CANATICS

Canadian National Insurance Crime Services

CANATICS Comments Re:

FINANCIAL SERVICES REGULATORY AUTHORITY OF ONTARIO

Proposed FY 2019-20 FSRA Priorities and Budget

Date: February 7, 2019

Submitted To: Financial Services Regulatory Authority of Ontario

Submitted By: CANATICS

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2 Introduction

Canadian National Insurance Crime Services (CANATICS) wishes to thank FSRA for the opportunity to comment on its 2019-20 Priorities and Budget. We welcome this consultative approach and FSRA's commitment to broad stakeholder engagement. We look forward to working closely with FSRA and other stakeholders to support all priorities related to the development of the fraud reduction strategy, including the review of Health Service Provider (HSP) regulation.

3 About CANATICS

CANATICS, established on the recommendation of the Ontario government's Anti-Fraud Task Force, is a private-sector, not-for-profit corporation that was incorporated in February 2013 as a property and casualty insurance industry solution to help combat auto insurance fraud. Membership is open to all insurers and current members represent 77% of the Ontario auto insurance market. CANATICS' mission is to support the fight against insurance crime by providing individual insurers, and the industry, with superior intelligence derived from analytics performed on industry pooled data with an unwavering focus on data quality, privacy and security.

CANATICS uses state-of-the-art analytical tools to identify potentially suspicious claims in insurance industry pooled data, to facilitate further investigation by individual insurers. The sole purpose of CANATICS is to assist the government and the insurance industry in the detection, suppression and prevention of insurance fraud. In addition to the Policy and Claim data provided by Insurers, the current CANATICS Fraud Analytics Solution (CFAS) also includes Statutory Accident Benefits data, obtained primarily through forms approved and mandated by FSCO, as well as data provided by FSCO on business entities.

4 The Request for Comment

CANATICS is responding to the two sections which connect to our mandate to fight insurance crime, both among FSRA's Targeted High-Impact Priorities for Auto Insurance in the 2019-20 Priorities and Budget document:

- Develop Fraud Reduction Strategy
- Review Health Service Provider (HSP) Regulation

4.1 Develop Fraud Reduction Strategy

CANATICS wishes to respond to each of the following topics identified by FSRA in the section "Auto Insurance: Develop Fraud Reduction Strategy":

- clarifying the appropriate roles and expectations of the various parties;
- working with stakeholders to review and improve the effectiveness of information and technology systems and tools to control and deter auto insurance fraud;
- identifying opportunities for improved use of data and analytics; and
- considering the need for improved public communications about the costs of fraud for Ontario consumers, and the potential benefits of increased public awareness in reducing fraud.

4.1.1 Summary of CANATICS response

The Expert Panel's Final Report on the Review of the Mandates[1] and the *Financial Services Regulatory Authority of Ontario Act, 2016* (the FSRA Act) subsequently put in place to implement it, correctly saw the fight against insurance fraud as one in which both the regulator and the regulated must work together, with the regulator (FSRA) playing the role of enabler of the industry's anti-fraud strategy. CANATICS believes that this framework should continue to guide FSRA and the industry in the fight against insurance fraud in Ontario.

It is important that in Year 1 FSRA identify potential regulatory impediments to effectively fighting insurance fraud and put measures in place to quickly resolve them. From CANATICS experience, a major impediment is the lack of clear statutory authority to use insurance data to fight insurance fraud. The FSRA Act gives FSRA the authority to make rules in respect of any matter relating to the objects set out in Section 3 of the Act. FSRA should use this power to make a regulation in Year 1 that will authorize and facilitate the development and enhancement of (1) industry anti-fraud data analytics services, and (2) a centralized insurance intelligence data hub with an insurance fraud registry.

Identifying opportunities for improved use of data and analytics is a very high priority for CANATICS as well as FSRA. The areas of greatest opportunity to improve on current industry initiatives are to enhance the quality of available data and resolve the obstacles to data sharing within the industry. Many of the key data sources which need improvement are within the mandate of FSRA already, and we encourage FSRA to further explore other areas in which limited to no data is currently available. Furthermore, the existing approaches to identifying fraud using data and analytics are often successful at flagging suspicious behavior, even given the limited data available, but there is often no clear recourse for the insurers to recoup costs or initiate criminal or civil proceedings against the perpetrators.

We will outline a three-pronged approach to improve the use of data and analytics. First, use FSRA's rule making authority to make a regulation that will explicitly authorize insurers to collect, pool, use, process and disclose data, across the industry, for the limited purposes of fraud detection, suppression and prevention. Second, establish medium term initiatives to improve data quality, not only for individual insurers but also government managed data sets such as HCAI. Third, create a short and medium term plan to strengthen and add enforcement tools to enable insurers and the government to create meaningful consequences for individuals and businesses caught defrauding the system. These are three tightly related aspects of one holistic approach to auto insurance fraud, and the full benefit of investment in anti-fraud initiatives in any of these areas cannot be realized without also addressing the others.

Public perception of the existence of insurance fraud, its magnitude and its costs to the public, influences the ability of the industry and its regulator to meaningfully reduce fraud. FSRA should consider implementing the recommendations made by the Ontario Automobile Insurance Anti-Fraud Task Force for improved public communications about insurance fraud, and public awareness of FSRA and industry's anti-fraud initiatives.

[1] FSRA was established on the recommendation of an independent expert advisory panel that reviewed the mandates of the Financial Services Commission of Ontario (FSCO), the Financial Services Tribunal (FST) and the Deposit Insurance Corporation of Ontario (DICO). Final Report available at https://www.fin.gov.on.ca/en/consultations/fsco-dico/mandate-review-final-report.pdf

4.1.2 Detailed Response

4.1.2.1 Clarifying the appropriate roles and expectations of the various parties

CANATICS is a consortium of Ontario auto insurers who are themselves key stakeholders with interests in developing an effective auto insurance fraud reduction strategy. CANATICS has played a key role in the development of an industry-wide anti-fraud strategy in Ontario,[2] and is a key anti-fraud service provider in the Ontario auto insurance industry. CANATICS is therefore in a unique position to assist FSRA in developing an effective fraud reduction strategy.

