provided above. With respect to this application or any renewal or change in coverage, I authorize you to collect, use and disclose my driving record, auto insurance history and auto claims history, and those of the listed drivers from whom I declare I have obtained consent for these purposes, as permitted by law for the limited purposes necessary to assess the risk, to investigate and settle claims, and to prevent, detect and suppress fraud.

Warning — Consent

When you make an automobile insurance claim, personal information relating to the claim will be collected with your consent; such consent includes the provision of such information relating to the claim, as well as the above information, for the limited purposes necessary to prevent, detect or suppress fraud, and in accordance with applicable law, to i) fraud prevention organizations and the police and ii) databases or registers used by the insurance industry to analyze and check information provided against existing information.

Application for Accident Benefits (OCF 1)

*Part 11
Signature*

TO THE INSURER TO WHOM THIS APPLICATION IS BEING SUBMITTED:

I UNDERSTAND that you, and persons acting for you, will collect and use i) personal information and personal health information about me that is related to my claims for accident benefits arising out of the accident described in this application and ii) my driving record, auto insurance history and auto claims history, and those of the listed drivers on my policy, and that all such information will be collected directly from me, or from any other person with my consent, or from the listed drivers, or from any other person with their consent.

I ALSO UNDERSTAND that this information will be collected and used only as reasonably necessary for the purposes of:

- Investigating my claims and processing my claims as required by law, including the Ontario Automobile Policy;
- Obtaining or verifying information relating to my claims in order to determine entitlement and the proper amount of payment;
- Recovering payment from insurers and others liable in law for amounts that you pay in connection with my claims;
- Identifying and analyzing the nature and costs of goods and services that are provided to automobile accident victims by health care providers;
- Preventing fraud, ~~and detecting fraud where there are reasonable grounds to suspect fraud and suppressing fraud~~;
- Compiling anonymized statistics for government agencies; and
- Assessing underwriting risks and claims experience.

I ALSO UNDERSTAND that you, and persons acting for you, may disclose this information to the following persons ~~or organizations~~, who may collect and use this information only as reasonably necessary to enable you ~~or them~~ to carry out the purposes described above:

Insurers; insurance adjusters, agents and brokers; employers; health care professionals; hospitals; accountants; financial advisors; solicitors; organizations that consolidate claims and underwriting information for the insurance industry; ~~fraud prevention organizations and the police; databases or registers used by the insurance industry to analyze and check information provided against existing information; and my agents or representatives as designated by me from time to time.~~

I CONSENT, and declare that I have obtained consent from listed drivers on my policy, to you collecting, using and disclosing this information in the manner described above, but no more of such information than is reasonably necessary to meet the legitimate purpose of such collection, use or disclosure.

I UNDERSTAND that if I have any questions about this consent I am free to consult with my insurance company representative or legal advisor before signing this document.

I AM ALSO AWARE that you, and persons acting for you, may be required or permitted by law to disclose this information to others without my knowledge or consent.

I certify that the information provided is true and correct.

I understand that it is an offence under the *Insurance Act* to knowingly make a false or misleading statement or representation to an insurer under a contract of insurance. I further understand that it is an offence under the federal Criminal Code for anyone, by deceit, falsehood, or other dishonest act, to defraud or attempt to defraud an insurance company

Appendix 6: Licensing and Regulation of Health Clinics

In our report we made many references to specific provisions that would promote transparency, accountability and sanctions in the regulatory model we are recommending for health clinics that treat and assess auto insurance claimants.

This appendix provides greater detail on those provisions. The final report of Willie Handler and Associates, which is also publicly available, provides a greater level of detail regarding the basis of our proposal for interested parties.⁴⁴

Transparency: Required Information

Facility Information

- Corporate or legal name of facility
- Facility's physical address and mailing address, email address, telephone numbers and other contact information
- Facility's hours of operations
- Overview of services to be provided (important for Restricted Licence applicants)
- Fee schedule for services to be provided
- Aggregate amount of billings to auto insurers over the past 12 months including other facilities under common ownership
- Floor plan of the facility showing the location and size of waiting area, location and size of treatment/examination rooms and location and type of diagnostic and therapy equipment (Facility Licence only)

Ownership Information

- Ownership structure (sole proprietor, partnership, incorporation)
- Articles of incorporation (where applicable)
- Identity of all owners
- Police background checks for owners covering all jurisdictions lived in over the previous five years

⁴⁴ The report is available online at <http://www.fin.gov.on.ca/en/autoinsurance/reg-health.html>

- List of related companies through common shareholder ownership
- Disclosure of all conflicts of interests in relation to other business interests of owners and their family members as it relates to insurance, health care and legal/paralegal representation

