

October 7, 2024

Financial Services Regulatory Authority  
25 Sheppard Avenue West, Suite 100  
Toronto, ON  
M2N 6S6

Dear

**Re: Consultation on Proposed Fraud Reporting Service Rule and Guidance**

The Ontario Psychological Association (OPA) is pleased to provide feedback on FSRA’s proposed Fraud Reporting Service Rule and Guidance.

The OPA is the professional organization representing psychologists in Ontario. On behalf of the over 2800 members, the OPA leads initiatives to promote the mental health and well-being of Ontarians, inspire excellence in the profession of psychology through research, education, clinical treatment, rehabilitation, and advocacy. The OPA advocates for a healthcare system where psychological services are accessible to all Ontarians, where psychologists can practice to their full potential, and the value of their services is recognized. The OPA’s Planning and Policy Development Committee includes an Auto Insurance Subcommittee, composed of psychologists and psychological associates who work with Ontarians involved in motor vehicle accidents and are affected by various aspects of auto insurance.

At the outset, we commend FSRA’s efforts to strengthen the regulatory framework around fraud prevention and reporting. We fully support the development of the Fraud Reporting Service Rule (FRS Rule) and its objectives, which are:

* Quantifying the prevalence of automobile insurance fraud in Ontario
* Establishing a baseline for fraud detection
* Identifying fraud trends within the automobile insurance industry

We understand the FRS aims to enhance the use of data in the auto insurance industry’s fraud management activities by authorizing and enabling insurers to report fraud incidents. That reporting obligation is important. We believe that reducing or eliminating fraud in the automobile insurance sector will be impossible without insurers providing accurate data on fraudulent activities related to insurance policies and claims.

There is also, however, an urgent need for a process that allows health service providers (HSPs) and claimants to access HCAI data so that they are also able to report instances of fraudulent behaviour. This will ensure that there is a more robust and comprehensive data collection process with which to identify fraud.

As part of the consultation process, FSRA has issued a Guidance outlining its interpretation of the requirements under the FRS and the statutory authority under which it is proposed (i.e., section 101.3 of the Insurance Act). The Guidance supports outcomes aligned with the following objectives:

* Deterring deceptive or fraudulent conduct within regulated sectors
* Promoting transparency and disclosure within regulated sectors
* Contributing to public confidence in the automobile insurance sector
* Monitoring and evaluating developments and trends in the automobile insurance sector
* Promoting high standards of business conduct
* Protecting the rights and interests of consumers

The OPA fully supports these objectives and their underlying premise: to reduce consumer harm, including the unnecessary costs consumers bear due to automobile insurance fraud.

Proposed Rule 2024 – 003 defines a “fraud event” and prescribes the information insurers must provide to FSRA under section 101.3(1) of the Insurance Act, along with additional reporting requirements. The key element of the Rule is the definition of a “fraud event”:

“Fraud event” refers to a deceptive act or omission, or a series of such acts or omissions, intentionally committed by a person(s) to gain an advantage, financial gain, or benefits beyond entitlement in relation to any policy, claim, provision of goods or services, or other occurrence related to automobile insurance. This includes:

1. Obtaining an automobile insurance policy through fraudulent means, including underwriting fraud;
2. Obtaining benefits under an insurance contract through fraudulent claims;
3. Providing goods or services to a beneficiary under an insurance contract through fraudulent means or manner;
4. Fraudulent activity in the selling or distribution of insurance products; and
5. Fraudulent activity committed by internal employees of an insurer.

Clearly, a definition of a “fraud event” is necessary to fully implement the Rule and the FRS. Like most fraud definitions, the proposed Rule identifies the following elements:

* A dishonest act intentionally deceiving another person and depriving them of money, property, or legal rights
* Dishonesty resulting in gaining a benefit or causing a loss

While we support the Proposed Rule, we also believe that FSRA must align the fraud event definition with a separate process that will provide the opportunity for claimants and health service providers to access Health Claims for Auto Insurance (HCAI) data for the purpose of preventing, detecting and reporting suspected instances of fraud.