The Final Report on Review of the Mandates of the Financial Services Commission of Ontario, Financial Services Tribunal, and the Deposit Insurance Corporation of Ontario noted that:

> Throughout our consultation process, we were consistently encouraged to clarify the regulator's role in fraud detection and prevention. Given the serious nature of fraud and the ability of perpetrators to cross sectoral boundaries, we agree that fraud is an issue that should be paramount within the regulator's mandate.
>
> Each sector provided examples of fraud during our consultations. We were taken by these examples and feel we need to recommend strongly that FSRA should have the appropriate authorities embedded in statute and should work to develop better mechanisms to proactively protect the public from unscrupulous groups and individuals.
>
> This could include the authority to make use of, or participate in, data analytics designed to identify fraudulent activities.
>
> …
>
> We do not intend to imply that FSRA should be the only responsible entity for fraud prevention, deterrence and detection. Each regulated sector and the businesses operating within them must also participate actively in fighting fraud. FSRA ought to have the authorities necessary to require and enable the sectors to do their part.[3]

The Expert Panel correctly saw FSRA's paramount role as one of fighting fraud, and the fight against insurance fraud as one in which both the regulator (FSRA) and the regulated must work together, with FSRA playing the role of enabler of the regulated's anti-fraud strategy.

Based on its experiences, CANATICS recommends that FSRA should ensure that it has in place in Year 1 a regulatory framework that authorizes, fully supports and facilitates the development and implementation of the following anti-fraud data services that the insurance industry is currently exploring, among others, in its long-term anti-fraud strategy:

1. industry anti-fraud data analytics services;

[2] In 2017 the Insurance Bureau of Canada (IBC) established the Industry Insurance Crime Advisory Group (IICAG) whose mandate includes setting the industry's priorities and defining an industry-wide anti-fraud strategy and a plan for implementing cross-insurer shared services to more effectively detect, prevent, investigate and prosecute insurance crimes. CANATICS developed the framework upon which IICAG's initial strategy was further developed and has continued to be a key participant in IICAG's activities.

[3] See https://www.fin.gov.on.ca/en/consultations/fsco-dico/mandate-review-final-report.pdf, pages 16 and 17

2. a centralized insurance intelligence data hub that includes an insurance fraud registry system.

CANATICS will be available to discuss these initiatives in detail with FSRA. In summary, CANATICS is an example of "industry anti-fraud data analytics services". CANATICS uses state-of-the-art analytical tools to identify potentially suspicious claims in insurance industry pooled data, to facilitate further investigation by individual insurers. FSRA should encourage enhancement of such services and development of new ones.

The United Kingdom's Insurance Fraud Intelligence Hub (IFiHub) is an example of a "centralized insurance intelligence data hub".[4] Developed by the Insurance Fraud Bureau (IFB) and the UK insurance industry, IFiHub is currently undergoing final testing. It will enable the UK insurance industry to share information about all types of suspected frauds, trends and patterns across all product types. The IFB plans to integrate its existing "data analytics services" into the IFiHub.

The IFB also operates one of the most efficient "insurance fraud registry systems" in the world – the UK Insurance Fraud Register (IFR) launched in 2012. Insurers use the IFR to crosscheck their policyholder information against records of known/proven insurance fraudsters. Where a check identifies a match, the insurer can take action to limit or prevent becoming exposed to fraud. The IFR is also the conduit through which insurers share data with other industries – so a proven insurance fraudster might not just find it more difficult and more costly to get insurance, but may also find it more difficult and more costly to access other financial services and products. IFR is subject to strict privacy governance and appropriate checks and balances, including public access rights, subject notification requirements and data correction rules.

CANATICS anticipates that FSRA will hold further consultations on the design of the proposed regulation to facilitate these services. In addition further consultations will be needed to flesh out the details of a centralized insurance intelligence hub with an insurance fraud registry, who manages it, and how to ensure maximum participation in the registry and the appropriate consumer protection controls.

Full development of data analytics-based fraud detection services and intelligence data sharing has great potential for rapid and substantial improvement in the industry's anti-fraud strategy initiatives. As will be discussed in more detail in the sections below, CANATICS' expectation is that FSRA will utilize its statutory powers and mandate to fully support and facilitate the development of these services, including putting in place any legal, regulatory and privacy framework needed to ensure that these services can be provided.

4.1.2.2 Working with stakeholders to review and improve the effectiveness of information and technology systems and tools to control and deter auto insurance fraud

The effectiveness of anti-fraud information systems depends on both the soundness of the technology and the legal/privacy framework within which it is deployed. It is important that in Year 1 FSRA explore potential regulatory impediments to an effective anti-fraud strategy and how to quickly resolve them.

Since 2014 CANATICS has operated the only major cross-insurer auto-insurance anti-fraud data analytics system in Ontario. Consequently, CANATICS has amassed a wealth of experience with respect to not only the technical aspects of what makes an anti-fraud solution work efficiently, but also the legal/privacy framework and controls required to ensure that the solution works efficiently to help users detect, suppress and prevent fraud, while keeping consumers confident that their information is used only in accordance with Canadian privacy laws.

[4] https://www.insurancetimes.co.uk/insurers-testing-ifbs-new-fraud-sharing-hub/1427226.article

There are at least two avenues that FSRA can utilize to work with stakeholders to review and improve the effectiveness of anti-fraud systems. One is through public consultations on its annual Statement of Priorities like the ongoing. A second avenue is through a Rule Making process, either proactively on its own motion or in response to a request from a stakeholder.