Designated Regulated Professional (or Designated Contact for Restricted Licence applications) Information

- Name and contact information of designated regulated professional (or designated contact)
- College registration number
- Hours that the designated regulated professional or designated contact is on site
- List of all college disciplinary action taken against designated regulated professional since their college licence was issued
- Police background checks for designated regulated professional or designated contact covering all jurisdictions lived in over the previous five years

Professional Staff Information

- Name and contact information of each professional staff member
- College registration number
- List of other FSCO-licensed facilities that each professional staff member is employed with
- List of all college disciplinary action taken against professional staff since their college licence was issued
- Indicate professional staff that conduct insurer examinations indicating number years of applicable clinical experience (must have five years minimum)

Attestations Signed by Clinic Owners and the Designated Regulated Professional or Designated Contact

- Owners attests to the accuracy of the information in the application
- Owners agree to provide FSCO with additional information once application has been reviewed as a requirement to be licensed
- Owners agree to provide FSCO with supplement that may be requested after licence has been issued and to update FSCO within 30 days of any changes to the information in the application
- Owners agree to cooperate with compliance audits or investigations of the facility by a FSCO investigator, law enforcement officer or any other person authorized by FSCO to enforce compliance
- Owner attests to comply with all business practice standards set out by FSCO
- Designated regulated professional or designated contact attests to the accuracy of the information in the application
- Designated regulated professional or designated contact attests to having unrestricted access to the facility's financial information
- Designated regulated professional or designated contact agrees to cooperate with compliance audits or investigations of the facility by a FSCO investigator, law enforcement officer or any other person authorized by FSCO to enforce compliance
- Designated regulated professional attests that professional staff conducting independent examinations are working within their scope of practice, have a minimum of five years applicable clinical experience and are providing opinions that are not subject to undue influence
- Designated regulated professional or designated contact agree to complete quarterly HCAI billing attestations regarding accuracy and appropriateness of bills submitted through HCAI

Accountability: Business Practice Standards

1. No owner, designated regulated professional, or designated contact shall have a criminal or serious *Provincial Offences Act* conviction in the five years prior to submitting a licence application.
2. Facility owners must disclose to FSCO all conflicts of interest in relation to other business interests of the owners and their family members as it relates to insurance, health care and legal/paralegal representation.
3. A facility with a Facility Licence or a General Licence shall identify a designated regulated professional who will be accountable for the operations of the facility. A facility with a Restricted Licence shall identify a designated contact who will be accountable for the operations of the facility. The designated regulated professional or designated contact must be onsite at least three days per week.
4. If the facility conducts independent examinations, all professional staff conducting the examinations shall have at least five years of applicable clinical experience and the designated regulated professional shall attest that the assessors work within their scope of practice.
5. A facility shall cooperate with compliance audits or investigations by a FSCO investigator, law enforcement officer or any other person authorized by FSCO to enforce compliance.
6. A facility shall not accept, solicit, demand or pay a referral fee in respect of a person claiming benefits under the SABS.
7. A facility shall not intentionally submit duplicate treatment and assessment requests in respect of a claimant or duplicate invoices to an insurer.
8. A facility shall not intentionally invoice for goods and services that have not been provided to a claimant or that have not been approved by the insurer.
9. A facility shall cooperate with an insurer's request to verify an invoice.
10. A facility shall only bill once for each Treatment and Assessment Plan (OCF-18) or no more frequently than once every thirty days.
11. A facility shall file all fees with FSCO and shall not invoice for amounts that unreasonably exceed amounts charged by others for similar goods and services.
12. A facility shall comply with all applicable Canadian laws and regulations, Superintendent's Guidelines and HCAI Terms and Conditions.

Sanctions: Examples of Non-Compliance

- An application that contains false or missing information
- Failure to meet the business practice standards established by FSCO
- Failure to allow for inspection of facility for compliance by a FSCO investigator, law enforcement officer or any other person authorized by FSCO to enforce compliance
- The conviction of an owner or designated regulated professional or designated contact for fraud related to the operation of the facility
- The facility's designated regulated professional has been disciplined by their health regulatory college
- Failure to notify FSCO in writing of a change in a designated regulated professional or designated contact within thirty days
- Failure to notify FSCO of a substantive change in licence application information within thirty days

Appendix 7: Proposals to Increase FSCO's Authority to Obtain Information

FSCO investigators cannot easily obtain information and investigate certain persons involved in the insurance sector, such as formerly licensed persons, health care and assessment providers, and other business persons providing services to insurance claimants.