Access should include relevant HCAI data pertaining to:

* historical claims data
* treatment plans, and
* other pertinent information that can be used to detect patterns of potential fraud.

This will result in an enhanced capacity for fraud detection and prevention, and reporting, fostering a more transparent and accountable system.

FSRA’s recently released consultation paper entitled “Health Claims for Auto Insurance (HCAI) System Review includes various stakeholder recommendations for improving HCAI and, in particular, to make the claims process more efficient. We note with approval this recommendation for system efficiency:

* Allowing consumers to monitor their claims through HCAI may help identify fraudulent

Activity/behaviour (Page 10)

* Create a pathway in HCAI for HSPs/assessors who are performing assessments for

independent examination companies to monitor what is being billed in their name

on HCAI. (Page 21)

While these additions to the HCAI system would assist immeasurably in the ongoing effort to control fraud in the auto insurance system, access to HCAI should be expanded to all HSPs so that they can monitor what is being billed in their names. The purpose of granting access to HCAI data to HSPs as well as to consumers is to:

* allow them to monitor how their professional identities are being used in claim submissions. How else can they proactively detect if their identity is being misused to submit fraudulent claims or identify unauthorized use of their credentials or any discrepancies in treatment records.
* add another level of scrutiny to the claims process and extending FSRA’s oversight capabilities
* support FSRA’s objective of collaborating with HSPs and claimants in ensuring a fair, efficient and transparent system of processing
* reduce fraud by providing claimants with the ability to verify that the services reflect the care they received, thereby increasing consumer protection in the auto insurance sector
* align with other data verification systems that, for example, allow HSPs and consumers to access credit reports to check for inaccuracies or fraud.”

 Quite apart from granting access to HCAI data for the purpose of allowing FSRA to better regulate fraud, we must never lose sight of the fact that claims involve information about a person’s injuries, how they are being treated and how benefits they have paid for under a contract of insurance are being allocated in order to promote their recovery. The claims process, including the detection of fraudulent events, should allow claimants to become more informed participants in their health care treatment. Continuing to allow access to insurers alone frustrates that objective.

An important element of extending access to HCAI data to HSPs and claimants is to provide education regarding HCAI data and how to use it to detect fraud. That responsibility should be shared between consumers, insurers, HSPs and FSRA.

Moreover, FSRA should also establish clear guidelines regarding how fraud events should be reported and should provide HSPs and claimants with the necessary tools to report suspected fraud based on HCAI data analysis. FSRA should consider developing a secure, reporting mechanism for fraud that would protect the informant of any reprisals from the individual, insurer, etc. that is the subject of the reporting.

An important consideration for creating a fair and effective fraud detection system necessarily involves ensuring a proper balance between encouraging the disclosure of suspicious behavior and guaranteeing that valid claims aren’t unjustly targeted. FSRA should consider how that balance can be achieved:

* Is suspicion of fraudulent activity enough, for example discrepancies in billing? This would encourage reporting at an early stage before the claims process is undermined and negatively affects treatment. Conversely, suspicion alone may divert time and resources away from treatment in cases where ultimately it is found that no fraud has occurred. Moreover, innocent parties need to be protected from wrongful accusations.
* Should concrete and verifiable evidence of wrongdoing be required before a report is made? Moreover, since the reporting is based on fraud, should the individual have to also prove that the conduct was intentional? While evidence of misconduct will ensure that legitimate claims will not be targeted, claimants or HSPs might hesitate to report valid cases of misconduct for fear that they do not have sufficient evidence or proof of intentional misconduct.

A balanced approach is more likely to result in reporting of legitimate concerns about conduct that meets the proposed definition of “fraud event”.

Thank you for the opportunity to provide our recommendations. We look forward to continuing to work with you on this and other issues.

Respectfully submitted,

Ontario Psychological Association