Based on the Final Report's Recommendation #22, FSRA's statutory objects were clarified in Schedule 16 of *Bill 177, Stronger, Fairer Ontario Act (Budget Measures), 2017*, (received royal assent on December 14, 2017). Bill 177 amended the *Financial Services Regulatory Authority of Ontario Act, 2016* to, among other things, explicitly grant FSRA the authority to make rules in respect of any matter relating to the objects set out in Section 3 of the Act. One of the objects set out in Section 3 is "(g) to deter deceptive or fraudulent conduct, practices and activities by the regulated sectors".

CANATICS strongly recommends that FSRA should proactively initiate a proceeding in Year 1 to make a regulation that will explicitly authorize insurance companies to collect, process, use, pool and disclose data, across the industry, for the limited purposes of detecting, suppressing and preventing insurance fraud. Such a regulation will reassure the public that their data is being utilized to fight fraud, and enhance the public education and awareness objective of FSRA. As discussed later in section 4.1.2.3.3 with respect to bodily injury claims data, the new regulation will also provide a "safe harbour" compliance with privacy consent requirements in situations where insurers have no practicable ways to obtain express consent for anti-fraud collection, use and disclosure of data. The regulation will also provide general stimulus for the establishment and improvement of cross-insurer anti-fraud services, like data analytics-based fraud detection and a centralized fraud intelligence data sharing hub. FSRA and the industry should work together to explore ideas for ensuring completeness of information in such a hub, as well as the pros and cons of different ways the solution could be built, operated and governed.

Such a regulation will reassure the public that their data is being utilized to fight fraud and will also serve as a safe harbour for consent concerns. The reason why a consent safe harbour regulation is needed as part of the industry's anti-fraud strategy is discussed later in these comments, with particular reference to the use of bodily injury data to fight fraud.

4.1.2.3 Identifying opportunities for improved use of data and analytics

4.1.2.3.1 Data Quality

The most consistent data source across Ontario insurers is the Health Claims for Auto Insurance System (HCAI), which is governed by FSCO and by Health Claims for Auto Insurance Processing (HCAIP). Its FSCO-mandated use industry-wide makes it uniquely suited to data pooling. Because it is such a rich and valuable data set, improving the quality and usability of this data is a very high priority for industry-level analytics. While this system contains valuable data[5], it was designed over ten years ago as a transaction processing tool, and its data model has never been seriously revised to enhance its value as a data source. There is virtually no validation to ensure the accuracy of data entered into the system, and none whatsoever to resolve duplicate claimants, health care providers, clinics, or claim forms. Neither of these problems can be solved with Band-Aid solutions as they require a serious overhaul of the data capture process, which includes both changes to HCAI and to the Ontario Claim Forms (OCF) which define the fields to be entered.

An effective solution to the problem of inaccurate health care provider records in the database would be to automatically validate HCAI provider registration numbers against health regulatory college records. As either a future design, or retrofitted to the current HCAI solution, this approach could be applied at the time a clinic enters the provider into HCAI, or, each time an invoice or treatment plan is submitted on behalf of that health care provider. This would require secure electronic transmission of registration numbers between the health regulatory colleges and a central source accessible to HCAI. FSCO was very successful in building bridges between the health regulatory colleges and HCAI during the Professional Credential Tracker project, as described in the Final Report of the Ontario Auto Insurance task force, and FSRA could play a similar role going forward.

In addition to greatly improving the quality of the data, this approach would go a long way to addressing two of the problems adjusters face in promptly reviewing and approving claim forms: clinics billing for health care providers under incorrect or outdated names and credentials, and, individuals remaining active as health care providers in the HCAI system while their license to practice had been revoked or suspended. Claims adjusters are responsible for ensuring that the invoices and treatment plans they approve are both reasonable and compliant with FSCO rules, within very short turnaround times. Yet, nearly all their validation process is entirely manual, for example using college websites to verify that health professionals have the appropriate credentials or doing so by telephone in the case where the college does not share registration numbers on the public website.

The scope of HCAI is also limited in ways that hamper use of its data for anti-fraud purposes. Although it is called a “health claims” system, its actual scope is much narrower. Exclusions under the SABS include: Surgical, dental, optometric, hospital and ambulance services; medication, prescription eyewear and dental devices; supplies purchased by the claimant; transportation of the insured person; financial or employment counselling; vocational or academic training; home and vehicle modifications required because of disabilities; and attendant care services. These exclusions apply even when the treatment plans issued through HCAI are the basis for the provision of such goods and services.

[5] We note in this respect the following statement from the Final Report:
“FSRA could work with those who administer and govern Health Claims for Automobile Insurance (HCAI) data to ensure that additional uses are properly evaluated and implemented. HCAI already serves anti-fraud and anti-abuse purposes by serving as the portal through which health care providers invoice auto insurers directly. The system maintains a wealth of data that FSRA ought to explore for additional purposes that could significantly benefit consumers. “ at page 17

This reduces the benefit of the dataset by showing an incomplete picture of total Accident Benefits costs and associated suppliers. It also incentivizes workarounds that adversely affect HCAI data quality, such as clinics listing these other businesses or services as health care providers in their employ. We recommend that FSRA work with the industry and with CANATICS to explore opportunities for expanding the scope of goods and services that are transacted through HCAI, where practical and where there is evidence of significant fraudulent activity. In particular our members have identified attendant care invoicing (when the services are provided by a business and not by a family member) as their highest priority for HCAI scope enhancement.

HCAI can only transmit Ontario Claim Forms (OCF), but not all OCFs are included in HCAI's scope, nor do all yet contain claimant consent language to support use in insurers' anti-fraud data pooling solutions such as CANATICS. CANATICS worked with FSCO and consulted with the Office of the Privacy Commissioner of Canada (OPCC) to modify consent language on both the Ontario Application for Automobile Insurance Owner's Form (OAF) and several OCF forms, including all the OCF forms mandated by FSCO for HCAI submission at that time. Unfortunately, not all OCF forms have been equivalently modified, including the Form 1 which since then has been added to HCAI as a mandatory form.[6] The priority would be to add this consent language to the Form 1, rendering it immediately usable as part of the existing HCAI data stream by insurers and anti-fraud data pooling solutions such as CANATICS. Subsequently this language should also be added to other OCF.