Proposed Changes to <i>Insurance Act</i>	References
Expand the scope/type of person from whom information can be requested and obtained by FSCO.	Similar to provisions contained in the <i>Ontario Mortgage Brokers, Lenders and Administrators Act, 2006</i> and Alberta insurance legislation.
Expand the type of information that can be sought by FSCO.	Similar to provisions contained in the <i>Mortgage Brokers, Lenders and Administrators Act, 2006</i> .
Allow FSCO to specify the format and timeline for delivery of information.	Similar to provisions contained in the <i>Mortgage Brokers, Lenders and Administrators Act, 2006</i> .
Establish an expeditious process to resolve disputes about information requests.	Similar to provisions contained in Alberta insurance legislation.

Appendix 8: Enhanced Investigation and Enforcement Authorities for FSCO

Proposals to increase FSCO's power to investigate and enforce provisions under the *Insurance Act*

Over the many years since the *Insurance Act* was first introduced many aspects of the insurance business have changed. To keep pace with these changes, such as the growing role of technology in the insurance system, it is necessary to clarify and update some of the language in the *Insurance Act* so that FSCO can deploy twenty-first century investigation tools in a twenty-first century business context.

Proposed Changes to <i>Insurance Act</i>	References
Provide authority for a person to enter into a binding compliance undertaking with the Superintendent, a practice often used in enforcement matters.	Similar to provisions contained in Alberta insurance legislation.
Expand the list of things that FSCO can examine during an investigation from “money or things” to, for example, all money, valuables, documents and records relevant to the investigation.	Similar to provisions contained in the <i>Mortgage Brokerages, Lenders and Administrators Act, 2006</i> , the <i>Real Estate and Business Brokers Act, 2002</i> and other regulatory acts.
Allow FSCO to make use of a data storage/retrieval system that is being used by those being investigated to produce information for the investigation.	Similar to provisions contained in the <i>Mortgage Brokerages, Lenders and Administrators Act, 2006</i> .
Clarify that FSCO can take other forms of information besides paper documents (such as computer disks, hard drives, equipment) to obtain information during an investigation.	Similar to provisions contained in the <i>Mortgage Brokerages, Lenders and Administrators Act, 2006</i> .

Proposed Changes to <i>Insurance Act</i>	References
Expand the duty to assist by a person being investigated to include things like answering questions as well as providing documents.	Similar to provisions contained in the <i>Mortgage Brokerages, Lenders and Administrators Act, 2006</i> .
Require FSCO investigators to provide evidence of his or her authority to conduct the examination, on request.	Similar to provisions contained in the <i>Mortgage Brokerages, Lenders and Administrators Act, 2006</i> .
Provide authority to authorize persons with special, expert or professional knowledge to accompany and assist the person executing a warrant.	Similar to provisions contained in the <i>Mortgage Brokerages, Lenders and Administrators Act, 2006</i> .
Update warrant provisions more generally to reflect the standards and practices of investigations undertaken by FSCO to investigate mortgage brokers.	Similar to provisions contained in the <i>Mortgage Brokerages, Lenders and Administrators Act, 2006</i> .

Proposals to increase FSCO's power to investigate and sanction unfair or deceptive acts or practices

FSCO investigators do not have adequate authority to investigate all the parties involved in the insurance sector (besides licensed insurers, agents and adjustors), such as formerly licensed persons, health care and assessment providers, and other business persons who may be involved in providing services to insurance claimants.

These proposed provisions could be considered to enhance FSCO's powers to investigate and sanction actions that constitute a UDAP, as well as update and clarify investigative and enforcement standards so that FSCO can be better equipped in a 21st-century business environment.

Proposed Changes to <i>Insurance Act</i>	References
Expand the scope of persons who can be investigated by FSCO regarding UDAPs to include unlicensed persons (such as formerly licensed persons).	Similar to provisions contained in the <i>Mortgage Brokers, Lenders and Administrators Act, 2006</i> .
Expand the type of persons who can be investigated by FSCO regarding UDAPs to include not only those engaged in providing insurance but also those with a close connection to insurance business (such as health care providers).	Similar to provisions contained in the <i>Mortgage Brokers, Lenders and Administrators Act, 2006</i> .

Appendix 9: Glossary of Terms

Acronym	Full Name and Description
AA	Administrative Authority <i>Administers a set of regulatory requirements on behalf of the government as a not-for-profit, private organization.</i>
CADRI	Canadian Association of Direct Relationship Insurers <i>Represents insurance companies who offer automobile, home and commercial insurance products to Canadians on a direct basis.</i> http://www.cadri.com/
CLHIA	Canadian Life and Health Insurance Association <i>Represents life and health insurance companies operating in Canada.</i> http://www.clhia.ca/
CRA	Canada Revenue Agency <i>Administers tax laws for the Government of Canada and for most provinces and territories, as well as various social and economic benefit and incentive programs delivered through the tax system.</i> http://www.cra-arc.gc.ca/
FHRCO	Federation of Health Regulatory Colleges of Ontario <i>Represents 21 health regulatory colleges that regulate health professionals in Ontario.</i> http://www.regulatedhealthprofessions.on.ca
FSCO	Financial Services Commission of Ontario <i>A regulatory agency of the Ministry of Finance that regulates insurance, pension plans, loan and trust companies, credit unions, caisses populaires, mortgage brokering, and co-operative corporations in Ontario</i> http://www.fsco.gov.on.ca

Acronym	Full Name and Description
GISA	<p>General Insurance Statistical Agency <i>Provides governance, accountability and oversight of the mandated statistical plans of participating provinces and territories.</i></p> <p>http://www.gisa.ca/</p>
HCAI	<p>Health Claims for Auto Insurance <i>Transmits specific Ontario auto insurance health claims forms to auto insurance companies to obtain approval for payment.</i></p>
IBAO	<p>Insurance Brokers Association of Ontario <i>Represents insurance brokers in Ontario.</i></p> <p>http://www.ibao.org/</p>
IBC	<p>Insurance Bureau of Canada <i>Represents private home, car and business insurers.</i></p> <p>http://www.ibc.ca/</p>
Law Society	<p>Law Society of Upper Canada <i>Regulates Ontario's legal profession to ensure a competent and ethical bar.</i></p> <p>http://www.lsuc.on.ca/</p>
MAG	<p>Ministry of the Attorney General <i>Responsible for the oversight of Ontario's justice system.</i></p> <p>http://www.attorneygeneral.jus.gov.on.ca/</p>
MCS	<p>Ministry of Consumer Services <i>Responsible for informing Ontarians about their rights and protections as consumers and administering Ontario's Consumer Protection Act.</i></p> <p>http://www.sse.gov.on.ca/mcs/en/Pages/default.aspx</p>
MCSCS	<p>Ministry of Community Safety and Correctional Services <i>Responsible for law enforcement services in Ontario and for ensuring that public safety systems are safe, secure, effective, efficient and accountable.</i></p> <p>http://www.mcscs.jus.gov.on.ca/</p>

Acronym	Full Name and Description
MOF	<p>Ministry of Finance <i>Responsible for managing the fiscal, financial and related regulatory affairs of Ontario.</i></p> <p>http://www.fin.gov.on.ca/</p>
MOHLTC	<p>Ministry of Health and Long-Term Care <i>Responsible for providing health care services and administering the health care system Ontario.</i></p> <p>http://www.health.gov.on.ca/</p>
OBA	<p>Ontario Bar Association <i>Represents lawyers in Ontario and provides representation to government on topics of current concern on behalf of its members.</i></p> <p>http://www.oba.org/</p>
PACICC	<p>Property and Casualty Insurance Compensation Corporation <i>Protects eligible policyholders from undue financial loss in the event that a member property and casualty insurance company becomes insolvent.</i></p> <p>http://www.paciccc.com/</p>
PCT	<p>Professional Credential Tracker <i>Helps health care practitioners prevent their identities from being stolen by fraudulent health care facilities by allowing practitioners to see which facilities are using their professional credentials to bill insurers.</i></p>
PIPEDA	<p>Personal Information Protection and Electronic Documents Act <i>Sets out rules and requirements for when and how a private sector organization can collect, use or disclose an individual's personal information.</i></p>
RSLA	<p>Repair and Storage Liens Act <i>Sets out the rights of repairers and storers of goods, as well as the rights of individuals whose goods have been repaired and stored.</i></p>

Acronym	Full Name and Description
SABS	<p>Statutory Accident Benefits Schedule</p> <p><i>Provides benefits for individuals injured in a motor vehicle collision, regardless of fault. Benefits include medical, rehabilitation, attendant care and income replacement.</i></p>
UDAP	<p>Unfair or Deceptive Acts or Practices Regulation</p> <p><i>Sets out unfair or deceptive acts or practices in Ontario's auto insurance system, which can be subject to review and investigation by FSCO.</i></p>
WSIB	<p>Workplace Safety and Insurance Board</p> <p><i>Provides Ontario employers with no-fault collective liability insurance and Ontario workers with loss of earnings benefits and health care coverage.</i></p> <p>http://www.wsib.on.ca</p>