Our member insurers have indicated that continuing to expand the number of OCF submitted through HCAI by health care facilities would add a great deal of value for fraud analytics. Many of the high-value forms from a fraud perspective are currently submitted by fax or as image files, which renders them useless for data analytics. Furthermore, the OCF themselves (including but not limited to those already in HCAI) are poorly designed for data analysis and lack many key fields that would allow analytical tools to identify unique individuals.

The Minor Injury Guideline (MIG) forms have extensive shortcomings for both data capture and adjudication. They should be redesigned to address this, giving the highest priority to changes that will consistently attribute hours, dollars and services performed on a specific day to a specific provider. The Minor Injury Guideline itself needs to be revised to provide clearer limits and entitlements. In many cases, full MIG blocks are billed to insurers when very few services appear to have been provided to the claimant, and dollars billed cannot be clearly attributed to any one service provider. It also does not include any information on the progress or outcomes of the claimant, giving insurers no information on whether the treatment (or lack thereof) is either reasonable or necessary. Given the high numbers of claimants that go on to additional and more expensive treatment outside of the MIG, it is essential to capture better data about the services that claimants are receiving within the MIG and their outcomes.

This is not only an issue from the perspective of billing abuse. As David Marshall highlighted in his 2017 report, Fair Benefits Fairly Delivered: A Review of the Auto Insurance System in Ontario,

> There is no record kept of outcomes or the effectiveness of medical treatments. In the absence of understanding how effectively medical care is being delivered, the system is open to inefficiency,

[6] FSCO may add OCF to HCAI at two levels: On a mandatory basis, or a non-mandatory basis. A mandatory form is one that can only be submitted using HCAI. A non-mandatory form is one that can be submitted either via HCAI, or via other means such as fax. When introducing the Form 1 to HCAI, it was originally made non-mandatory, which resulted in very low uptake by health care facilities of the HCAI option. It has since been made mandatory, which greatly increases its value to insurers and anti-fraud data pooling solutions such as CANATICS.

> excessive cost and over treatment. Moreover, there is no opportunity to improve outcomes for patients. Considering that support for medical recovery is one of the cornerstones of the legislation, the system is not currently meeting this standard.[7]

One of the most significant data gaps on the OCF, from the perspective of auto insurance fraud, is that while treatment plans clearly identify both the supervisor and the provider of treatments, the invoices include no such distinction. This leaves the insurer in the position of not knowing whose work they are paying for, and unable to determine if the rates are compliant with the Professional Services Guideline (PSG). It is extremely common for clinics to exploit this limitation of the form to list the supervisor as the service provider, in clear violation of the FSCO invoice submission rule that the primary provider listed on the invoice is the one who spent the most time rendering the good or service to the claimant.

The incentive for them to do so is very strong, as the PSG rates for the treatment supervisor and the service provider may vary by more than $90 per hour. The PSG itself does not provide rate guidance for all of the professions that treat MVA claimants, and the rates it does specify are not rationalized with respect to rates paid by other payers such as the WSIB and Canadian life and health insurers.

This is an issue not just of form design, but of rule ambiguity. Lack of clear guidance prevents insurers from taking action on certain types of billing abuses when clinics explain them as data entry errors; the HCAI Guideline and Professional Services Guideline should be expanded and clarified so that both clinics and insurers clearly recognize when a line has been crossed. We request that FSRA clarify how insurers can and should respond to poor data entry practices by clinics, including escalation guidelines. Also useful would be clear guidance as to insurers' latitude to reject forms with inaccurate data, lack of appropriate granularity, and inappropriate use of billing and unit of measure codes.

CANATICS recommends that the OCF and associated HCAI processes be completely redesigned to resolve the data gaps, remove ambiguity, and simplify the paperwork burden for health care professionals. The OCF design committee should include a CANATICS representative to ensure the fields are structured to support industry-level fraud data aggregation and entity resolution techniques.

4.1.2.3.2 Data Access

The HCAI mandate should be broadly reviewed to make the best use of its uniquely valuable capacity to identify bad actors in the healthcare sector. Those who are using HCAI to defraud auto insurers are likely also committing similar fraud against the Workplace Safety and Insurance Board (WSIB), and life and health insurers. Improving lines of communication and data sharing about fraud across lines of business that are fighting to find and remove the same criminals will not only increase the effectiveness of fraud investigation but also provide a powerful deterrent to organized crime.

As a start, expanding the availability of all HCAI data to anti-fraud service providers like CANATICS (which currently pools 68% of all Ontario HCAI data) would greatly increase the ability of insurers to identify fraud. Pooling data across insurers is essential to identify clinics billing for services that could not possibly have been provided as described, because they include health care providers working in more than one city simultaneously, or an individual health care provider billing for more than 24 hours of services on a given day. Should the HCAI contract be revised to allow CANATICS and other anti-fraud stakeholders – and possibly FSRA – their own credentials to extract HCAI data for clearly specified purposes, all industry stakeholders would benefit. Allowing

[7] David Marshall (2017). "*Fair Benefits Fairly Delivered: A Review of the Auto Insurance System in Ontario*"

further collaboration and data sharing with other health insurance payers, such as WSIB and Canadian life and health insurers operating in Ontario, could provide even more insight into which businesses in the health care system may be systematically defrauding insurers.

Outside of HCAI, a data issue that affects the industry and needs to be solved by the industry is that many types of valuable supplementary data are not currently available to insurers. Tow truck services, rental cars, and paralegals are frequently part of organized auto insurance fraud and staged collisions, but there is to date little capture of this information in any consistent format that would allow individuals or vehicles to be identified from the claims data. When insurers do capture it as part of their claim data entry it is not currently stored in any standardized format that would allow it to be included easily in data pooling for anti-fraud purposes.

Other data which is both valuable and effectively captured, under the purview of other Ontario Ministries, is not readily available to insurers. CANATICS seeks to supplement the data provided by claimants on their motor vehicle accidents. CANATICS' negotiation with the Collision Reporting Centre for the purposes of data sharing have been hampered, for several years, by challenges obtaining approval from the Ministry of Transportation of Ontario (MTO). Police reports on motor vehicle accidents, thefts and vandalism from the relevant Ontario and municipal police services would also be useful, as would health regulatory college data that could be used to automatically validate legitimate, active healthcare providers in good standing. CANATICS would welcome FSRA's assistance in obtaining such datasets by working with the relevant ministries, particularly the MTO and the Ministry of Health and Long Term Care (MOHLTC), to enable insurers and fraud detection organizations like CANATICS to access data.

4.1.2.3.3 Need for Anti-Fraud Data Use Safe Harbour

The challenge in securing data sets for anti-fraud purposes is not merely red tape. Indeed, the challenges in establishing and enhancing the anti-fraud services discussed in Section 4.1.2.1 of these comments may be primarily tied to regulatory uncertainty. There is an absence of clear province-wide guidelines on how data should be collected, and no regulatory authority to collect, access and use insurance data to provide these services. As such, insurers in the current environment must independently develop ad-hoc legal risk and regulatory risk mitigation strategies, with the result that data sharing is spotty and rife with format inconsistencies that prevent aggregation.

While there are some potential concerns over sharing of data (for anti-fraud purposes) relating to competition law and litigation rules of procedure, the biggest risk by far is privacy law compliance. Insurers are often reluctant to share data and collaborate on the use of data to fight fraud because of concerns over privacy laws. Although recent amendments to the federal *Personal Information Protection and Electronic Documents Act* (PIPEDA) added a new consent exception for personal information disclosed for purposes of detecting, suppressing or preventing fraud, it remains unclear to what extent this new addition affords a safe harbour for collaborative processing and sharing of data for insurance anti-fraud purposes.[8]

CANATICS current anti-fraud data analytics service provides an illustration of how the absence of clear and explicit regulatory authority impedes the efficiency and effectiveness of the fight against insurance fraud. The

[8] Paragraph 7(3)(d.2) was added to PIPEDA in 2015 by the *Digital Privacy Act*. It provides that an organization may disclose personal information without knowledge or consent if the disclosure is:
"made to another organization and is reasonable for the purposes of detecting or suppressing fraud or of preventing fraud that is likely to be committed and it is reasonable to expect that the disclosure with the knowledge or consent of the individual would compromise the ability to prevent, detect or suppress the fraud".

apparent ambivalence of PIPEDA's anti-fraud consent exception, and the absence of a clear and explicit regulation authorizing insurers to collect, pool, process, use and share data for anti-fraud purposes, is significantly limiting CANATICS' ability to optimize its fraud detection solution for its members' benefit. This is particularly so with respect to bodily injury claims data (BI data). Bodily injury claim costs are a significant portion of auto insurance claim costs in Ontario. Yet BI data is not currently included in CANATICS' anti-fraud solution because CANATICS members have no practicable way to collect express consent to use clients' data for fraud detection as they do with respect to Statutory Accident Benefits Schedule (SABS) claims data.

CANATICS' insurance fraud analytics solution currently includes SABS claim data obtained from consumers by insurers through forms approved and mandated by the Financial Services Commission of Ontario (FSCO). These forms contain notice to and consent of individuals that their personal information may be collected, disclosed, pooled and used for auto insurance fraud analytics and for purposes of detecting, suppressing and preventing auto insurance fraud. Unfortunately, our members do not currently add BI data into the solution because of the ambivalence over the consent requirements. Yet, insurers already validly obtain BI data from BI tort claimants and BI tort third parties (e.g. witnesses, passengers, tow truck operators, body shops and health care providers), for purposes of processing (including defending) the tort claim.

Adding BI data to the fraud solution will enhance insurers' fraud-fighting capability and facilitate the government's objective of fighting insurance fraud. CANATICS believes that the most effective and important step in solving this challenge is for FSRA to make a safe harbour regulation that clearly authorizes insurers to collect, process, use and share data (including personal information) without consent for the limited purposes of detecting, suppressing and preventing insurance fraud. Properly crafted, the regulation will satisfy the consent exemption under subsection 7(3)(i) of PIPEDA.[9]

As CANATICS discussed above we believe that FSRA has clear rule making power to legislate such a safe harbour regulation. The regulation could further stipulate, similar to the FSCO-approved SABS forms, that insurers may disclose BI claim data to the following persons or organizations, who may collect and use the information only as reasonably necessary to enable them to carry out the anti-fraud purposes described:

- 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; other insurance companies; 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; and
- Further, the insurance company may pool BI information with information from other sources and may analyze this information for the limited purpose of preventing, detecting or suppressing fraud.

A safe harbour regulation for anti-fraud collection, use and sharing of data will benefit not only CANATICS insurance fraud analytics services but also the larger FSRA anti-fraud strategy. The regulation can accomplish a lot by authorizing, fully supporting and facilitating the development and enhancement of the anti-fraud database services discussed in Section 4.1.2.1 of these comments (namely, data analytics-based fraud detection services, and a centralized insurance intelligence data hub with an insurance fraud registry system). Other jurisdictions, notably the UK and Germany, have implemented intelligence hubs to allow insurers to exchange

[9] Subsection 7(3)(i) states that an organization may disclose personal information without the knowledge or consent of the individual if the disclosure is "required by law".

information about known and suspected fraud. This approach could add significant value in Ontario as well, seeking to mirror the successes of these other jurisdictions. One of the key barriers identified to the implementation of such a hub is the lack of safe harbour provisions, without which many insurers will not participate.

4.1.2.3.4 Enforcement

Although there are many opportunities to improve and expand the data available to insurers, most of the industry has been sharing what data they can through the CANATICS analytics solution to identify thousands of suspicious claims and suppliers. However, insurers are finding it very challenging to identify actions they can take to reduce fraudulent costs and deter future fraud from the suppliers responsible. Data and analytics can and does identify patterns of suspicious behavior, but a pattern is not a chargeable offence, and prosecuting individual fraudulent claims one at a time for a frequent offender is not a good use of resources either within the insurance industry or the justice system. We recommend a three-part strategy for increasing enforcement and reducing insurers' administrative overhead related to non-compliant and fraudulent behaviours by suppliers, particularly in the health care sector.

First, FSRA must clearly communicate to the health care community the requirement to enter HCAI data completely and accurately, not only for anti-fraud purposes but to better collect data to support research into more effective treatment protocol research, as outlined in the Marshall report. It is not always easy or quick for claims adjustors to distinguish between an invoice riddled with errors and omissions, and one that is a deliberate attempt to mislead. The very high volume of misleading or incomplete information on invoices adds administrative overhead and wastes investigative resources, as well as drawing no doubt unwelcome attention to legitimate clinics as a result of their employees' data entry practices. Similar communications strategies towards other insurance payees such as physical damage businesses and tow trucks may also be of value, as poor data entry practices on invoices are a widespread concern with auto insurance.

Second, for those suppliers who continue to submit inaccurate and misleading invoices on an ongoing basis, the industry requires clear guidance as to how to proceed. Insurers must have the latitude to decline OCF that do not meet submission guidelines, in particular those which do not include valid names and/or registration numbers for regulated health professionals.

There is also no clear escalation method for such compliance violations. The HCAI Guideline and Professional Services Guideline currently have no teeth and are disregarded with impunity. There must be a mechanism to enforce compliance that does not require the insurer to run a full investigation of each non-compliant OCF to find evidence of fraud. The existing Health Service Provider licensing program has the opportunity to apply Administrative Monetary Penalties (AMPs), but these are infrequently used, and insurers need an effective and straightforward process to submit complaints about noncompliance issues. Such a process must include an option for coordinated submission from multiple insurers, including through anti-fraud collaborative groups such as CANATICS, and must also include a path to provide clear and prompt feedback to the complainants as to outcomes.

Finally, FSRA should utilize its powers under the FSRA Act to ensure that fraudulent conducts that may not meet the threshold for criminal prosecution are nevertheless dealt with under its administrative powers. The industry's heavy reliance on the Criminal Code definition of "fraud" and the criminal law procedures have contributed to the anemic state of insurance fraud prosecution in Ontario. For instance, a pattern of repeated misrepresentation on claim forms, despite warnings and other escalation, would hardly be considered for criminal fraud investigation and prosecution. Such conduct may also not meet the prosecutorial thresholds of

most provincial offences because of the required burden to prove intent to make and/or knowledge of the false insurance claim.

To this end, CANATICS recommends that in Year 1 FSRA should explore how to use administrative penalties to punish and deter fraudulent conduct in the absence of criminal prosecution. We note that Subsection 3(g) of the FSRA Act explicitly empowers FSRA to "(g) to deter deceptive or fraudulent conduct, practices and activities by the regulated sectors". The expression "deceptive" underscores that FSRA's mandate in this respect is not limited only to "criminal conduct" within the definition of the Criminal Code of Canada. Then Subsection 20.1(i) of the FSRA Act provides that FSRA's "Chief Executive Officer may issue a certificate, … stating the day on which the Chief Executive Officer became aware of a contravention or failure to comply for which an administrative penalty may be imposed under any Act that confers powers on or assigns duties to the Chief Executive Officer." CANATICS believes that these powers should be explored for purposes of rooting out seemingly "routine" administrative compliance violations that are actually deceptive if not outright fraudulent.

4.1.2.4 Improved public communications about the costs of fraud and the potential benefits of increased public awareness in reducing fraud

Public perception of the existence of insurance fraud, its magnitude and its costs to the public, influences the ability of the industry and its regulator to meaningfully reduce fraud. FSRA could take a leadership role in communicating to the public about fraud and what the government and the industry are doing cooperatively to combat it.

The Final Report of the Ontario Automobile Insurance Task Force (2012) recommended that the Ontario government should work with the industry to develop and implement a consumer engagement and education strategy. The Report included detailed structural recommendations for implementing anti-fraud awareness and illustrative touchpoints to deliver communications about insurance fraud and reducing fraud. CANATICS believes that these recommendations could be valuable to FSRA's public fraud awareness object and their possible implementation should be included in Year 1 priorities.

4.2 Review Health Service Provider (HSP) Regulation

CANATICS wishes to respond to FSRA's call for comment on the section "Auto Insurance: Review Health Service Provider Regulation", and in particular the opening paragraph:

> "The current licensing regime for health service providers in Ontario's auto insurance system is seen by some as ineffective in achieving the intended objectives of controlling costs and ensuring effective provision of benefits by reducing fraud, and is therefore of questionable regulatory benefit, particularly when there is already supervision by health regulatory colleges." (page 19, section 8.1.3)

4.2.1 Summary of CANATICS response

There is not, in fact, "already supervision", by health regulatory colleges or any other organization, of Ontario health and rehabilitation facilities. Only the health care practitioners themselves are licensed by their colleges. The core mandate of the colleges is to make sure healthcare professionals are safe, ethical, and competent. They are therefore unable to deal effectively with inappropriate billing practices and other types of insurance fraud. This has created a gap in which fraud can and does thrive, to the detriment of the insurance industry as well as health care providers and motor vehicle accident claimants.

FSCO implemented the Health Service Provider (HSP) Licensing program to address this gap, by regulating the billing practices of those clinics which invoice insurers directly. If the benefit of the current regulatory approach

cannot clearly be articulated and quantified, a new approach is required to replace it. For FSRA to develop a more effective version of the FSCO licensing regime, legislation should include authority for the regulator to act in any areas affecting the costs of auto insurance, so as to broaden the scope of licensing beyond the billing rules currently within the mandate of a financial services regulator. As clinic regulation is a multi-stakeholder issue not unique to the auto insurance industry, we are also open to supporting alternative clinic regulation models developed through collaboration between the industry, FSRA and the MOHLTC.

4.2.2 Detailed Response

The current HSP regulation, as implemented and enforced by FSCO, partially fills an important gap in Ontario licensing and oversight. There is no oversight body in Ontario that regulates or licenses clinics, or any places of business providing health and rehabilitation services. There is also no requirement in Ontario that clinics be owned or operated by regulated health professionals, and so many clinics fall outside of the scope of health regulatory college supervision simply by being owned and operated by individuals with no license to practice any health care profession.

This gap, in which only those Ontario clinics which are owned and operated by regulated health professionals are subject to oversight and standards of practice enforcement by health regulatory colleges, creates risks for quality of care, as well as opening the door to fraud. It is essential that auto insurers be able to distinguish between invoices from legitimate places of business, and those who may be invoicing insurers fraudulently, in some cases without even the knowledge or consent of the health care provider named on the invoice. Systemic lack of confidence in the legitimacy of invoices for health care treatments risks undermining confidence in the auto insurance accident benefits system, and wastes insurer investigative resources while driving up premium costs for Ontario drivers. This is the risk that the HSP regulation was designed to mitigate.

There is significant evidence demonstrating that health claims billing fraud, including auto insurance billing fraud, is a major risk in Ontario due to the limited regulatory oversight of this sector. In support of the Ontario Auto Insurance Anti-Fraud Task Force, the FSCO HCAI Anti-Fraud Working Group ran a pilot project to explore a possible solution to health care professional identity theft. Six health regulatory colleges participated. This project, called the Professional Credential Tracker (PCT) Project, found that most health care professionals did not know how many clinics were using their credentials in the Health Claims for Auto Insurance (HCAI) system. In fact, the average participant found their college registration number being used in twice as many clinics as they had authorized. Based on the findings of this project, the Ontario Auto Insurance Anti-Fraud Task Force recommended in their final report in October 2012 the continuation of the PCT pilot project with the objective of gradually moving to full adoption by all regulated health practitioners. To date, this recommendation has not been implemented.

The findings of the FSCO Service Provider Licensing Program have also validated the need for regulatory oversight of the sector. FSCO's published examination results from 2017-2018 found a 34% compliance rate from on-site examinations and 63% from on-line reviews. Two of the most frequent findings of non-compliance included Ontario Claims Forms (OCFs) not signed by regulated healthcare professionals and/or patients (35% of on-site examinations), and invoices submitted in a name that does not correspond to the service provider's licence (16% of desk reviews).

The FSCO Service Provider Licensing program was intended to partially address the lack of clinic regulation in Ontario, for auto insurance only, by licensing clinics which bill insurers directly for treatment provided to motor vehicle accident claimants. There is, however, little evidence that this solution has been effective. The insurance

industry must be able to trust that the clinics submitting treatment plans and invoices for accident benefits claimants are legitimate and honest businesses, but the mandate of a financial services regulator limits the scope of such regulation to billing practices alone, excluding (for example) fraudulent assessments and certificates, or the ineffective treatments being provided to many injured auto insurance claimants as outlined in the Marshall report.

A regulatory framework providing oversight of health care facilities with regard to both quality of care and business practices is by definition outside of the scope of a financial services regulator such as FSRA or FSCO, even when the lack of such a framework is a major driver of auto insurance billing fraud. FSRA could however be a highly effective advocate for the industry by working with the MOHLTC and the Health Regulatory Colleges towards initiatives that would close the gap.

Furthermore, the concern about the lack of oversight of Ontario clinics is not unique to the auto insurance sector. The Ontario Clinic Regulation Project, run by a subset of the health regulatory colleges, found that 74% of their respondents were concerned about billing fraud in Ontario health care facilities. The majority of respondents were themselves health care professionals. With the formal conclusion of the Ontario Clinic Regulation Project in spring 2018, citing MOHLTC prioritization challenges, there is no longer any other stakeholder or regulatory body actively working to address this regulatory gap.

If the existing Health Service Provider Regulation cannot be found to have improved transparency and accuracy in facility billing practices, then an alternative solution must be put in place. It is encouraging that the stakeholder engagement section of this Priorities and Budget document commits to a close working relationship between FSRA, the Ministry of Finance (MOF), and other regulators. As the Clinic Regulation Project's 2016 submission to the MOHLTC clearly indicates, this is an issue that affects not just insurance fraud but all stakeholders of Ontario health and rehabilitation providers. CANATICS would support either the option for FSRA to develop a more effective version of the FSCO licensing regime, along with legislative changes to include authority for the regulator to act in any areas affecting the costs of auto insurance, or, to work with the MOHLTC to ensure an alternative program is implemented that would address the needs of the insurance industry.

Collaboration on clinic billing practice regulation between FSRA and the MOHLTC would have broad value to the auto insurance sector beyond decisions about how to administer a licensing regime. There are significant differences in how various regulatory stakeholders rule on billing practices, creating loopholes in which fraud can thrive. Regulators must present a united front, and not allow evasive or fraudulent payees to pit one regulator against another. Rationalization of health billing practices across sectors to promote honest and accurate disclosure of what services were provided, by whom and to whom, will benefit both the health services sector and all insurance sectors. CANATICS looks forward to exchanging relevant information with FSRA to support decision making around the effectiveness and benefits of the current model.

Finally, the Fraud Reduction Strategy section of the 2019-20 Priorities and Budget proposal asks "what FSRA and other regulators can do to support insurers (e.g., provision of data); and reviewing the role of information and technology in fraud reduction." This is also relevant in the context of HSP licensing. FSCO license data currently plays an important role in identifying relationships between clinics and other businesses for fraud detection purposes. Furthermore, such information sharing can and should be bidirectional. CANATICS may be valuable as a data provider to FSRA, for example identifying anomalies and discrepancies for FSRA use in audit management and information verification.

5 Other remarks

This document has focused on the specific priorities outlined in the FSRA 2019-20 Priorities and Budget proposal, but we would like to take this opportunity to discuss some additional potential anti-fraud strategies and measures, including some that have been successful in other industries and jurisdictions.

Beyond the safe harbour provisions recommended in the previous sections, it is worth noting that other jurisdictions including the United States have successfully implemented immunity laws to make it more feasible for insurers to fight fraud without risk of civil repercussions.[10] This approach ought to be further investigated to determine if the Ontario auto environment would also benefit.

As discussed previously, health claims fraud is not unique to auto insurance but is common among all payers for health services in Ontario. Many life and health insurers publish lists of clinics and health care providers that they will not reimburse, requiring their policyholders to find alternative providers. Unlike health insurers, however, auto insurers are not permitted to delist or deny specific providers. If this right were to extend to auto insurers, it could also include body shops and other services under appropriate conditions. Insurers often find that a tow truck has taken the vehicle to a suspicious body shop over the protests of the claimant, and that the body shop is unwilling to release it; insurers also require the means to rescue a vehicle that is being held by such a provider.

Finally, we would like to observe that Ontario auto fraud stakeholders include regulators and insurers from other provinces, as fraudsters can and do operate in multiple provinces. Insurance crime and in particular stolen vehicles often involve cross-province transfer, to hide trails of VIN numbers and other CRC-equivalent data. Thus, stakeholder engagement should not be limited to Ontario regulators only, and bidirectional data exchange with other jurisdictions as appropriate should also be considered.

[10] In the USA, all 50 states and the District of Columbia have enacted statutes with insurance fraud immunity clauses based on the model of the National Association of Insurance Commissioner's (NAIC's) or variations of it, specifically designed to allow insurers and others to share information related to insurance fraud detection and investigations. NAIC Model Act Section 7. Immunity from Liability, states:

A. There shall be no civil liability imposed on and no cause of action shall arise from a person's furnishing information concerning suspected, anticipated or completed fraudulent insurance acts if the information is provided to or received from:
(1) The commissioner or the commissioner's employees, agents or representatives;
(2) Federal, state or local law enforcement or regulatory officials or their employees, agents or representatives;
(3) A person involved in the prevention and detection of fraudulent insurance acts or that person's agents, employees or representatives; or
(4) The NAIC or its employees, agents or representatives.
B. Subsection A of this section shall not apply to statements made with actual malice. [Some statutes substitute "in good faith" rather than "actual malice.

6 Conclusion

In conclusion, we would like to reiterate the key recommendations outlined above:

- The industry requires a safe harbour regulation that clearly authorizes and facilitates data collection, pooling, processing and sharing when it is for the limited purposes of detecting, suppressing and preventing fraud, and the development and operation of a fraud intelligence data hub and fraud registry, to identify actual or suspected organized crime and perpetrators of fraud across the industry. FSRA should use its rule making power to make that regulation as part of Year 1 targets.
- New enforcement mechanisms for supplier noncompliance are needed, both for health care facilities as well as other suppliers such as towing services, body shops and vehicle rentals, at a variety of levels to encompass fraudulent conducts that may not meet the threshold for criminal prosecution.
- Clear and enforceable direction from the regulator is needed as to acceptable submission guidelines for Ontario Claim Forms and other invoices, including both accuracy and completeness, and empowering insurers to reject appraisals, assessments, and invoices that do not fully meet the criteria.
- The industry requires an escalation mechanism to address suppliers which demonstrate a pattern of repeated misrepresentation on claim forms, despite warnings and other escalation.
- New chargeable offences are needed for those that deliberately and repeatedly misrepresent their goods and services to insurers for the purposes of inflating claim costs.
- The Ontario Claim Forms must be redesigned to more effectively capture the data needed to identify fraudulent claims, structured to include the kinds of data relationships and unique identifiers necessary to use this dataset in business intelligence and analytics solutions.
- The HCAI Guideline and Professional Services Guideline should be enhanced to make it much clearer what billing and related behaviours are acceptable, and what cross the line into fraud, with clear escalation and enforcement mechanisms for compliance violations.
- The HCAI data model and access rules must be restructured to meet the insurers' needs for anti-fraud data analysis.
- HCAI must include more validation and edit checks to ensure the accuracy of data entered into the system, and to clearly identify duplicate claimants, health care providers, clinics, and claim forms.
- The most effective solution to the problem of inaccurate and duplicate health care provider records in the HCAI database would be to automatically validate HCAI provider registration numbers against health regulatory college records.
- The scope of HCAI should be expanded to include as many of the Ontario Claim Forms submitted by health care facilities as possible, with appropriate consent language to facilitate use of the data in anti-fraud solutions.
- The scope of HCAI should be expanded to include more Accident Benefits payees, particularly including providers of attendant care services.

- FSRA could provide assistance to the industry in sharing relevant data bilaterally with other groups by working with the relevant ministries, particularly the MTO and MOHLTC.
- FSRA should explore empowering individual auto insurers to refuse work from specific suppliers and service providers, requiring their policyholders to find alternative vendors; this approach is already used by life and health insurers.
- CANATICS is supportive of the FSRA aim to evaluate the effectiveness of the current Health Service Provider Licensing model, and open to new approaches, but does not support eliminating the current model without a clear alternative strategy to address clinic billing fraud.
- FSRA could take a look at implementing the recommendations made by the Ontario Automobile Insurance Anti-Fraud Task Force for improved public communications about insurance fraud and public awareness of FSRA and industry's anti-fraud initiatives.